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Senate Hearings

Before the Committee on Appropriations

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

Fiscal Year 2024

118*th* CONGRESS, FIRST SESSION

H.R. 5894/S. 2624

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

Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations, 2024 (H.R. 5894/S. 2624)

S. HRG. 118–522

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

HEARINGS

BEFORE A

SUBCOMMITTEE OF THE

COMMITTEE ON APPROPRIATIONS

UNITED STATES SENATE

ONE HUNDRED EIGHTEENTH CONGRESS

FIRST SESSION

ON

H.R. 5894/S. 2624

AN ACT MAKING APPROPRIATIONS FOR THE DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION, AND RELATED AGENCIES FOR THE FISCAL YEAR ENDING SEPTEMBER 30, 2024, AND FOR OTHER PURPOSES

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

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

WEDNESDAY, MARCH 22, 2023

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

The subcommittee met at 2:36 p.m., in room SD–138, Dirksen Senate Office Building, Hon. Tammy Baldwin (chairwomen) presiding.

Present: Senators Baldwin, Murray, Reed, Shaheen, Merkley, Manchin, Capito, Moran, Hyde-Smith, Britt, and Collins.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF THE SECRETARY

STATEMENT OF HON. XAVIER BECERRA, SECRETARY

OPENING STATEMENT OF SENATOR TAMMY BALDWIN

Senator BALDWIN. Good afternoon. I want to welcome everyone to the Senate Appropriations Subcommittee on Labor, Health, and Human Services, Education, and Related Agencies.

It is our first hearing on the Biden Administration's fiscal year 2024 budget request. And it is an honor to serve as the Chair of this subcommittee and follow in the footsteps of Chair Murray's incredible leadership over the past 8 years. I am also looking forward to working together with Ranking Member Capito, as we both take on new roles on this subcommittee.

The Labor HHS (Health and Human Services) bill includes important investments that touch the lives of every American. We won't agree on everything, but I am committed to working together to find common ground, and make progress for Wisconsinites, West Virginians, and communities across this country. I look forward to the hard work of finding compromise, and marking up a bipartisan Labor HHS bill later this year.

Today, I am happy to welcome Secretary Becerra for our hearing on the Administration's fiscal year 2024 budget request, for the Department of Health and Human Services. These hearings provide an important opportunity to assess our country's needs for the coming year. It is critical that we strengthen our non-defense investments that support a stronger economy, keep our communities healthy, and safe, and strengthen and expand our workforce.

Secretary Becerra, this budget highlights the need for continued investments in substance use, and mental health services, access to childcare, biomedical research, public health, home energy assistance, and so much more. These are bipartisan priorities, and let me be clear, there is no way to make progress on these fronts without steady increases in non-defense priorities, like we have worked together to provide in recent years regardless of which party controlled the Congress.

In fiscal year 2023, this subcommittee provided significant funding for 988 behavioral health crisis programs, childcare, maternal health, substance use treatment and prevention, and biomedical research. We also provided over $600 million to end the HIV/AIDS epidemic, and over $300 million in targeted investments to combat the maternal mortality crisis.

Secretary Becerra, I am very pleased to see that this year's budget request calls for additional investments to improve access to, and integrate mental and behavioral healthcare services, to bolster behavioral healthcare, workforce development programs, and mental health crisis services, to ensure that we are better prepared for and able to rapidly respond to emerging biological threats by investing in vaccine preparedness, and medical countermeasures development, and enhancing domestic and global disease surveillance.

This budget prioritizes and puts additional investments in strengthening the core public health infrastructure and workforce nationwide to improve readiness for the next public health crisis. It supports biomedical research and innovation to better develop diagnostics, improve treatments and precision care for patients. It expands the Title X Family Planning Program, which helps so many patients, particularly women of color, get birth control, cancer screenings, STD (Sexually Transmitted Diseases) screenings, and other essential healthcare, and it reduces maternal mortality and morbidity.

Alarming new data from the National Center for Health Statistics last week, revealed that our country's maternal mortality rate climbed dramatically during the pandemic. This marks the third year in a row that the rate of Americans dying of medical conditions caused by, or aggravated by pregnancy, has increased. The data show that 1,205 women died in 2021, up from 861 in the year 2020, an increase of 40 percent. This spike is significant for all racial and ethnic groups, but the trend in disparity continues. The mortality rate for Black women is roughly 2.6 times higher than the rate for White women.

This increase in deaths is devastating and unacceptable, and demonstrates how the Department has chronically and acutely fallen short of its mission to the public.

Secretary Becerra, HHS must do better. And I expect to hear from you about how this budget is going to help us accomplish that. I also want to learn about the proposed increases for advancing health equity and public health programs. As we face the aftermath of COVID, and how it has exacerbated our Nation's healthcare challenges, we can't lose sight of the lessons learned over the last 3 years, we must maintain the preparedness, and biodefense capabilities that we built during the pandemic. We must strengthen our health workforce, and public health system, and in-

vest in our domestic manufacturing and research capacity to be prepared when the next public health emergency strikes.

I also want to hear about the administration, how you are working to address our Nation's mental health and substance use disorder crises, which have gotten also, so much worse during the pandemic.

In my State of Wisconsin, there were over 1,427 opioid-related deaths in 2021, a 16 percent increase over 2020, and a 70 percent increase over the number of deaths in 2018. I know my colleagues are seeing similar grim statistics in their States.

Of particular interest, I will want to know what the administration is doing to curb the tragic increase in overdoses and poisonings, due to fentanyl. This drug is wreaking havoc across the country, and we must partner to take an all-of-government approach to prevent it from coming into our communities, we must reduce use, and misuse, and overturn the overdoses, with drugs like naloxone.

Finally, Mr. Secretary, the two of us have talked about what HHS is doing to ensure that migrant children entering the Department's care receive the services they need, and are placed in safe and appropriate homes and protected from exploitation. These kids are fleeing incredibly dangerous situations in their home countries, risking their lives because their situation is so dire, and seeking relief in the United States.

Health and Human Services has a vital role to play to make sure these kids have the opportunity to learn and grow like all other children, and that the families who care for them have the support they need. We have seen record increases in the number of unaccompanied kids during each of the last three administrations. Making sure these kids are safe and cared for is not a partisan issue, and I look forward to more discussions about what this budget does to ensure that.

I look forward to your testimony, and appreciate your being here today. In a quick moment I will turn it over to Ranking Member Capito for her open opening remarks.

Following Senator Capito's opening statement, we will hear from you, Secretary Becerra. And after that all Senators will each have 5 minutes for their questionings.

Senator Capito.

STATEMENT OF SENATOR SHELLEY MOORE CAPITO

Senator CAPITO. Thank you, Chair Baldwin. It is great to have our first kickoff hearing. Appreciate your leadership. We have worked together in the past. There is no reason we can't do that here on the Labor, HHS Subcommittee. And so we have both been on this subcommittee for several years, and I know we have a great vision.

Speaking of new roles, I would like to take a moment to recognize Senators Murray and Collins, who are the new Chair and Ranking Member of the Full Committee—and Vice Chair, Senator Collins is the Vice Chair. They are committed to returning to regular order to write and pass appropriations bills in a bipartisan and timely manner. I wholeheartedly support this approach, and this budget hearing is a necessary first step for the process.

Secretary Becerra, we served in the House together. It is very nice to see you. And thank you for your communications with me. I appreciate the give and take. This is an important opportunity for us to hear about the HHS budget proposal, and better understanding the priorities.

First, the success of our process depends on finding common ground, as our Chair just enumerated. Unfortunately, this budget appears to be another bloated, partisan request that simply spends too much money, after the record level of spending that we have seen over the past few years.

Simply put, the budget should not be enacted. I don't think it will be. We can't afford to ramp up base discretionary spending by a whopping 13 percent, at a time when we should be looking at common goals to improve the health of Americans across the Nation, the budget further wades into polarizing issues such as repealing the Hyde Amendment, proposing additional flawed climate change activities, doubles funding for controversial gun violence research, and increases funding for family planning by almost 80 percent.

But I am really disappointed, not about what was included, but what wasn't included. Programs and activity that typically enjoy bipartisan support receive little or no attention in this budget, and are flat-funded. For instance, there are no new resources specifically for Alzheimer's research at NIH (National Institutes of Health), the CDC's (Centers for Disease Control and Prevention) Alzheimer's activities; nor the Administration for Community Living Alzheimer's Disease Program.

I would note in the audience today we have a lot of Alzheimer's advocates, of which I am, they are a great champion, and one of their little signs said, "More time—I wish I had had more time with both of my parents as they suffered with this horrible disease."

Similarly, the budget stalls funding for the Children's Hospital's Graduate Medical Education Program, and Diabetes Prevention; we have a huge problem with diabetes throughout the country, particularly in our State. And I was surprised to see that the budget, yet again, requests mandatory funding for pandemic preparedness and response, as our Nation, thankfully, moves past the COVID–19 public health emergency, Congress will now need to better understand how HHS is ramping up—or ramping down programs that received emergency supplemental and mandatory resources to avoid funding cliffs in the future.

Not only that, but this subcommittee also has a responsibility to provide oversight, and ensure accountability of the Federal dollars that have already been spent. A new mandatory program is, basically, a non-starter.

That being said, there are a few notable areas of the budget that address important national priorities that will have to be explored in more detail. One of these is a focus on biomedical research, which the Chairwoman talked about, that has long enjoyed bipartisan support.

The budget devotes significant resources for the third year for the Advanced Research Projects Agency for Health, better known as ARPA–H. Additionally, the budget proposes additional resources

for the Cancer Moonshot, a cross-cutting initiative that touches several HHS agencies, including CDC, CMS (Centers for Medicare and Medicaid Services), and the National Cancer Institute at NIH.

Far too many of us have been touched by cancer. West Virginia, my home State, is especially hard hit, racking above the national average in both new cancer diagnoses and deaths.

Substance abuse challenges continue to face the Nation, and I don't think have received enough mention in this budget, while the budget repeats many of the unattainable funding levels for substance abuse programs from the previous 2023, the White House Budget's overview rarely mentions fentanyl or opioids.

My home State has been in the crosshairs of this opioid and addiction crisis for several years now. We continue to lead the country in overdose deaths per capita. Since fiscal year 2018, the subcommittee has increased resources towards opioid prevention, and treatment programs by more than $4 billion. I know we need to shape the programs we have got, so I want to know how these funds and programs are moving the needle in the addiction crisis.

Without a doubt, our jobs will be challenging. And your job is very challenging, given the economic and financial constraints that we find ourselves in. It is my hope we can come together in a responsible way to find areas of efficiencies, and focus in these areas of Government.

And thank you, again, for being here.

Senator BALDWIN. Now, we turn to your testimony, Secretary Becerra.

SUMMARY STATEMENT OF HON. XAVIER BECERRA

Secretary BECERRA. Chairwoman Baldwin, and Ranking Member Capito, thank you for the invitation to chat with you about the budget.

HEALTH AND HUMAN SERVICES ACCOMPLISHMENTS

A lot has happened in the year since I last spoke before this committee about budgets, 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 now carry insurance to cover their healthcare, another historic high.

The President's new lower-cost prescription drug law has capped insulin at $35 per month, and made preventative vaccines, like the flu, COVID, and 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 vaccine—vaccination program in U.S. history, achieving nearly 700 million shots in the arms of Americans during the COVID pandemic, all without charge.

FISCAL YEAR 2024 HEALTH AND HUMAN SERVICES BUDGET REQUEST

The fiscal year 2024 budget proposes $144 billion in discretionary funding, and $1.7 trillion in mandatory funding for HHS. It posi-

tions us to tackle the urgent challenges we face, including a growing behavioral health crisis, and future public health threats.

It also funds operations, a 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, on the other hand, lets you get mental healthcare the minute you walk through the door of your family physician's office. Illness care, well, it forces hard-working Americans to deplete their life savings to get the long-term care that they need. Wellness care, it 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. We invested more than $30 billion to prepare us for the next COVID or public health crisis, including a billion dollars to replenish the Nation's Strategic National Stockpile.

On behavioral health, too many of our loved ones are dying from suicide or 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 six 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 that will make healthcare more affordable for millions of Americans.

It will 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 also protects and strengthens it for the next generation. We also take care of our family members in this budget, investing $600 billion in childcare and preschool programs, and $150 billion to strengthen Medicaid, home and community-based services.

This budget funds the Cancer Moonshot, and ARPA–H, it invests in Title X Family Planning programs, essential to so many families. It delivers on 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 Health Care Fraud and Abuse Detection and Enforcement work.

And the President's budget honors our responsibilities to Indian Country, with more than $2 billion in new resources in 2024. Last year, for the first time, you gave the Indian Health Service Advanced Appropriations, 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. And I thank you for letting me come before you today.

[The statement follows:]

PREPARED STATEMENT OF XAVIER BECERRA

Chair Baldwin, Ranking Member Capito, and Members of the Subcommittee, thank you for the opportunity to discuss the President's Fiscal Year (FY) 2024 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.

It is my great pleasure to serve as the head of the Department of Health and Human Services—a department full of dedicated civil servants who work tirelessly to meet our mission of enhancing the health and well-being of the American people. We know this goal is also shared by all of you, and we are excited about working with you to fund key initiatives that will enable us to continue to meet that mission.

The FY 2024 budget proposes $144 billion dollars in discretionary funding and $1.7 trillion dollars in mandatory funding to continue the work of the Department and make major investments in several critical areas. Our country faces numerous healthcare challenges—and HHS is at the center of addressing many of these issues—including the need to transform behavioral healthcare; prepare for future public health threats; support unaccompanied children and refugees; expand access to healthcare especially in rural America; address the needs of those most at risk; improve the health and well-being of our children, families, and seniors; grow and retain the health workforce; and advance and sustain medical research capabilities. We also continue to focus on additional priorities like protecting Medicare, expanding insurance coverage, decreasing drug costs, meeting the health needs of Indian Country, and making critical investments in improving our regulation of food and drugs.

TRANSFORMING BEHAVIORAL HEALTH CARE

In response to the current behavioral health crisis, HHS makes substantial investments in services to provide more Americans with access to the care they need when they need it. The 9–8–8 National Suicide Prevention Lifeline operates 24/7 to provide access to trained counselors to people in crisis. In the FY 2024 budget, the Substance Abuse and Mental Health Services Administration (SAMHSA) will dedicate an additional $334 million to the 9–8–8 program to meet an expected volume of 9 million contacts. Investing in the crisis response continuum more broadly is critical to ensuring that the system is responsive at any time and in any place. The budget builds on previous investments to provide $100 million for mobile crisis response to expand partnerships with 9–8–8 local crisis centers, community providers, 9–1–1 centers, and first responders to promote health-first responses to mental health, suicidal, and substance use crisis events.

One in 4 adults in the United States had a mental illness and 46 million Americans had a substance use disorder in the past year.[1] To address these challenges, the budget continues to invest in the nation's mental health infrastructure and to further integrate behavioral healthcare into healthcare, social services, and early childhood systems. The FY 2024 budget proposes to increase the Community Mental Health Services Block Grant by $645 million and proposes to increase the Substance Use Prevention, Treatment, and Recovery Services Block Grant by $700 million. The budget converts the Certified Community Behavioral Health Clinics demonstration to a permanent program to further ensure access to comprehensive behavioral healthcare for all who need it.

The budget invests in the behavioral health workforce, providing an increase of $190 million at the Health Resources and Services Administration (HRSA) for workforce development and an additional $17 million at SAMHSA for minority fellowships. Additionally, the FY 2024 budget expands Medicare coverage of, and payment

[1] "Facts about Suicide", Centers for Disease Control and Prevention.

for, additional behavioral health professionals. The budget supports more than 27,000 mental health and substance use disorder trainees and providers.

To develop new approaches to addressing mental health and substance use disorders, the FY 2024 budget includes an additional $200 million for the National Institutes of Health (NIH) to prioritize innovative mental health research and treatment, with the agency allocating a portion of these resources to launch a new precision psychiatric initiative. NIH will also continue to invest over $1.8 billion in research on opioid misuse, addiction, and pain disorders, including the Helping to End Addiction Long-term (HEAL) initiative. HEAL aims to develop innovative treatments for opioid addiction and chronic pain and associated health disparities. The budget also includes proposals to modernize and expand Medicare's mental health benefits and improve behavioral health for the private insurance market, with an emphasis on improving access, promoting equity, and fostering innovation.

PREPARING FOR FUTURE PUBLIC HEALTH THREATS

On February 11th, HHS renewed the COVID–19 Public Health Emergency (PHE) for what we expect will be the final time. The nation has made tremendous progress: the Administration effectively implemented the largest adult vaccination program in U.S. history, with nearly 270 million Americans receiving at least one shot of the COVID–19 vaccine. Second, we made available to the American public 1.16 billion COVID tests at no cost. And we were able to provide over 23 million therapeutic courses of treatment to Americans. According to the Commonwealth Fund, 2 years of COVID vaccinations saved over 3 million lives, in addition to preventing more than 18.5 million hospitalizations.

The FY 2024 budget prioritizes preparedness for the next health crisis. The budget includes $20 billion in mandatory funding, available over 5 years, across the Administration for Strategic Preparedness and Response (ASPR), Centers for Disease Control and Prevention (CDC), Food and Drug Administration (FDA) and NIH to support the President's plan to transform the Nation's capabilities to prepare for, and respond rapidly and effectively to, future pandemics and other biological threats. This includes investments in enhancing early detection and warning systems, advancing, and securing safe and effective supplies and medical countermeasures, and strengthening public health systems and core capabilities. For ASPR, the budget includes $1 billion in discretionary funding for the Biomedical Advanced Research and Development Authority (BARDA) to develop innovative medical countermeasures, $995 million for the Strategic National Stockpile, and $400 million to bolster the medical supply chain and create medical countermeasures that address key preparedness gaps. The FY 2024 budget also includes $10.5 billion in discretionary funding for the CDC to protect health, safety, and security at home and abroad. Additional strategic investments, including at the FDA and the NIH, are proposed to bolster our national preparedness posture as we ready ourselves for the next public health threat—no matter its origin. These funding proposals are paired with a suite of legislative proposals that would provide HHS with authorities to enable HHS to respond to future threats nimbly and effectively.

SUPPORTING UNACCOMPANIED CHILDREN AND REFUGEES

Children presenting at the border without a parent or guardian, and refugees arriving in our nation, must be cared for in a safe and humanitarian manner. At HHS, we will continue to do our part to protect the safety and wellbeing of unaccompanied children by providing them appropriate child-centered care while they are in our custody; placing them in the custody of parents, relatives, and other appropriate sponsors after thorough vetting; and providing post-release services including safety and wellbeing calls. HHS already provides post-release services to more than 40 percent of children released from our care, nearly double the percentage receiving services when the Biden Administration took office and is on track to provide services to nearly 60 percent of children by the end of this fiscal year, and all children within the next two years.

The FY 2024 budget provides $5.5 billion for unaccompanied children and $1.7 billion for refugees and other new arrivals eligible for benefits. In addition, to address the inherent uncertainties in budgeting for these populations, the budget includes a discretionary contingency fund, which would provide additional resources if either population exceeded certain levels, and is estimated to provide $2.8 billion in FY 2024. The fund expands on the unaccompanied children contingency fund that Congress enacted in FY 2023. These services and resources are critical to our country, and I would like to thank Congress for your continued dedicated support.

PROTECTING THE HEALTH OF ALL AMERICANS

The Administration aims to reduce maternal mortality and morbidity, through proposals such as the "Birthing-Friendly" hospital designation which drives improvements in maternal health outcomes. The budget includes $1.9 billion for HRSA Maternal and Child Health programs, an increase of $205 million, directing $276 million toward reducing maternal mortality and morbidity and $185 million to the Healthy Start program to reduce racial disparities in maternal and infant health outcomes. The budget also provides $30 million for NIH to continue the Implementing a Maternal health and PRegnancy Outcomes Vision for Everyone (IMPROVE) initiative to support research focused on interventions for preventable maternal mortality and morbidity and associated risk factors that contribute to health disparities in maternal care. The budget further includes $3 million for NIH's continued research on the effects of COVID–19 on individuals during pregnancy, lactation, and the postpartum period. The budget also requires states to provide 12 months of postpartum coverage through Medicaid and the Children's Health Insurance Program.

HHS is also committed to protecting and strengthening access to reproductive healthcare. The budget provides $512 million to the Title X family planning program to address increased need for family planning services for approximately 4.5 million individuals, with 90 percent having family incomes at or below 250 percent of the Federal poverty level. 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 also includes an additional $63 million to strengthen access to healthcare in rural communities, including a $20 million increase in funding for opioids response and $30 million for new initiatives to support rural hospital sustainability. There is a $80 million increase in discretionary funding for Health Centers, which provide healthcare services to underserved populations across the country, along with substantial increases on the mandatory side. The budget proposes a pathway to doubling the program's funding with a critical three-year down payment on this goal.

EXPANDING AND RETAINING THE HEALTH WORKFORCE

The health workforce plays a vital role in responding to public health needs. As the demand for healthcare workers increases, HHS remains committed to strengthening, expanding, and retaining the workforce. The FY 2024 budget provides $2.7 billion for HRSA workforce programs, including $947 million in mandatory resources, to expand workforce capacity across the country. The discretionary budget includes $28 million for a new program to support innovative approaches to address healthcare workforce shortages and strengthen retention efforts. The budget also provides $25 million for a program to support the adoption of workplace wellness in healthcare facilities including hospitals, rural health clinics, community health centers, and medical professional associations. The budget includes $106 million within CDC to support public health training and fellowship programs to strengthen the existing workforce as well as support a pipeline of personnel ready and able to address public health threats. In addition to these investments, HHS prioritizes diversifying the healthcare workforce to better serve all communities and build a more equitable healthcare system.

IMPROVING THE WELL-BEING OF CHILDREN, FAMILIES, SENIORS, AND PEOPLE WITH DISABILITIES

Early childhood programs have a return of up to $9 for every $1 spent due to the positive long-term health, educational, and social impacts on vulnerable children. The budget includes $13 billion for Head Start, an increase of $1.1 billion, to provide comprehensive early learning and development services to roughly 760,156 slots for eligible children and pregnant women. Within this total, $440 million is included for a cost-of-living adjustment for Head Start workers, and $575 million is included to further improve compensation. Collectively, these investments ensure that families have access to high-quality services by retaining and supporting the workforce. In addition, the budget includes a legislative proposal to expand tribal, migrant, and seasonal Head Start eligibility.

The budget likewise invests in child care, critical to both working parents, and particularly mothers, and children. For the discretionary Child Care and Development Block Grant, the budget provides for an investment of $9 billion, an increase of nearly $1 billion over the FY 2023 enacted funding level.

The President's Budget also includes a new initiative that expands access to high-quality early care and education. The budget includes a mandatory proposal to invest $400 billion over 10 years in high-quality child care, and $200 billion over 10 years in universal preschool. This funds states to expand access to high-quality child care to more than 16 million young children and dramatically expand access to and increase the quality of preschool so that all of the approximately four million 4-year-old children in the United States have access to high-quality preschool, while also charting a path to expand free school to 3-year-olds. Implementing the child care and universal preschool proposals concurrently saves $24.3 billion over 10 years and is reflected in the estimated child care costs.

The COVID–19 pandemic revealed that millions of children, families, seniors, and people with disabilities are living with food insecurity. The increased need for nutrition programs has not abated, and the FY 2024 budget supports the Administration's National Strategy on Hunger, Nutrition, and Health by including $137 million across HHS to reduce hunger, food insecurity, and malnutrition. Within the $137 million, the budget includes $12 million at the Administration for Community Living (ACL) for nutrition services for older adults and people with disabilities and $72 million to expand CDC's State Physical Activity and Nutrition program, which implements evidence-based strategies to reduce chronic disease. In addition, the budget proposes to increase funding at NIH for nutrition research. Further, within ACL, the budget includes $1.3 billion for Nutrition Programs for older adults, to provide healthy meals served in both home-delivery and congregate settings. These programs enable seniors to live in their homes independently and help them stay engaged with critical community-based supports.

HHS is likewise committed to ensuring that seniors and people with disabilities have the essential resources and services they need. In addition to providing nutrition services in older adults and people with disabilities through ACL as previously mentioned, the budget also expands Medicare coverage for nutrition and obesity counseling services, and includes a new pilot project on medically tailored meals. The FY 2024 budget also makes key investments in the Elder Justice Adult Protective Services program. As noted above, the budget also includes a $150 billion mandatory investment over 10 years in improving and strengthening Medicaid home and community-based services and provisions to improve safety and quality in our nation's nursing homes.

The budget extends the solvency of the Medicare Hospital Insurance Trust Fund by at least 25 years without cutting benefits. The budget builds on efforts in the Inflation Reduction Act to lower prescription drug prices. It also invests $8 billion to enhance Medicare benefits, such as preventing diabetes, expanding access to behavioral health services and community health workers, improving the quality and safety of long-term care services, expanding coverage for nutrition and obesity counseling, eliminating hepatitis C, and advancing equity. Additionally, the budget aligns income and asset determination processes for Medicare low-income assistance programs, easing administrative burdens for states and removing enrollment barriers for individuals.

ADVANCING SCIENCE TO IMPROVE HEALTH

As President Biden has said, "cancer does not care if you're a Republican or a Democrat," which is why the President and First Lady reignited the Cancer Moonshot 1 year ago. HHS is committed to leading the public sector in pursuit of cutting the cancer death rate by 50 percent over the next 25 years and supporting families, their caregivers and family members, living with and surviving cancer.

NIH will continue to build on the Cancer Moonshot's momentum by supporting projects that will deliver important insights into preventing, detecting, and treating cancer. The FY 2024 budget includes $716 million in discretionary resources for dedicated Cancer Moonshot activities at NIH. In addition to the FY 2024 resources, the budget also proposes to reauthorize the 21st Century Cures Act Cancer Moonshot through 2026 and provide $2.9 billion in mandatory funding in 2025 and 2026, $1.45 billion each year. To support the goals of the Cancer Moonshot, the FY 2024 budget includes an additional $183 million for a total of $839 million to support cancer prevention and control programs across CDC, including screening programs, tobacco prevention, Human Papillomavirus (HPV) prevention and analysis of cancer clusters, and laboratory and environmental health activities. An additional investment of $20 million for HRSA is also provided, to expand partnerships between federally funded health centers and NCI-Designated Cancer Centers to facilitate access to lifesaving cancer screening and early detection services for medically underserved populations. The budget also includes $108 million within IHS to address specialized cancer care needs in tribal communities. The budget also proposes to create a

new Cancer Care Quality Reporting Program for all Medicare providers furnishing cancer care services. This unified program would enable the Centers for Medicare & Medicaid Services (CMS) to assess and compare cancer care delivered through multiple provider types, drive improvements in the quality of cancer care, and standardize data collection to identify and address potential inequities in care.

The budget will prioritize innovative mental health research and treatment and the NIH climate change initiative. NIH will continue to invest funds to address the opioid crisis, end HIV, and advance other research areas, such as improving health disparities and inequities research, as well as continuing the agency's progress towards a universal influenza vaccine. NIH's budget also continues support for the All of Us and Brain Research Through Advancing Innovative Neurotechnologies (BRAIN) initiatives, both started by the 21st Century Cures Act.

The budget also invests in high-impact research advances that drive innovation through the Advanced Research Projects Agency for Health (ARPA–H). As an independent research entity, ARPA–H will be able to accelerate health breakthroughs with the potential to transform important areas of health and medicine. The budget provides $2.5 billion for the agency's approach to prevent, detect, and treat cancer and other diseases such as diabetes and dementia. ARPA–H will advance high-potential, high-impact biomedical and health research that cannot be readily accomplished through other existing research or commercial activity.

In keeping with the Agency for Healthcare Research and Quality's (AHRQ) mission to provide evidence-based research, data, and tools to improve healthcare quality, the FY 2024 budget includes $564 million to support AHRQ's research on health costs, quality, and outcomes to make healthcare safer, more accessible, equitable and affordable for all Americans. Included are additional resources to further Long COVID care, primary care, and diagnostic safety research.

PROMOTING EFFECTIVE AND EFFICIENT MANAGEMENT AND STEWARDSHIP

To protect against potential information technology threats and to coordinate information sharing across the public health sector, the FY 2024 budget prioritizes cybersecurity enhancements. The budget provides an increase of $88 million above FY 2023 enacted for cybersecurity initiatives in the Office of the Chief Information Officer, for a total of $188 million in FY 2024. At this funding level, the Cybersecurity Program will support greater Department-wide and interagency information technology capability and security development, including directing $50 million for investment in a robust Zero Trust architecture to continue to secure HHS's cybersecurity posture.

As Federal stewards, it is our duty to ensure that taxpayer dollars are spent appropriately through the delivery of quality services, and through preventing waste, and abuse. Continued investment in the Department's operational needs will ensure HHS's ability to carry out its mission to enhance and protect the health and well-being of all Americans while appropriately shepherding our resouces. General Departmental Management (GDM) supports the Secretary's role as chief policy officer and general manager of HHS in administering and overseeing the organizations' programs, and activities of the Department. Unfortunately, since FY 2012, HHS leadership has managed growing responsibilities with fewer resources and staff. The budget would begin to reverse the steep 24 percent decline in GDM "Federal funds" which fund oversight and management staff, representing 228 full-time equivalents.

Two operating divisions face particular challenges with respect to their own administrative funding. The CMS Program Management discretionary appropriation has not kept pace with the growth in enrollments, responsibilities, and complexity within Medicare and Medicaid, putting both beneficiaries and taxpayers at risk. A substantial funding increase is needed to meet fundamental responsibilities to our seniors. The FY 2024 Budget requests an increase of $425 million for Program Management to keep pace with eligibility and claims processing for people with disabilities, strengthen nursing home oversight, reduce prescription drug prices, advance health equity, improve healthcare quality, and conduct Medicaid eligibility determinations as the public health emergency winds down. Likewise, ACL requests an additional $17 million to keep pace with growing programming to improve access to care and community supports for older adults and people with disabilities and to meet the needs of a rapidly aging population: ACL has had roughly 200 staff since 2018, yet its grants have doubled in value and increased by more than 50 percent in number.

The budget provides $75 million for new projects to improve the customer experience for Americans at significant points in their lives. For example, CMS, with other Federal partners, will test ways to improve access to benefits for people facing financial shock—such as loss of income—by working to improve underlying eligibility

data services and systems. ACF and partner agencies will also continue and expand demonstrations to improve service delivery and to help states adopt leading practices in delivering benefits to ease application burden, lower time to access benefits, and improve cross-enrollment rates. CMS and the Social Security Administration (SSA) will also jointly pilot efforts to improve the Medicare enrollment experience. For people new to Medicare there are other customer service focused improvements that would align income and asset determination processes for Medicare low-income assistance programs, easing administrative burdens for states and removing enrollment barriers for individuals.

The Nonrecurring Expenses Fund permits HHS to transfer unobligated balances of expired discretionary funds into an account for information technology and facilities infrastructure acquisitions necessary for the operations of the Department. Since FY 2013, the fund has allocated over $6.5 billion in capital investment projects across HHS. For FY 2024, HHS is proposing to use $650 million from the fund for information technology and infrastructure projects across the Department, including at IHS, NIH, and CDC. These proposed investments will ensure aging systems and facilities do not compromise the Department's ability to carry out its mission.

To support more effective use of health data, the budget also includes $104 million in Public Health Services Act Evaluation set-aside funds for the Office of the National Coordinator for Health Information Technology (ONC). These funds will support more equitable access to healthcare data by updating health information technology and data standards for interoperability. ONC will also work to improve the secure exchange of electronic health information between patients and providers, and lead coordination efforts between key Federal and industry partners in health information technology.

HHS values the importance of protecting individuals seeking services from HHS programs, from discrimination based on race, color, national origin, sex, age, disability, and religion. The privacy and security of individuals' health information is a critical part of HHS's work. The FY 2024 budget provides the HHS Office for Civil Rights (OCR) a much needed $78 million to carry out its important work. OCR is projected to have 80,000 cases in FY 2024, up from about 45,000 in FY 2020, yet its budget authority has been essentially flat over this period, and essentially flat for over a decade. Since FY 2017 OCR has received a 28 percent increase in Health Insurance Portability and Accountability Act of 1996 (HIPAA) complaints, and a 100 percent increase in HIPAA large breach reports, while enforcement staff decreased by 45 percent due to not receiving increases in its annual appropriations.

HHS has also made robust investments in new discretionary and mandatory Health Care Fraud and Abuse Control funding to provide oversight of CMS health programs, strengthen the HHS Office of Inspector General investigations, and protect beneficiaries against healthcare fraud, yielding a combined return-on-investment of $19.7 billion over 10 years. Our comprehensive program integrity legislative package includes a significant new investment in the mandatory Health Care Fraud and Abuse Control program, expands nursing home oversight, and promotes good governance.

CONCLUSION

I want to thank the Committee for inviting me to discuss the President's FY 2024 budget for HHS. The budget represents the continued investment in the health, growth, protection, and vitality of the American people. With adequate funding in these critical areas, we can support the forward mobility of our country and continue to make stride towards a brighter future. Thank you for your dedication and partnership in our shared goal to improve the health, safety, and well-being of our nation.

Senator BALDWIN. Thank you, Secretary Becerra.

We will start our round of questioning. I will take the prerogative to go first.

Our communities continue to struggle with the opioid crisis. Just last year nearly 108,000 Americans died from a drug overdose; that is a record high. Reversing this trend has only become harder because of the growing prevalence of fentanyl in our communities. Fentanyl can be fifty times stronger than heroin, and a hundred times stronger than morphine. And it is increasingly involved in the vast majority of accidental fatal overdoses. So how are HHS

programs adapting to the new challenges of substance use and abuse that we are seeing?

SUBSTANCE USE INVESTMENTS AND ACTIVITIES

Secretary BECERRA. Madam Chair, this budget, you will see, invests some $11 billion, including some $10 billion in discretionary funding, for programs that try to target opioids and overdose-related activities. It is a significant increase over previous years, and it complements the work that we have done to establish a new strategy when it comes to drug overdose and treatment, where we don't only try to prevent people from taking up a drug, but also beyond the treatment. We worry about harm reduction, to make sure that we are preventing people from harming themselves before they finally can get the treatment they need.

And then finally, we are trying to focus a great deal more of our time and resources, to ensure that there is post treatment services available in the community, so once you finish the treatment you don't fall off the wagon. And we keep you as a productive member of society.

Senator BALDWIN. Drilling down a little bit more deeply, and I just want to reflect that just in the time that I have been in the United States Senate I feel like I have seen the opioid epidemic, the substance use disorder crisis really change, fundamentally. And especially, obviously, I just referenced fentanyl, but I am also particularly concerned about the increase in overdose deaths among really young adults.

Throughout the country the average age of opioid overdose victims has been dropping, spurred by the abundance of fentanyl, and again what I refer to as accidental fatal overdoses.

So what is HHS doing, specifically, focused on our children and young adults, to prevent young people from seeking out illicit, or fake pills, and make life-saving—what are you doing to make life-saving overdose reversal drugs available to under-resourced communities?

REACHING YOUNG PEOPLE IN CRISIS

Secretary BECERRA. Madam Chair, we are doing the best we can right now to reach out with our States as partners, to try to get to where kids are. The 988 Program is a perfect example of how we are trying to reach children, young people today in ways that we hadn't before. And so it shouldn't surprise anyone that the most effective tool today to reach a young person who is experiencing a mental health crisis, is not to give them a phone so they can call 988, it is to let them text, or chat to us, because that is what we have seen a dramatic increase in, is the texts and chats that we are getting, principally, from young people.

Then, of course, what we want to do is, to the degree possible, offer them peer support. We know that sometimes it is tough for young folks to talk to adults. We know that sometimes they are afraid to talk to adults, but to their peers, they seem to open up a great deal more. So whether it is providing the resources to actually know how to reach them, and then provide them with the most-friendly way to discuss their concerns; we are going to do all we can to try to get our young Americans.

Senator BALDWIN. Thank you. It was brilliance for the Federal Communications Commission to figure out that we needed to be able to text 988, not just call 988.

Secretary BECERRA. Yes.

988 & THE LGBTQ COMMUNITY

Senator BALDWIN. And I was so pleased to learn they were doing that. I want to stick with 988 for a moment. Recent data from the CDC shows that teens who identify as lesbian, gay, bisexual, transgender, or questioning, are experiencing high levels of mental health distress.

In 2021, almost half of LGBTQ students reported seriously considering suicide, including more than half of transgender or nonbinary youth. Nearly one in four LGBTQ youth attempted suicide, and nearly three in four reported persistent feelings of sadness or hopelessness. These are startling numbers, and we must redouble our efforts to support these children and young adults.

I have been glad to work with you and the Department in creating a pilot within the suicide prevention Lifeline, which is now 988, to provide particular services to LGBTQ youth. And so I am asking: What kind of need are you seeing for crisis service among LGBTQ youth? And how has the Specialized Service Pilot—help support this population?

Secretary BECERRA. Madam Chair, our budget actually calls for support, funding support for specialized services for LGBTQI+ communities. And so we are already working on that. We know that, in many respects, the population within that community is at far greater risk of suicide. And so we are already targeting there. And we look forward to working with you to try to expand that scope.

Senator BALDWIN. Thank you.

Senator Capito.

SUBSTANCE USE PREVENTION AND TREATMENT

Senator CAPITO. Thank you. Secretary Becerra, I am very interested in the Substance Use Prevention and Treatment; the prevention aspect of this. I know the DEA (Drug Enforcement Administrations) has an initiative going called, "One Pill Can Kill". And what kind of things are you doing, and how does this budget reflect a larger impact on the prevention side of this enormous issue?

Secretary BECERRA. Yes. And Senator Capito, thank you for your dedication to this particular issue as well. We are doing things that have been proven effective, where evidence shows us that they help save lives. So for example, until a year, and a-yeay-and-a-half ago, we would not support a program if it was providing fentanyl strips to drug users, because many thought that that was a way of increasing drug use.

It is our way of trying to prevent someone from using a drug that they are not aware is laced with fentanyl. And so we are going to try to do the things that have proven themselves, by the evidence, to be effective, so we can provide, during that scope of prevention, treatment, harm reduction, and post-treatment services, a continuity of the services that they need so they can get off of the drugs and get back to their life.

Senator CAPITO. Yes. I think some of the harm reduction, at least in my State, has been subject to some controversy if they are not well managed. So you have to be very, very careful with those programs.

UNACCOMPANIED CHILDREN

Let me talk about the unaccompanied children, the UACs that HHS is in charge of. I was really stunned, and maybe you were too, to read the article by The New York Times that talked about the youth, a number of unaccompanied children who were placed by HHS with sponsors, who were supposed to be vetted, who were then found packing cereal boxes, and roofing, and other kinds, slaughterhouses. I was surprised to read that they go to school in some cases, and then work all night. I mean very barbaric kinds of situations that were reflected in this article.

What is your vetting process? Are you trying to fast track it too fast? Why has this, you know—are the sponsors, I noted in here one of them wasn't the relative that the person was supposed to be coming to—that the child was supposed to come and live. What are you doing to ensure that you are placing every child in an appropriate placement?

Secretary BECERRA. Thank you for the question. And let me try to encapsulate what this program is for the unaccompanied migrant kids. We receive these children from the Department of Homeland Security, which is not supposed to hold them because they only have detention facilities for adults.

Senator CAPITO. Right.

Secretary BECERRA. We then take these children and offer them the care that you would expect to offer any child, children are children. And so we offer them care, while we try to place them in a more appropriate setting, because no one believes that a large government-funded congregate care setting is the best for a child. And so we make every effort to find a sponsor who would care for that child and do it well.

And so we go through that vetting process, background checks, and the rest. And more than 90 percent—about 90 percent of the cases we are placing a child with a family member, whether it is the parent, aunt, uncle, sometimes an older sibling, but in about 90 percent of the cases we are placing them with a family member.

There are fewer cases, far fewer cases where it is not a family member, sometimes it is a known friend, acquaintance, someone that the parents say, please, that is the person we would like you to place them with. But rarely do you see a case of a placement that hasn't gone through a vetting, where a family——

Senator CAPITO. But what kind of follow up do you do? Because obviously this is reflected in this article, is that you are falling short in more than a few areas.

Secretary BECERRA. Actually, I don't think the article speaks to our process of vetting, it speaks to the process that kids are going to work at a very young age.

Senator CAPITO. Well, I don't think it—it doesn't sound to me like they were doing it voluntarily. It sounds like they are in a home, they are in a sponsor, and like I said, one of them is a relative, and they are encouraged, and you have to go work, and so

obviously it is not the right sponsor, if you are going to tell a 13-year-old you have got to go pack cereal at night.

Secretary BECERRA. And those kids that apparently are reported on never called us and said: We are being exploited, we are being taken advantage of, and this was not what we were expecting. And so what we do is, again, we try to place them with someone we believe will be a responsible sponsor of them.

Senator CAPITO. Yes. I mean, I think we need to do a better follow up here on the—certainly on the ones that are suspect, and certainly around the industries, and others that are exploiting our—any child. I mean, I think we agree that is abominable.

Secretary BECERRA. I don't think anyone disagrees with that.

Senator CAPITO. Right.

Secretary BECERRA. That we should do the best we can with any child.

ALZHEIMER'S DISEASE

Senator CAPITO. Right. Let me talk about Alzheimer's and the Leqembi decision that was made by CMS to not move forward with the approval, that only very limited, and I understand from my Alzheimer's advocates, really cuts out Rural America as well, because we can't access the trials, and the clinical trials, like you can and more compacted, and more urban areas. We have trouble with healthcare delivery systems.

I mean, I can speak from personal experience, which I probably should quit doing, but with my parents we couldn't even find a gerontologist, hardly, in our area that could help me understand them. And so anyway, other agencies have taken a different approach than CMS. The VA (Department of Veterans Affairs) announced last week that it would cover this for our veterans. We are desperate for something to help. This has been—gone through clinical trials. It has positive science behind it. Why is that decision being made?

Secretary BECERRA. Well, a couple of things. First, the VA has made some moves to include it, but it also has restrictions and exclusions. It is not just a straight out approval. The second part is the clinical trials have not been done in this particular case. This was an accelerated approval which is still requiring, FDA (Food and Drug Administration) is still requiring that the manufacturer of the drug provide clinical evidence that it works.

They went ahead and gave a conditional approval, but they are still waiting to get the evidence from clinical trials, and that is where CMS is saying, that is the kind of information we need, the clinical trials showing success, so that we can move under the standards that guide CMS, which are different from the standards that guide FDA, in making determinations for a particular drug.

Senator CAPITO. It is interesting that you would phrase it that way, because my understanding is that there have been clinical trials, that there is science-based evidence, that this does move the needle. You know, it doesn't cure anything, I don't want anybody listening thinking it could do that, but this is something that we all obviously have our eye on. You, I am sure, received many letters, one from me.

Secretary BECERRA. Yes.

Senator CAPITO. In this area. So I think. My time is way over.
Secretary BECERRA. Thank you.
Senator BALDWIN. Senator Merkley, you just arrived. But in the spirit of going back and forth between the Majority of Minority, you would be next, if you are ready.
Senator MERKLEY. Okay. I will jump right in, although I just came from Foreign Affairs. So if I ask you a question totally off topic, you will know my mind is still where it was 2 minutes ago.

FLORES REGULATIONS

I wanted to start by asking you about the new Flores Regulations. The Department of Health and Human Services has the opportunity to codify the best practices and improve the treatment of children who are in Government custody through the Flores Settlement. And I think you are working on new regulations, and wanted to check in on how they are going, because it is so important that we treat children well.
Secretary BECERRA. Senator, we were just discussing the situation with children, the migrant children that are placed under our custody, and then are released to a sponsor. We would agree with you, a child is a child, and we have to do our best with any child. And so we are going through that review.
The Flores Settlement requires us to—well, one of the things that the Flores Settlement requires is that we find a placement for this child, and not keep them in our custody any longer than necessary. And so we are going to be going through that.
We want to thank Congress for the resources you gave us, so that we could actually go about trying to ensure that there is some follow up for these children, because once we have placed them in the care of a sponsor we essentially lose custody of that child. And so the more authorities you give us, and of course the resources, the better we could do the follow-up with these kids.
Senator MERKLEY. I am very pleased to hear it. And I introduced bill, the Children's Safe Welcome Act, which we have shared with your team, which was designed to kind of lay out the gold standard, and I hope you will take a look at that bill as you put these together.
Secretary BECERRA. I will take a look.

STANDARDS FOR VAPING PRODUCTS

Senator MERKLEY. The next thing I wanted to address, was to have you address vaping, and the standards that are established for candy-flavored, fruit-flavored vaping. And this goes way back. When I first came to the U.S. Senate, Oregon and Ohio where the experimentation grounds for the tobacco industry for new products; and they had tobacco toothpicks, they had tobacco breast strips, and they had tobacco mints. And to tell you how far those go back, the mints were in a case that was shaped like a flip phone, a cell phone, so if you remember those ages, just 14 years ago.
But none of those caught the market, but vaping did, and has led to the addiction of, probably at this point, millions of children. Time and time again, with both administrations, both Democratic and Republican administrations, we have failed to get the regulations in place to control this seductive strategy to addict a new gen-

eration of children to nicotine, with really lifelong health consequences. So can you fill me in and tell me that this time will be different?

Secretary BECERRA. I want to tell you that it absolutely will be different. I was the Attorney General in California, and we sued some of these vaping companies, because we could prove that they were marketing to children, and so now, as Secretary, we are taking every action we can.

It is a partnership. We work with the Department of Justice to help us do the enforcement against these vaping companies. And as you know, there have been, literally, millions of applications by these companies to be able to sell different products. Unfortunately, every one of those applications has to be gone through thoroughly otherwise we end up in court.

And at this stage, the vast majority, substantially, more than nine out of every ten of those applications has been disposed of. We still have several large ones, but as, you know, Senator, we are now caught in court. The companies are using every tool at their disposal, including lawsuits, to keep us from moving forward.

Senator MERKLEY. Okay. Well, I encourage you to persist aggressively, given the consequences of failure, and we certainly have a deeply entrenched company, or companies, determined to keep addicting children.

I heard a knock, am I out of time? No.

Senator BALDWIN. You have a full——

Senator MERKLEY. I have a full minute?

Senator BALDWIN [continuing]. 50 seconds left.

MATERNAL AND CHILD HEALTH BLOCK GRANTS (TITLE V)

Senator MERKLEY. Mr. Secretary, can you clarify whether or not Title V, the Maternal and Child Health Block Grant's funds can be used for stillbirth prevention activities?

Secretary BECERRA. Senator, I will confirm that, but I see no reason why it could not. But let me confirm that for you.

Senator MERKLEY. Okay. I am going to keep working to pass the Maternal and Child Health Stillbirth Prevention Act, to clarify in statute. But I think you already do have the power, and I think it is a very important area to be pursued around the country. Thank you so much.

Secretary BECERRA. Thank you very much.

Senator MERKLEY. I yield back 17 seconds.

Senator BALDWIN. Thank you. Next we have Senator

Hyde-Smith.

Senator HYDE-SMITH. Thank you Chair Baldwin, and Ranking Member Capito, and thank you Mr. Secretary for being here today.

HOSPITAL BOARDING CHALLENGES

The concerns in Mississippi are very similar to many other States, many hospitals are experiencing unbelievable financial and workforce restraints, and many have forced to end services in order to keep their doors open. There is a hospital in the Mississippi Delta that has had to stop any OB (Obstetrics), intensive care units, all of that has come to a close, for them just to offer, you know, primary care. But those services are very vital because the

closest OB is like 45 minutes to an hour away. As they lose the ability to care for the more complex patients in their communities, the hospitals often have to transfer these patients hours away.

And upon discharge many of these patients require, of course, post-acute care, and long-term acute care hospitals and rehabilitation hospitals have become less willing to accept these patients without the backup of their local hospitals. So I am sure you hear this all the time.

But then the staffing challenges have significantly affected the ability for these facilities to continue on, and we are seeing longer stays in these tertiary care hospitals, because the locals cannot back them up. Hospitals get paid on a diagnosis-related group payment as you are well aware of, DRG, which typically covers a normal stay for that respective diagnosis.

So patients are staying longer, and they are exceeding those DRG payments, and hospitals are losing money hand over fist. More patients are boarded, so to speak, in the ER (emergency room) waiting rooms on room beds. And they are just walking out of the ERs without being seen. Patients are held longer in their smaller hospitals, while waiting for bed placements in a larger hospital. We have all these issues that I am sure you have heard from many others.

How do we overcome a financial challenge that was made worse by COVID and inflation; inflation that we are seeing, not only in Mississippi, but all across the Nation? And have you or the Agency considered establishing a temporary per diem payment targeted to hospitals, to help address this?

Secretary BECERRA. Senator, everything you have said I have heard, not just in States like yours, but when I was further up north in some of the Northwestern States they have large spans where there are very few physicians and healthcare providers. It is the same everywhere, distance has caused a real issue, telehealth was a saving grace during COVID, but that doesn't resolve it all.

My wife who is an OB–GYN tells me about how, in Sacramento, California, she will see patients who are coming from the very northern reaches of our State because the facilities there are not equipped to handle the needs of an OB patient. And so what you are speaking to is something that everyone is trying to figure: How do we get resources and commitments into these communities?

One of the things we are trying, and we look forward to working with you on this, if you are interested, is we are trying to make sure that graduate medical education slots, the slots where you send a resident into a practice, that maybe we could try to get some of these into communities that haven't always had these teaching slots available, because the evidence shows that if you locate a student who is in the Residency Program, by the time they finish that Residency Program in that community, they often stay there, and develop their practice there.

And so we would like to see, for example, if we could encourage people to locate in communities because that is where they are getting their resident training, and have them stay there as a result. The other thing we are doing, again small, but still can be helpful, are Public Health Service Corps. But there are programs that we

have that have loan forgiveness, or complete deferral, where, if you commit to 5 years of service in an underserved area, as you just described, we will pay for your 4 years of medical school education.

And we are trying to do what we can to direct some folks into some of these communities. On top of that of course, you see some of the money that is devoted specifically for rural healthcare providers. Still, small potatoes, overall, but it is an effort to try to keep those facilities alive.

Senator HYDE-SMITH. So are you saying the temporary per diem is not being considered?

Secretary BECERRA. I would have to get back to you, I am not sure if that is one of the considerations. I would suspect that one of those issues with the temporary per diem would be the cost. Where would the money come from to do that?

Senator HYDE-SMITH. But you would let us know if——

Secretary BECERRA. Absolutely.

Senator HYDE-SMITH [continuing]. That is in the plans, or if that is even something that anybody is working on at the office.

Secretary BECERRA. We will follow up with your staff.

Senator HYDE-SMITH. We hear from the hospitals, and they are thinking that may be a solution. And they asked me. And I said, well, I will have the opportunity to ask him. So I would appreciate it if you would do that.

Secretary BECERRA. We will follow up with you.

Senator HYDE-SMITH. And my time is out.

Senator BALDWIN. Senator Manchin.

Senator MANCHIN. Thank you, Senator. And thank you, Madam Chairwoman, appreciate the consideration.

DOMESTIC MANUFACTURING SUPPLY CHAIN

And Secretary, thank you for being here. Appreciate it very much. Domestic manufacturing, I think you and I have talked about this before, that is needed to supply our chains, our supply chain is not caught off guard again, especially for life-saving essential medication. I was pleased to see your Department established the Office of Assistant Secretary for Preparedness to better help build out the United States manufacturing industrial base, and invest in long-term capabilities to better respond to emerging biological threats.

Your budget request is $400 million, I think, to bolster the medical supply chain, but there has been about $10 billion that was approved for that before. Can you tell me if there is any money left from that that we could apply to this, or how the $400 million will be spent?

Secretary BECERRA. Senator, we have had discussions of this before. Most of that money was either—went out the door, or is on the verge of being obligated for services that are still related to COVID. In order for us to really increase our capacities with the domestic supply chain, we will need some resources. And that is where the President's budget does actually identify that as one of the things we would really like to do, because it is not just a matter of meeting our supply needs, it is also creating domestic manufacture of that product.

JESSE'S LAW

Senator MANCHIN. Second, I am going to into drugs right now. Senator Capito and I, on the Jesse's—what we call Jesse's Law, Jessica Grubb's Legacy Act; I know you have heard us talk about this before. We passed that bill quite some time ago, it came in, and the CARES Act in 2020. I was pleased to see the Department issue proposed regulations last fall. What is Department's time line to implement the Final Rule of the Jessica Grubb's Legacy Act, this young girl who lost her life to drug overdose?

Secretary BECERRA. You are getting granular on me, Senator. Let me get back to you, so I don't give you the wrong time line on that.

Senator MANCHIN. I hope it is quicker than what it has been.

Secretary BECERRA. Yes. I know you are hoping it is quicker. So we will get back to you.

DRUG OVERDOSES

Senator MANCHIN. Okay. The LifeBOAT Act; let me ask you this. You know, with the drugs that we have in the situation right now, we lost 106,000 Americans last year. Over the last 10 years we have lost more Americans to drug overdoses, opioid addiction, than we have in any wars we have ever fought, all of them accumulated together.

With that being said, it is time for us to take, with the deaths that we have, take a realistic approach. The LifeBOAT Act simply says this: A penny per milligram for all manufacturers. If you think you need to put this much product in the market, then at least pay so we can use it just so we can get people cured, if you will, this, every penny of this goes towards treatment centers, and treatment centers could be in every part of the country.

I have been trying, and trying, and trying, and everyone, for whatever reason, we haven't had any success. Have you heard about this? I think you and I have talked about it. Does it make sense to you? Was it tight?

Secretary BECERRA. Anything that gets us the resources to catch up to this plague makes sense, because we are losing ground on occasion, and we need to get ahead of this. And so any way that we could try to figure how to fund this, would be instrumental in saving lives.

Senator MANCHIN. Would you all be able to support something such as that?

Secretary BECERRA. We certainly would take a close look, because you are trying to get resources, and we need resources to make it work.

PHARMACEUTICAL BENEFIT MANAGERS

Senator MANCHIN. Let me speak about PBMs (pharmaceutical benefit managers) then. Let us speak PBMs, okay. PBMs, 80 percent, the amount of money that they receive and the way they are able to control and classify on drugs to the highest sourcing, the highest drug prices, because they get a better rebate. How did we allow this to happen? And how do we stop it?

Secretary BECERRA. Senator, you have been in this business for a while, and I was in this body as well. I think we know that there

are some folks who are very clever and creative in how they do this work. The middlemen have always skimmed money off the top, and it is a matter of how we can try to keep the resources where they are most needed, with consumers, not with middlemen.

Senator MANCHIN. Well, for the PBM, pharmaceutical benefit managers, they are basically middlemen right now, as we are reducing price. And finally, the Inflation Reduction Act, the amount of money that we were able to save by negotiating on certain drug prices, that money is being able to help bring down prices as being used directly for reducing the price. What more can we do if we expanded that? How much quicker can we do this?

Secretary BECERRA. Transparency would be very helpful to see how they are operating. And as you know, the difficulty here is that the moment we try to do something, we likely find ourselves in court. And so we are trying to move this dial, and we look forward to your help in that.

Senator MANCHIN. Okay. Back to the PBMs the drug formularies, are they the ones that set the drug formularies?

Secretary BECERRA. Well, those formularies are worked out with CMS, and others, that we take comment from.

Senator MANCHIN. So they are not totally in control directly on that. And why are we getting so many of the higher priced drugs approved on the market, basically, for use other than the lower priced or generics?

Secretary BECERRA. We get that—I don't know if you have the time to go into the specifics of that.

Senator MANCHIN. Okay.

Secretary BECERRA. But we can try to get back to you on that.

Senator MANCHIN. I would love to get back with you on that one. PBMs, my number one concern, about the high prices of drugs.

Secretary BECERRA. Look forward to working with you.

Senator MANCHIN. Okay.

Senator BALDWIN. We are joined by our Full Committee Chair, and Ranking Member, continuing with the back and forth, I will next recognize Vice Chair Collins for her questions.

Senator COLLINS. Thank you very much, Madam Chair. Senator Moran has been here longer, I know, but more important he has to get back to another committee, so I will yield to him.

Senator BALDWIN. So I am——

Senator COLLINS. But I do have questions.

Senator BALDWIN. Okay. And both the Chair and Vice Chair have already been gracious in yielding time to other members.

So Senator Moran, take it away.

Senator MORAN. Chairwoman, thank you. And thank you to the Chair and Vice Chair of the Committee. I hope this is the evidence that I expect it to be of the amount of cooperation on both sides of the aisle, in the effort to get us through our legislative process and appropriations.

LIVER ALLOCATION RULE

Secretary, the front page of The Washington Post today, about a joint investigation the paper conducted into the Liver Allocation Rule that was implemented in 2010 of 2020. Since that rule was announced in 2018 my former colleague, Senator Roy Blunt, and I

have continually flagged for your Department, how harmful and unfair the rule is to the Midwest and the South.

The results of The Washington Post investigation prove that we were correct. Quoting from The Washington Post story, "The analysis from data from Federal health authorities found sharp declines in life-saving surgeries in Puerto Rico and seven States, all but one Southern and Midwestern; Kansas, Alabama, Louisiana, North Carolina, South Dakota, Iowa, and Pennsylvania."

Mr. Secretary, I raised this topic with you the first time you were in front of this committee. The analysis in addition to what is in addition to what we learned in 2021 from internal conversations between United Network for Organ Sharing and a New England OPO (Organ Procurement Organizations) that proved intentional collusion against Americans living in health professional shortage areas. All of these facts, combined, are more than enough to halt the Liver Allocation Rules implementation, and for HHS to rethink its over 30-year relationship with UNOS (United Network for Organ Sharing).

Today's announcement, the Health Resources and Service Administration is proposing—so there is the good news—is proposing to divide up the OPTN (Organ Procurement and Transplantation Network) contract, and open competition for contracts to new organizations to step, and it is certainly a step in the right direction. I am hoping that the Department is finally, in my view, taking the life and death battles of Americans, the battles they are facing through the current OPTN system, seriously.

To that end, HHS, the 2024 budget request is $67 million for Modernization Transplant Network. Could you please confirm your Department's commitment to working with my office, with Congress, to improve the OPTN system for all Americans, and fill the details in on the $67 million dollar modification—excuse me—modernization request?

And are you able to commit to this subcommittee that in addition to the important announcement from HRSA (Health Resources and Services Administration) today about rebuilding our Nation's transplant infrastructure, organ allocation; organ allocation formulas will be on the table for a complete overhaul, resulting in a more equitable formula?

Secretary BECERRA. Senator, probably the best way to put it is: You had me at hello, on that one. Simply because you have been ringing this bell for quite some time, we took a little time but we wanted to make sure we could do it right. And so I am glad you heard about our announcement, we are going to open up the process so that this one contractor doesn't believe that it owns this shop. And we are hoping that through competition, we are going to really be able to open this up in a way that lets the best of those who could offer this service take over the contract.

Secondly, we are going to do everything we can to add transparency into the way this works, because as you just pointed out, you had to go dig for this information to find out that there may have been fraud and abuse. We are going to try to move towards much more transparency, especially with the data that they are collecting, because we don't have full sight of where they are sending organs, how they are doing it. And the more we have the data

the more we can show whether they are doing it the right way or not.

And so open up the process to the best bidder, make sure we have transparency, and then you mentioned, the President is calling for $67 million. So we can do principally one thing, catch up with the times, because the technology that is being used is too outdated. When we can transmit and communicate with folks around the world instantaneously, there is no reason why organ transplantation information cannot be made available quickly as well, because these organs have a certain shelf life. And so we are going to try to do what we can to make sure that no organ goes to waste, and we have to make sure that we bring in an infrastructure that can accommodate that.

Senator MORAN. Mr. Secretary, you know as a member of Congress, that you get people who bring you problems, and we do things, like we call "casework", and this started out a bit like that, but it became evident, and I am glad the Department now is apparently seeing this. This is really about life and death. And the analysis that we have seen, indicate there are people who have died in those States because of the allocation process that was put in place by a process that was far from even satisfactory.

So I thank you. Is there anything that you are not doing that I should insist you do?

Secretary BECERRA. Please bird-dog this. It is not easy. We are trying to—you know, it is not easy to make the boat—the big ship switch direction. And there will obviously be those who lobby to keep the status quo. And so please persist, persist.

Senator MORAN. I will do that.

Secretary BECERRA. Amen.

Senator MORAN. Thank you.

Secretary BECERRA. Thank you.

Senator BALDWIN. Chair Murray.

Senator MURRAY. Well, thank you very much, Chair Baldwin, Ranking Member Capito. It is really great to be back at this subcommittee, which is in great hands, with two women I am very glad to have as colleagues as well. And I am looking forward to working alongside the Chair and the Ranking Member, and all members of this subcommittee, as we return to regular order, and work to find common ground to build a stronger economy, and make our communities safer.

WOMEN'S HEALTH

And today's hearing really offers a really important reminder, that when it comes to making our country safe and strong, investing in our families, and workers, is really key to our economic success. Defense spending is absolutely important, but it is only part of the equation, because our families across this country, being safe includes knowing they can get healthcare that they need, it means addressing the devastating maternal mortality crisis, and the opioid epidemic.

It means training and retaining a strong healthcare workforce. It means building a robust public health system so we can prevent and respond to threats like dangerous disease outbreaks, and mak-

ing sure that women, in every corner of this country, can get the healthcare and family planning services that they need.

CHILD CARE CRISIS

And while these health challenges make people less safe, there is also the childcare crisis. And Mr. Secretary you know; Madam Chairman you know, this is really important, this is straining our parents' budgets, it is forcing them out of the workforce, we have to solve this crisis, which is why I will continue to raise this as a top priority of mine. And I am going to be reintroducing my Child Care for Working Families Act fairly shortly.

I also want to note, Secretary Becerra, we need to live up to our obligation to care for the migrant children in our Nation's custody. I am going to be working hard with all of my colleagues to make sure we draft a funding bill that provides the investments that keep our families safe and healthy, and our economy strong.

So welcome to this committee. I do have some questions.

The Child Care Stabilization Program, it was created by Democrats in the American Rescue Plan, it has been an incredibly successful program, in my State, over 6,800 providers received funding, and that has helped us with over 184,000 children, in my State alone. And stabilization funds kept those providers' doors open, they supported wages and benefits for workers, and critical operational costs. But as we know this funding is set to end, and the childcare crisis is still with us.

Secretary Becerra, the President has proposed a significant investment in both mandatory and discretionary funding for childcare. Can you tell us about the current state of the childcare sector, and why this significant investment is needed?

Secretary BECERRA. I have to begin, Senator, by first saying, thank you for helping us ensure that we could come to you with a decent budget. And so thank you for the work that you have done over the years on this subject.

The second thing I will say is this probably explains it all when it comes to childcare. You can still make more money flipping burgers than you can working, caring for our next generation of leaders. I just don't understand it, how it is that we expect someone who is taking care of the people we love most, our children, less than we pay someone to go to McDonald's and flip burgers.

That essentially, points out why childcare is in such a difficult state. We don't pay enough, yet it is still too expensive for most families to afford it, only one in seven families is able to send a child to childcare. And so you can understand why the President is committed to this. These are hundreds of billions of dollars that the President is trying to commit, because that is what it will take.

He is also making a commitment to pre-K, and to Head Start. He would like to see every child who is 4 years of age have access to pre-K.

And so, my mom used to say it best, "Mejor prevenir que remediar": better to prevent than to remediate. We know if we start early with our kids, they are going to have a chance to grow up strong. Frederick Douglass said it better, "Easier to build strong children than to repair broken men." We are letting a lot of kids

become broken, and then we try to repair them. Let us build them strong at the beginning, investing in childcare does it.

MATERNAL MORTALITY CRISIS

Senator MURRAY. Well, thank you for that. And let me ask you about a report that the CDC released, it is really shocking, on the alarming maternal mortality crisis in our Nation, which found that the maternal mortality rate has risen 40 percent since 2020. Can you tell me how the Department's existing work is going? And what the additional investments in maternal health in this budget will do?

Secretary BECERRA. We have really zeroed in here. You are aware that today we have challenged every State to offer to a woman and her new baby postpartum care, not just for 60 days under Medicaid, but for 365 days. So we just got the 30th State, Oklahoma, just came on board. But that means there are still 20 States in America that are not offering this care. That is hundreds of thousands of women who are about to deliver who will only have postpartum care for 60 days. And we know that in many cases the woman, the mother, or the baby will have an outcome, including death, that will leave America hurting.

And so we believe expanding access to Medicaid, we are concentrating monies directly on maternal healthcare. We know the crisis is biggest in the African and Indigenous communities of our country, and so we are going directly where we know these women are.

Senator MURRAY. Thank you. Thanks very much. Thank you, Madam Chair.

Senator BALDWIN. Vice Chair Collins.

Senator COLLINS. Thank you so much Madam Chair.

Secretary Becerra, welcome. You may have noticed this week that there is a sea of purple in Washington D.C.

Secretary BECERRA. Okay. Yes.

ALZHEIMER'S DISEASE

Senator COLLINS. And that purple is worn by advocates for those who are suffering from Alzheimer's disease, are afflicted with it themselves, or are caring for someone, or who have lost someone to this devastating disease. I know that is true of both your family and my family as well.

So it is with great disappointment that the CMS is blocking, and acting as a roadblock for patient access to drugs that could be very helpful to these patients particularly, in the early stages of this devastating disease. I just do not understand CMS's misguided and outright unprecedented decision to not cover a whole class of Alzheimer's drugs.

It is not CMS's job to second guess the drug approvals of the FDA. That is not what CMS is supposed to do. So last month I led a bipartisan letter signed by 20 Senators, bipartisan, asking HHS and CMS to reconsider the restrictive coverage requirements in light of the FDA's accelerated approval. And I am disappointed that I haven't received an answer to that letter which was sent more than a month ago.

Secretary BECERRA. I am sorry.

Senator COLLINS. I am also perplexed why CMS does not respond to a letter from the American Academy of Neurology that was sent on February 2, that says that the questions CMS has raised have been answered in a massive, successful clinical trial, and a peer-reviewed publication reviewing the results of that trial. And that was Phase III data.

So CMS promised to expeditiously look at the data, and yet we just get silence. Furthermore, 200 Alzheimer's researchers have also written to CMS, and said there is no question, but that this drug should be allowed for patients who are receiving Medicare.

It is not enough, as I believe Senator Capito pointed out earlier, to say you can get it if you are in a clinical trial, that is of so little help to States like ours, where there may not even be a clinical trial going on, or there may be one that is far away from most of the people in the State. So I am just asking you to tell CMS to let this drug be used; and let people get access to it when the patient and his or her clinician agrees it is the appropriate treatment. That is all we are asking.

Secretary BECERRA. Senator, I don't know if there was a particular question, other than to ask CMS. And certainly CMS has had to review this, many of the people who are at CMS who went through this process, have also had loved ones who have gone through illnesses like Alzheimer's. I myself, I had mentioned this, and my wife have gone through this.

There is no doubt that we want to get to the types of life-saving treatments that Americans can benefit from. The difficulty here is that we have to remember that the process that the Food and Drug Administration uses is different from the process that—legally, that the Centers for Medicare & Medicaid Services must use to make their determinations. And while it may not make a lot of sense to folks, and it is, you have to go into the weeds to understand the distinction, there is a legal distinction, and CMS has to remain consistent in the way it treats any drugs.

And so I will absolutely make sure I take back the information. CMS has said that as soon as they collect the evidence that lets them believe that they now can move to a different level, a different stage, they would. If FDA were to give approval, standardized approval to the drug, they could then make further progress in broadening the scope of access. But CMS is trying to use the standard as it has in place to legally follow its obligations, and when it makes a determination for Medicare.

Senator COLLINS. Well, I would just suggest to you that CMS now has all the evidence that it can possibly need to grant that approval, given this clinical trial which was considerable and produced good results, and the 200 researchers. CMS needs to stay in its lane. FDA is in charge of drug approval, not CMS.

Secretary BECERRA. Senator, if you will allow me, even FDA is asking the drug manufacturer to continue to provide evidence of the efficacy of the drug. They have not said, with finality, that this drug is safe and effective. They are still waiting for more evidence to come in.

Senator COLLINS. Well, I don't know what more—I know my time has expired—but I don't know what more evidence you could need than a Stage III clinical trial. And it is just extremely frustrating,

as is the fact that the President's budget does not provide additional funding, specifically targeting Alzheimer's research. And that is something I hope we can correct. Thank you.

Senator BALDWIN. Thank you. Senator Shaheen.

Senator SHAHEEN. Thank you, Madam Chair. And thank you to Ranking Member Capito. Congratulations to both of you on your new roles on this subcommittee. And it is nice to have the Vice Chair of the Appropriations Committee here as well; and the Chair, with Senator Murray. So thank you all.

LOWERING PRESCRIPTION DRUG PRICES

Secretary Becerra, thank you for being here, and for your testimony this afternoon. I wanted to ask you about insulin because it is something that Senator Collins and I have been very concerned about, as the Co-Chairs of Diabetes Caucus in the Senate. And as you know, last session of Congress we put a $35 cap for Medicare beneficiaries on out-of-pocket costs for insulin. Do we have any data yet that shows what the impact of that has been? And can you also address why that is not enough, why we still need additional action on insulin affordability?

Secretary BECERRA. We are beginning to collect the data, Senator. And what I can tell you is the stories I am hearing, the anecdotal stories from actual insulin users, is perhaps the best evidence, when they find out that they only have to pay $35.

I had a woman, I believe, it was—I am going to get this wrong, because I have been to many States, North Carolina I believe; she was shocked when she only paid $35, she was accustomed to paying about $117 for her insulin for the month. She went back to the insurance: that I think I owe you some money. And she had to be told: No, that is the cost now. Because in December she had paid the higher price; in January, all of a sudden, magically, it was lower.

It is affecting a lot of folks. But in your State of New Hampshire, this is probably going to add up for this year, for someone on insulin, on Medicare, to about $536 that they will get to keep in their pocket.

Senator SHAHEEN. Well, that is very good news. And I assume that, long term; it is also going to be helpful in terms of the costs of treating diabetes, because if people are able to get their insulin without having to worry about episodes that would put them in the hospital, in the long term it is going to save the system money. Do we have any of that data yet? And are we collecting it?

Secretary BECERRA. We absolutely do, because we know people ration their insulin to make it last for the month. We know that people will skip their insulin shots, because they don't have enough to last them for the month. That changes now, because now it is only $35 for the full month.

And as you know, the President in the State of the Union Address said: It is great that this is available to the 67 million people on Medicare, but what about the rest of America. And today, the three largest manufacturers of insulin have agreed that they will drop their prices of insulin. And this is a result of the Inflation Reduction Act that you all passed, and the limits you put on insulin.

Senator SHAHEEN. And I think that is very good news. I am not confident, however, that that is going to address the problem that everybody is facing, so I think we still need further Government action on that, to make sure that everybody has those out-of-pocket expenses capped in a way that ensures they can get access to insulin.

OPIOID EPIDEMIC

One of the other issues that we are very concerned about in New Hampshire is the opioid epidemic, which because of fentanyl, has gotten exponentially worse. And as you know, the State opioid response grants are particularly important to States across this country.

As you and SAMHSA continue your work on the SOR allocation formulas, can you commit to working with my office, with Chair Baldwin, who I know is concerned about this because she and I worked on ensuring that SAMHSA (Substance Abuse and Mental Health Services Administration) is looking at the cliff that States might be facing if those opioid response grants got reduced dramatically?

Secretary BECERRA. Senator, the President in his budget, calls for $2 billion to go to SOR (State Opioid Response Grants) grants, because they have been effective, and we don't want to find that a center can provide services for 5 months out of the year, but has to close down after May. Or that they can't reopen during the hours of the day when people come most. And so what we are finding is that, we have to work hard to make sure that States can keep people coming, believing that this is going to be a continuation of service.

So they will take advantage of it. And so we look forward to working with you and your colleagues to make sure that we make this work right. And that no State finds that it is running out of money at the wrong time, and faces a cliff of funding when they need it most.

Senator SHAHEEN. And Senator Capito and I worked on legislation to try to encourage providers to prescribe non-opioid—pain, well, for pain; but we are not talking about medications, if they are not opioids, we would be talking about devices or something else. Can you talk about what you can do, as a Department, to try to encourage providers to look at something other than opioids when they are prescribing for pain?

Secretary BECERRA. Then, that is where we would turn to the best practices, where the evidence shows that they are effective, the FDA would be the agency that would make sure that a particular device or medication would be safe and effective for use. And I think a lot of us understand that we need to find other ways to provide pain therapy so that no one feels like they have to get on these very addictive medications, like opioids, in order to be able to survive the pain that they face.

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

And I would encourage the Department to think about ways in which they can make sure that providers understand that there are other alternatives other than opioids.

Secretary BECERRA. Yes.

Senator BALDWIN. And next, I recognize a new member of the Appropriations Committee, Senator Britt, welcome.

Senator BRITT. Thank you so much, Madam Chairman and Ranking Member, congratulations to both of you. It is an honor to serve on your committee.

Mr. Secretary, thank you for your time, and being here. Many of the questions that I have had on various issues have already been answered, so I am going to actually kind of take up something that I saw Senator Capito talked about, and dig a little bit deeper into it.

UNACCOMPANIED CHILDREN

The Department's fiscal year 2024 budget request includes $5.5 billion in baseline funding for the UAC Program, for unaccompanied migrant children, along with a request of $2.8 billion contingency funds to help address unaccompanied minors and other refugee issues throughout fiscal year 2024. But as has been mentioned here today, the UAC program is plagued by deficiencies, poor management, which combined with this administration's reckless and irresponsible policies, encourage illegal immigration, and I believe, have put the lives of children and their well-being at risk.

We are spending a lot of money on a program that just isn't working very well. I believe it is not a lack of funding, it is departmental policy and management failures that are our problem. In light of the piece in The New York Times last month, as well as many other well-documented reports regarding issues with the UAC Program, I want to ask you about some specifics here, that I believe HHS could and should address.

On March 31, 2021, HHS's Office of Refugee Resettlement, ORR, issued Field Guidance that waived background check requirements for adult household members and alternative adult caregivers, identified in a sponsor care plan submitted by Category 2 sponsors. As you know, Category 2 sponsors include certain relatives of a child other than a parent.

So the Department put in place a policy that allowed a waiver of background checks for other adults in the households of those relatives, that strikes me as deeply irresponsible. In light of recent events, can you tell me if the March 31, 2021, Field Guidance is still in effect?

Secretary BECERRA. Senator, first congratulations to you.

Senator BRITT. Thank you. I appreciate.

Secretary BECERRA. And I look forward to working with you in the future. On this particular question, I won't try to refute some of the things that you have said that I think are inaccurate about the program, because the men and women at HHS work very, very hard to protect these kids. Thousands of kids that have passed through our hands as we care for them, and we do everything we can to not only care for them while they are in our custody, but find them a very secure placement.

Senator BRITT. Yes, sir. And I don't believe that it is actually the people at HHS. I said it is the management and the policies. And so the policy of not checking the background of these individuals in a home that we are putting a child in, my question is, is that still the case?

Secretary BECERRA. Right. And I think you have not stated it properly.

Senator BRITT. Okay.

Secretary BECERRA. Because we do, do background checks.

Senator BRITT. Good.

Secretary BECERRA. So the sponsor of any child has to go through background checks.

Senator BRITT. Okay, and not the sponsor but anyone in their household.

Senator BECERRA. And so if the sponsor is one of the immediate relatives, so for example, if it is the parent——

Senator BRITT. Right.

Secretary BECERRA [continuing]. Then we, in order to get the child to the parent, because again, what we are always told, whether it is through the courts, or whether it is through the best advice, the professionals who know about the best interest of a child, they say: It is better to have a child with someone who loves them, than have them in a federally sponsored congregate care setting.

And so we place them with the child's parent if we can. And if it is a child's parent, for example, we will not do the full background checks of those who are in the household, assuming that the parent is going to be responsible for the child to make sure that anyone in the house will also take care of the child.

Senator BRITT. So if it is not a parent though, just so you and I are on the same page, so that we are speaking the same language here.

Secretary BECERRA. Yes.

Senator BRITT. If it is not a parent that you are placing them with, do you do a background check of the other individuals in that home?

Secretary BECERRA. It will depend on who that individual that we are looking at as the sponsor would be, because the further removed you get from the parent, the more we have to have a sense of security that the person who is going to be responsible as the sponsor can indeed take care of that child. And so it would really be based on that.

Senator BRITT. Okay. I just want to let the record reflect, obviously, if is it a parent, a parent knows what is best for a child and that is what we have to know, but if it is not a parent we need to be checking into everyone in that household. What we have seen happen to these children is completely and totally unacceptable. There are so many who have been forced into sex trafficking, have been forced into labor trafficking, of which we know—we have got to make sure that we are taking a look, and that we are trying to keep them safe.

And so the Field Guidance, then, I guess is not in effect then; the March 31, 2021, Field Guidance?

Secretary BECERRA. I will get back to you on the Field Guidance. But I am not aware of any sex trafficking of the kids that we have been able to place with a sponsor. If you can provide us with the evidence that there has been sex trafficking——

Senator BRITT. Certainly. Absolutely.

Secretary BECERRA [continuing]. I would love to see that.

Senator BRITT. Absolutely. And so the decisions to terminate any of those things, I certainly, I would love to follow up with, and I will submit some questions for the record for that as well. And so when you are looking at the different things that are occurring also too—I only have 14 seconds left—guys, I have got to learn how to do this quicker.

Senator BALDWIN. Negative-14.

Senator BRITT. Oh negative-14. Okay. Guys, thank you for your time. I have a number of other questions within that line——

Secretary BECERRA. We can follow up.

Senator BRITT [continuing]. That I would love to get to the bottom of. These children, it is a passion for me, as a mama of two school-aged children, that we are making sure that we are not putting them in harm's way.

Secretary BECERRA. I thank you for your passion.

Senator BRITT. Thank you.

Senator BALDWIN. We will have the opportunity for a second round of questions, and obviously an opportunity to submit questions for the record.

Senator Reed, it is now your turn.

Senator REED. Thank you very much, Madam Chairman.

Secretary Becerra, great to see you; I had the privilege of serving with you in the House, and you are doing a superb job as the Secretary. So thank you.

ARPA–H

We spoke on the phone a few weeks ago about the growing importance of research into RNA (Ribonucleic acid), that was the real driving force between the COVID vaccine, and as I indicated on the phone, Brown University in Rhode Island, is establishing itself as one of the leaders in RNA research. They are putting up an extraordinary amount of money for facilities, et cetera. At the same time, ARPA–H is quickly standing up, hopefully, making the RNA project one of their first and most important objectives.

So could you give me a sort of a read out of where we are? And also, going forward, keep me posted? And as I said, I think Brown is really the place where the Academia and ARPA–H can meet.

Secretary BECERRA. Senator, I communicated the information you—we discussed to the folks at ARPA–H, Dr. Wegrzyn, the Director is—she just recently, for example, announced that one of the three sites for ARPA–H will be based here in the DMV (District of Columbia, Maryland, Virginia). And what we know is that she is going to use a hub and spoke model, as she has mentioned, where it is not going to be a heavy footprint in any one particular place, because what they are looking for is, all these creative ideas that sometimes are generated by the smallest of business but they have a great idea they just don't have the capital.

And from what I can tell you, they are beginning to receive solicitations for grants, they have hired some of the program managers who will be in charge of the projects. And we can make sure that the folks at Brown are in touch with the correct program managers within ARPA–H, to make sure that their proposal is considered.

SUICIDE AND 988

Senator REED. Thank you very much, Mr. Secretary. Let me turn quickly to an issue that is extremely troubling. That is suicides in the United States, particularly with young people. It is a public health crisis. Recently with the cooperation of many people on this panel, we were able to get through the 988 number, which is a simplified way to seek out counseling support, just to speak to someone else.

Can you talk about the President's budget request for the 988, and all the associated support, and how that funding could be used to increase awareness to young people, especially? And also, I might add, young people, I have a 16-year-old, they don't use telephones the way we used to do. They don't dial.

Secretary BECERRA. Yes.

Senator REED. I don't know what they do, but a text, text is the thing. So are we going to get into the text world too?

Secretary BECERRA. Yes. Senator, I still don't understand it, how someone, especially someone who is going through a real crisis, thinks it is easier and better to text, than to actually speak to a live person but that is—and it is working. And I have got to tell you, we have seen a dramatic increase in the number of texts that we have received.

By the way, I need to say thank you to you and your colleagues, because it was the Federal Government's resources that helped stand up the Text and Chat functions within 988. The States, and we keep asking the States to come forward, because there are some States that have actually created a permanent stream of funding for their 988 operations.

Remember, 988 is not a national suicide prevention lifeline, it is a nationwide system that brings together the States. And we, because of the resources you gave us, were able to glue it together. But it still requires resources, and we are doing the Text and Chat function, we help stand up and expand a Spanish language function, so those who are limited in English can communicate as well. We are doing something that is specialized for LGBTQI+ communities as well. There is a line that has been stood up in the State of Washington for Native American community members.

And so we are finding that everyone is trying to figure out how they can really reach folks. And the President's budget continues his dramatic commitment to 988, by putting in several hundred million to make it work. Because people are calling, and it is kind of sad that people are calling, because that means people are hurting. But at least they are calling.

Senator REED. Thank you very much. Just a final point; I think you have also reached out to the veterans community, the specialized line.

Secretary BECERRA. Yes, we did. Yes, the special——

Senator REED. I commend you and your implementation. Many times, we do things, and they don't really get implemented. You have done a superb job.

Secretary BECERRA. Thank you very much.

Senator REED. Thank you, Mr. Secretary. Thank you, Madam Chair.

Senator BALDWIN. Thank you. We are now going to start a second round of questions. There may just be a handful of us coming around for a second round, but I will begin. And I am going to begin on a theme you were just talking about, and that I ended on, which is this continued focus on the 988 telephone number.

Since it was launched last summer, there has really been a dramatic increase in folks who reached out to it. I know when former Senator Gardner and I introduced the legislation we were like: Who memorizes a 10-digit phone number.

Secretary BECERRA. Yes.

988

Senator BALDWIN. And has it, like, available, handy when they are in crisis. But the budget that you are here discussing does request another significant increase in funding to be able to respond to an estimated 9 million contacts that will occur in fiscal year 2024. Some of the people who called need referrals in their own communities across the Nation for additional crisis intervention services after the initial phone call or text chat.

How does this budget, not just bolster the local crisis centers, but also help the Nation's crisis system, so that people who need follow up can receive that care in their own communities?

Secretary BECERRA. Great question, Senator, because that is the next big hurdle, is making sure people are receiving the post-contact services, and sufficient services. And so the great thing about 988, is it lets us bring that person in, start to find out what they need, and then direct them to the services that will help. Before then, it was usually the emergency room that would take a lot of these individuals. And so we are able to better make sure that we are sending them to the right place.

The other thing that we are finding; and I don't think anyone really thought of this. I don't know if you did when you all were thinking about this. The great thing about 988, we are getting people who were afraid to call 911, because they thought that law enforcement would come and respond, and that is the last thing they wanted.

And so we are getting more and more people who are actually communicating. And so that the beauty of it is that people have responded. They have taken up 988. Now, we have got to make sure we follow through. We did a very good job of making sure if you called you wouldn't get a busy signal, or be put on hold, but now we have to make sure that once you do talk to that professional, we guide you to the next professional, may be in person, but somehow we do the follow-up care.

UNACCOMPANIED CHILDREN

Senator BALDWIN. Next, I want to return to another topic that has been addressed, and that is the follow up for unaccompanied children. And just very specifically, because you have gotten so many questions about this, you walk through the steps that HHS has taken to ensure that kids are placed, first of all, with appropriate family members or sponsors, and the challenges associated with that. But then moving forward, what are you doing? And what are you asking to be enabled to do through this budget to expand

services for children after they have been released from the DHHS part of their care? And what can we do in fiscal year 2024 to support that greater follow up?

Secretary BECERRA. I am glad we are doing follow-up questions, because that gives you this opportunity to ask that question. People, I think, misunderstand the role of HHS, and our jurisdiction. We receive these kids because the Department of Homeland Security cannot keep them. They are immigrant individuals that would, typically, be held by DHS, Department of Homeland Security. Except for the fact that they are children and they are not with an adult.

So since they are detached from adult, they need to have someone who can take care of them, provide them custody. And that is where they come to our care, because we are the Agency that deals with healthcare and kids.

We then have jurisdiction with the statutes, the laws that you have passed, to actually care for these children. We care for the children, but because of the laws and court rulings, we are obligated to find them a better place to stay instead of in a large congregate setting. We do that by trying to vet a sponsor. Oftentimes, it is the parent himself or herself, oftentimes it is an immediate family member, aunt, uncle, older sibling.

We do everything we can to get them as close to an immediate family member as possible. Rarely do we assign a child to someone who is not known to the child. There has to be a compelling reason to do that. Our background checks also get more intense, the less it is a parent who would get that child.

But the moment we find that suitable sponsor that has gone through the background checks, and we place that child, our jurisdiction has actually ended. The jurisdiction we have is to try to do—and this is what we started doing ourselves, and now you have provided us with some money, is to do a post-release check, to find out how they are doing.

But the child doesn't have any obligation to respond, the sponsor doesn't have an obligation to respond. Under the laws that you all have passed, we don't have the jurisdiction to say: Hey, get back to us. We also, of course, don't have jurisdiction to say: Employer, you can't hire these kids. And so if folks would understand the roles that we play, the Department of Labor has said how they are going to try to get more aggressive when it comes to child labor enforcement.

And we are going to start working together, DOL (Department of Labor) and HHS, to make sure that if they are getting signs that there is somebody who is using kids to do labor in places that it is dangerous that they can let us know, confidentially, because they are doing investigations, and then we can try to check to find out if that individual happens to be someone who is trying to become a sponsor; that way we never will release that child to that sponsor.

Thank you for giving me a chance to sort of explain the process, because I think some people believe that we continue to have jurisdiction to continue to care for children even after placement.

Senator BALDWIN. Senator Capito.

MEDICARE ADVANTAGE

Senator CAPITO. Thank you, Mr. Chairman. Earlier this year, I helped to lead a bipartisan letter of 60 of my colleagues, in support of the Medicare Advantage Program. Medicare Advantage is a critical choice for seniors in West Virginia, 43 percent, and it is growing every year, are in Medicare Advantage, 189,000. Most of the beneficiaries of Medicare Advantage spend approximately 40 percent less than Medicare fee-for-service beneficiaries, which is critical because 53 percent of those beneficiaries are below, annual incomes below $25,000, so cost is an issue.

In the 2024 Advance Notice for Medicare Advantage, CMS proposed changes that I believe, and my colleagues believe, hence with 60, anytime we can get 60 on a letter that tells you something, could result in beneficiaries experiencing higher out-of-pocket costs for prescription drugs, for a very popular program that people have adjusted to and really, really like, and want, and request.

Can you provide assurances that the proposed policy changes will not lead to increased beneficiary costs, or disruption of Medicare Advantage to seniors in 2024?

Secretary BECERRA. Senator, I absolutely can provide assurance that the benefits that Medicare provides that are administered, whether it is through the Medicare Managed Care Program, what is called Medicare Advantage, or whether it is provided through the traditional Medicare Program, called Fee-For-Service, that the benefits that Medicare calls for in the law, are not changed, are not diminished, and therefore should not be cut.

If they are cut, it is not because the Federal Government has asked for them to be cut. It is because the provider has decided to make cuts in certain areas. They are not allowed to make cuts to Medicare benefits, they may change the package of benefits that they provide within a particular plan, and may change out certain benefits but they are not allowed, under law, to cut Medicare benefits from any beneficiary. And if they tell you they are going to have to, then I say to you right out front, that is an unequivocal untruth.

Senator CAPITO. Well, I am asking you the cost issue though. Will the changes that you make, or that you want to make in the Medicare Advantage program result in higher cost to the Medicare Advantage recipient, and the person who has chosen those programs?

Secretary BECERRA. Absolutely not, we are actually providing more money this year for the Medicare Advantage plans than we did last year.

Senator CAPITO. So what is causing the stir then?

Secretary BECERRA. Well, they don't like that they are not getting as much money as they are accustomed to getting, and that——

Senator CAPITO. Well, how could they not be getting as much, if you are getting more?

Secretary BECERRA. Well, they have been getting very large increases, year-over-year. And that is because they oftentimes, as you have perhaps heard, they over code. They list someone as being

more ill, more sick than they are, and as a result of the higher coding, they can bill a higher rate.

They don't like that we are going in and saying: No, we want to make sure it is an appropriate coding. So if someone has diabetes, okay, we will reimburse you for the diabetes care, but you have got to show us that you are giving diabetes care. And not just say it, then not provide the care, and still bill Medicare.

Senator CAPITO. Well, I just think the satisfaction numbers alone of Medicaid Care Advantage, are big. And again personal experience with this, with both my parents being on Medicare Advantage Plan, easy to do, easy to understand, and out-of-pocket costs very, very low; so we have got our eye on that one. And a quick question I have on——

Secretary BECERRA. And Senator, if I just may?

Senator CAPITO. Yes, you can. Yes.

Secretary BECERRA. There are absolutely plans that are doing well, doing the right thing, and doing well by their patients, absolutely.

PANDEMIC PREPAREDNESS

Senator CAPITO. Oh. Thank you. The last question I have is: the budget includes a proposal for $20 billion in new mandatory funding for pandemic preparedness and response. So I want to be clear here, I am supportive of efforts to bolster our Nation's pandemic preparedness and response, but I am concerned that this is sending mixed messages, because HHS came to us last year for $82 billion, so now it is down to $20 billion other—you know, what is the difference in this request? Because it wasn't granted because it was just—for a lot of reasons. I will leave it like that.

Secretary BECERRA. Honest truth, we could use the $80 billion, we don't expect that you all will give us the $80 billion, we hope that you would at least give us the $20 to $30 billion, because in order to prepare—let us put it this way, to prepare it takes a lot of work. We saw how much we had to spend once we were in the pandemic, we could absolutely use that money to prepare, to get States better prepared. But we want to be realistic. What will you move with? We think that $20- to $30 billion is a good place to go that gets us at least in a place where we are preparing.

Senator CAPITO. And I would just, last comment, the pushback on the original request last year, a lot of it was: You are sitting on a bunch of COVID dollars that are still not going to be spent out for several years, why can't we, you know, repurpose those?

Secretary BECERRA. Yes.

Senator CAPITO. I think that is a legitimate question, I will leave it to that. Thank you.

Secretary BECERRA. Okay.

Senator BALDWIN. Senator Moran.

MEDICAL RESEARCH INVESTMENTS

Senator MORAN. Thank you, Chairwoman. I would first like to acknowledge, as several of my colleagues have done, the purple in the audience, thank you much for your presence, and for the rounds of conversations you have had, and with me and my staff, and with others across the Senate.

I hope that you know, that your efforts on Capitol Hill do matter, and you should take great pride in the fact that they have mattered. This subcommittee, in particular, it has new leadership this year, but I have no doubt, will make every effort to prioritize the funding of medical research, and in a significant way, prioritize the funding of research to find the cure, delay, the drug that so desperately is needed by Alzheimer's patients and their families.

So thank you for your advocacy. It is something that I would speak on behalf of my colleagues, that we are all proud of ourselves, although the real credit belongs to you and many others for the success, a bipartisan success that has occurred now, I think, for 5 years, maybe we are on our 6 year, in which those of us still on the committee, and those who preceded us, have made certain that this topic is something that matters to us, because it makes such a difference.

STRATEGIC NATIONAL STOCKPILE

Mr. Secretary, the Strategic National Stockpile. You and I had this conversation in last year's appropriation process. And I want to ask a couple of questions. I understand, and you indicated in your testimony a year ago, that you understand the importance of maintaining a Strategic National Stockpile. I appreciate that acknowledgment.

This committee has acknowledged, as well, that there is a need for the funding for that stockpile to be increased, but we have been hesitant to have a significant, meaningful increase because we don't have the information that we need to do so. We have been unable to do oversight because of lack of information. And so I would ask you or the administration for strategic preparedness and response, if you would provide me, this subcommittee, a detailed and comprehensive update on the SNS (Strategic National Stockpile) since COVID–19 depleted it; is that something that is doable?

Secretary BECERRA. I don't see anything in the request that would be confidential or non-disclosable, so let me get back to you. But I think we can respond.

ADMINISTRATION FOR STRATEGIC PREPAREDNESS AND RESPONSE

Senator MORAN. And the second part of that, the second question in a part of this conversation is: How can ASPR (Administration for Strategic Preparedness and Response) work better with Congress, and specifically this subcommittee, to achieve our mutual goal of a well-stocked, and carefully managed stockpile.

Secretary BECERRA. Thank you for the question. By the way, I hope that your staff will follow up with us because the work that ASPR is doing, our administrator and the Agency first strategic preparedness and response has been phenomenal. If I were to ask anyone in this room: Can you name me the date when the—there was a Warp Speed transition from the Department of Defense on COVID, to the Department of Health and Human Services?

I doubt there is anyone in this room who could tell you when it happened, because it was seamless. And it is because the folks at ASPR handled this with professionalism, they have been doing this work since 2021, when they took over after Warp Speed

transitioned over to HHS from DoD (Department of Defense). And it has gone very well.

I mentioned close to 700 million shots in arms, as a result of the COVID vaccine. I would love to have Administrator Dawn O'Connell, speak to you and your staff directly, or to any members of the staff, because we have depleted the stockpile, and we need to get back to—for example when we did Mpox, monkeypox, we used a lot of the smallpox vaccines that we are storing in the event smallpox should ever hit this country, because that vaccine also worked against the monkeypox, against Mpox, we started using some of that vaccine.

We need to replenish that. We have got no money to address Mpox, and so we took that out of the stockpile, to replenish those smallpox vaccines will cost money, but we need to. And so I absolutely want you to have sight, because neither you nor I wants to be caught flat-footed if we find that our stockpile is depleted. So we will follow up.

Senator MORAN. Thank you. I appreciate you expanding. Certainly COVID was an important component of the necessity for vaccines, but this is broader than that.

Secretary BECERRA. Yes.

Senator MORAN. You mentioned monkeypox, there is a whole array in today's dangerous, adversarial face—circumstance we face in the world, and we need to be fully prepared.

My final question Chairwoman is, ASPR recently released its industrial base expansion platform. This is the desire that many of us have, to see that we are not dependent upon some other country to provide us with the necessary ingredients for a product to be stockpiled. Do you think there is a similar pathway to increase the opportunities for smaller biotechnology and manufacturing companies to offer their supplies to SNS?

Secretary BECERRA. The answer is yes. And by the way, Senator, great question, because it points out why it is so essential that we receive money that $20- to $30 billion that we are asking for with regard to COVID, because that will help us replenish some of the accounts that were depleted as a result of COVID, including, of course, the stockpile.

Remember that the stockpile maintains supplies of product and material that expire, and if we don't keep those supplies replenished, we may have something in our storage units but it really won't serve the true purpose. And so there is so much that goes on, that goes well beyond COVID, as you said. And absolutely, one of the things we would love to do, as we were trying to get the dollars, the $80 billion dollar request for COVID to replenish funds, would have given us a chance to actually start working on domestic production, because ASPR could have focused some resources, on actually trying to, you know, stand up that domestic production.

But we are so caught right now, we are trying to just backfill our reserves that it makes it tough to even consider try to help domestic production really launch in this country.

Senator MORAN. I hope my conversation indicates to those who are listening to you and I having this conversation, that there is an interest in finding ways to be helpful.

Secretary BECERRA. 150 percent.

Senator MORAN. Thank you.

Senator BALDWIN. Well, thank you, to my colleagues; thank you, Secretary Becerra, for being here today. I think we had a good discussion. And I am looking forward to working with the Department, and Members of the Subcommittee as we start this 2024 appropriations process.

ADDITIONAL COMMITTEE QUESTIONS

Questions for the record are due by next Wednesday, March 29. And I would certainly appreciate and expect DHHS's response within 30 days of that.

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

QUESTIONS SUBMITTED TO SECRETARY XAVIER BECERRA

QUESTIONS SUBMITTED BY SENATOR TAMMY BALDWIN

Question. Over 20 percent of Wisconsin counties are considered a maternity care desert. Last year, HRSA determined over 6,300 Maternity Care Target Areas exist nationwide.

What does HRSA need to support the maternal healthcare workforce and make sure that more women are able to access care?

Answer. As noted, HRSA has identified Maternity Care Target Areas (MCTAs) and scored them to rank those with the greatest need for maternity care health professionals. The National Health Service Corps (NHSC) is utilizing these scores in making loan repayment awards to maternal health practitioners (e.g., OB/GYNs, Family Medicine physicians who practice obstetrics regularly, and Certified Nurse Midwives) who agree to serve in MCTAs. HRSA's FY 2024 Budget includes a request for $965.6 million, which includes $175.6 million in discretionary funding, for the NHSC including to support the placement of maternal health providers in MCTAs.

Question. HRSA's FY24 budget includes a request for $175.6 million in discretionary funding for the NHSC, with $25 million set aside for mental and behavioral health providers. What is the estimated funding need for maternity care providers?

Answer. In FY 2023, the NHSC will for the first time use the new MCTA designation to distribute maternity care health professionals who will receive loan repayment in exchange for their service. A MCTA is a geographic area within a primary care Health Professional Shortage Area (HPSA) that has a shortage of maternity care health professionals. The higher the MCTA score, the greater the need for maternity care health professionals. The NHSC Loan Repayment Program will review and approve applications from maternity care health professionals by descending MCTA score and in consideration of the program funding priorities. Using this methodology, HRSA will make loan repayment awards to maternity care health professionals in the areas with the greatest needs until the funds are exhausted. Since HRSA is still accepting applications, we cannot estimate the total funding needs associated with MCTAs.

Question. The FY2024 President's Budget includes $400 million for new flexible funding to rapidly develop vaccines, therapeutics and diagnostics, support emergency manufacturing of critical medical countermeasures and supplies, and expand the domestic medical supply chain.

How does HHS plan to invest in domestic manufacturing with this funding? How much of this funding does HHS estimate would go toward domestic manufacturing?

Answer. The Administration for Strategic Preparedness and Response (ASPR) is investing in securing a strong domestic manufacturing base to produce essential products such as medical equipment, pharmaceuticals, vaccines, and personal protective equipment (PPE). Since the beginning of the COVID–19 response, ASPR has supported over 87 contracts to build and sustain domestic manufacturing of critical medical supplies and to produce medical countermeasures (MCMs) on U.S. soil. The $400 million requested in the FY24 President's Budget for this work will also ensure we are able to maintain the capabilities built and used extensively during the COVID–19 pandemic to strengthen medical countermeasure development and manufacturing. In addition, with ASPR's reorganization in February 2022, ASPR estab-

lished the Industrial Base Management and Supply Chain (IBMSC) Office to ensure we have dedicated, full-time staff devoted to addressing this long-term challenge.

Funds could support purchasing domestically made product for inclusion in the Strategic National Stockpile (SNS), reducing reliance on foreign production. The $400 million Pandemic Preparedness and Biodefense request will ensure the Biomedical Advanced Research and Development Authority (BARDA) has ready resources to immediately scale up manufacturing of vaccine, diagnostic, and therapeutic prototypes at the first indication of an outbreak. The requested funding would also accelerate advanced development and additional manufacturing of medical countermeasures for clinical trials and, when appropriate, patient care as part of an emergency response.

Question. How would this strengthen our national security and biodefense capabilities?

Answer. The recent COVID–19 and mpox responses emphasized the importance of flexible funding that is available for immediate actions as public health threats emerge. At the start of the mpox outbreak, the SNS was only able to deliver to five sites in each jurisdiction, resulting in each jurisdiction having to forward distribute the products to their hospitals and vaccination clinics. While such a system is more than enough for the high-consequence, large-scale chemical, biological, radiological, nuclear, and explosive events that the SNS typically plans for, there was increased burden on the jurisdictions in this nationwide mpox response. Incorporating lessons learned and being able to pivot and address needs in real time is critical to advancing and securing national preparedness. If appropriated, the $400 million for Pandemic and Biodefense would strengthen not only advanced development and additional manufacturing of medical countermeasures, but also when appropriate, address and strengthen patient care as part of an emergency response.

Ultimately, lack of readily available funding, as we saw with the H1N1 influenza and COVID–19 pandemics, can delay development of critical MCMs by weeks or even months until supplemental funds are appropriated. Paying for initial response efforts may require movement of funding from other ongoing development efforts for high priority threats, potentially impacting the nation's preparedness for those threats. Having this readily available funding at the start of an outbreak is essential for a robust and rapid response, especially to achieve the bold timelines outlined in the American Pandemic Preparedness Plan.

Question. HHS recently recognized the organizations that serve as hubs in the new public-private health information sharing framework called TEFCA. This marks important progress toward interoperability, but we must work to ensure that providers treating our most vulnerable and underserved patients are able to benefit from this framework.

What resources do providers, including those that serve underserved communities, need to join TEFCA?

Answer. The Trusted Exchange Framework and Common Agreement (TEFCA) establishes a floor for universal interoperability across the country through a network of networks. To establish nationwide exchange of health information, TEFCA creates common "rules of the road" to ensure trust and to create efficiency. Therefore, the Common Agreement, which will be signed by the Recognized Coordinating Entity (RCE) and each Qualified Health Information Network (QHIN), provides certain flow-down provisions that the QHINs will be required to include in their contracts with their Participants (which could be providers) and that those Participants will be required to include in their contracts with their Subparticipants (which also could be providers). All Participants and Subparticipants will be required to sign a contract that includes these flow-down provisions before engaging in TEFCA exchange activities.

In many cases, providers, including those that serve underserved communities, will be able to meet the above contractual requirements via modifications to existing contracts they have with entities that will become a TEFCA QHIN, Participant, or Subparticipant (e.g., a data sharing agreement with a Health Information Exchange or with their electronic health record (EHR) vendor). Providers will also generally be able to leverage existing technical connections with those same entities. In these cases, any new legal and technical costs could be relatively small.

Providers that are not currently engaging in data sharing would need to make investments to become a QHIN, Participant, or Subparticipant under TEFCA. This would include fees for participation in a network, legal costs associated with signing a data sharing contract, and both technical and human capital costs (e.g., updates to their existing EHR systems, developing new interfaces, and employing health information technology (IT) staff to enable and support the technology). These costs would include both upfront investments and ongoing costs.

The structure of TEFCA, with multiple QHINs as the foundation, will enable providers to choose from multiple options for connecting to the network of TEFCA-compliant QHINs. We believe this competitive marketplace of QHINs will benefit entities joining TEFCA, including providers, by allowing such entities to find and select a QHIN that fits their technical and cost needs.

We understand that costs related to electronic exchange of health information continue to be a challenge, particularly for small and rural providers. For instance, the costs for updating EHR systems or developing interfaces are significant challenges to providers' ability to electronically exchange health information because they often lack financial resources to afford more advanced EHR systems or pay for additional features to be added to their system.

We are also aware that the cost and availability of health IT staff is a barrier to electronic exchange of health information. For many practices, it is difficult to afford or find staff with health IT knowledge to support an infrastructure that is capable of electronic exchange of health information, particularly in rural areas of the country. In a 2019 survey of office-based physicians by the Centers for Disease Control and Prevention's (CDC) National Center for Health Statistics, 37 percent of physicians responded that the lack of health IT staff was a barrier in their ability to electronically exchange health information.

Recent data indicates that another need for healthcare organizations in relation to joining TEFCA is simply a lack of awareness about TEFCA itself. In a 2022 survey of hospital IT leaders, about half of respondents said they were not aware of TEFCA, and substantially more respondents from small, rural, and independent hospitals, and hospitals that are not currently participating in an interoperability network, indicated they were not yet aware of TEFCA. We believe that a substantial fraction of other healthcare organizations (i.e., healthcare organizations other than hospitals) require additional information about TEFCA as well, particularly organizations with fewer resources, paralleling what we see among hospitals.

Question. What is HHS doing to make these resources available?

Answer. ONC and the TEFCA Recognized Coordinating Entity (RCE) are committed to effectively educating and engaging healthcare providers and organizations about TEFCA. ONC and the RCE will continue to host public feedback sessions to provide information and educational resources to interested parties and elicit input from those parties as TEFCA is implemented and matures.

ONC and the RCE will continue to develop educational resources that are designed to inform interested parties about how TEFCA will work and how it may reduce their costs related to electronic exchange of health information. For instance, the RCE published the *Informational Resource for Flowing Down Common Agreement Provisions* into Framework Agreements, which is intended to assist QHINs, Participants, and Subparticipants in complying with their Common

Agreement flow-down obligations. We believe this resource, along with others the RCE has published, will save entities interested in joining TEFCA significant time, resources, and legal fees.

As noted in the question, on February 13, 2023, the first set of six QHIN applicants were accepted for onboarding to TEFCA. Once fully onboarded, the organizations would officially be "designated" as QHINs. ONC expects these entities, and potentially other candidate QHINs, would engage in significant marketing activities, which would also be a means of disseminating information to providers that are currently not aware of TEFCA.

Concerning financial resource needs, per State Medicaid Director's Letter #18–007, State Medicaid agencies were advised that enhanced Federal technology funding under section 1903(a)(3) of the Social Security Act (SSA) "could include any state investments in supporting Section 4003 of the [21st Century] Cures Act,[1] both in terms of the design, development and implementation of such connections as well as the maintenance and operations of such connections."

TEFCA could potentially address some of the financial challenges that providers face in other ways as well. In a 2019 survey of office-based physicians, the two most commonly cited barriers to interoperability were difficulty exchanging health information with providers using different EHR vendors (reported by 85 percent of respondents), and that exchange involves the use of multiple systems or portals (reported by 73 percent of respondents).[2] TEFCA is designed to help address both of these barriers. TEFCA will make it possible to significantly reduce the number of

[1] Public Law 114–255, Section 4003 includes the requirement for ONC to develop or support TEFCA.

[2] Pylypchuk Y., J. Everson, D. Charles, and V. Patel. (February 2022). Interoperability Among Office-Based Physicians in 2015, 2017, and 2019. ONC Data Brief, no.59. Office of the National Coordinator for Health Information Technology: Washington DC.

connections that healthcare providers need to make to get the health information they seek. As a result, once implemented, participating providers could have a reduced need to develop costly interfaces or connections to exchange health information with multiple other healthcare providers. This could be particularly helpful for small providers or those that serve rural areas of the country, as it could make exchange less costly and give providers potentially more options.

While we believe outreach and education and the potential use of Medicaid funding could help providers participate in TEFCA, including those that serve underserved communities, we are cognizant that these efforts do not address all resource needs for such providers, particularly those that are not currently engaging in electronic exchange of health information. These include expected network fees, legal and technical costs, as well as IT staffing shortages and gaps in broadband access that pose particular challenges to electronic exchange of health information for small and rural providers. Addressing such challenges will be essential to the widespread use and adoption of TEFCA by providers in underserved communities.

QUESTION SUBMITTED BY SENATOR JEFF MERKLEY

Question. Mr. Secretary, I appreciate the $122 million increase for the Maternal and Child Health Block Grant included in the President's Budget. However, I remain concerned that as many as 35 states are not using this block grant funding for stillbirth prevention activities even though it is an allowed use of funds—despite the fact that an estimated 1 in 4 stillbirths in the United States are potentially preventable.

Mr. Secretary, can you clarify whether or not Title V—Maternal and Child Health Block Grant funds can be used for stillbirth prevention activities?

Answer. Yes, stillbirth prevention and reporting activities are currently authorized under the existing Title V Maternal and Child Health (MCH) Block Grant statute and states are currently supporting stillbirth prevention activities. For example, as of 2022, 47 state Title V programs supported or partnered with fetal-infant mortality reviews (FIMRs) and Child Death Reviews (CDRs) to better understand the causes of fetal/infant deaths and to inform recommendations for changes to prevent deaths and reduce fetal and infant mortality.

QUESTIONS SUBMITTED BY SENATOR BRIAN SCHATZ

Question. I am concerned we are facing a telehealth cliff in 2024. My bill, the CONNECT for Health Act, would ensure permanent expansion of Medicare telehealth coverage. At the same time, I have questions regarding CMS's implementation of key elements of telehealth payment policy, and worry that these decisions may hamper our healthcare system as it permanently transforms to a hybrid of virtual and in-person care.

Audio-only services. There are a variety of high-value, low-tech telehealth modalities that benefit patients' access to care, including audio-only services. CMS could modify the definition of "interactive telecommunications systems" in regulations and program instruction to ensure that providers can utilize all appropriate means and types of technologies to furnish telehealth services. However, CMS stated in the CY23 Physician Fee Schedule (PFS) Final Rule that its regulatory interpretation of "telecommunications system" generally precludes audio-only services except under certain circumstances.

What clinical guidelines and peer-reviewed evidence is CMS using to draw the distinction outlined in the PFS to determine when to cover and exclude care modalities from the Medicare telehealth services list?

Since CMS has already determined that it can update its definition of "interactive telecommunications systems" in certain circumstances, what, if any, additional statutory authorities does CMS need to ensure continued coverage?

Answer. Requests for adding services to the list of Medicare telehealth services may be submitted on an ongoing basis. First, CMS determines whether or not the requested services are similar to the current list of telehealth services. Our review of requests that are not similar will include an assessment of whether the service is accurately described by the corresponding code when delivered via telehealth and whether the use of a telecommunications system to deliver the service produces demonstrated clinical benefit to the patient. Requestors submit evidence indicating that the use of a telecommunications system in delivering the candidate telehealth service produces clinical benefit to the patient. The evidence submitted should include both a description of relevant clinical studies that demonstrate the service furnished by telehealth to a Medicare beneficiary improves the diagnosis or treatment

of an illness or injury or improves the functioning of a malformed body part, including dates and findings, and a list and copies of published peer reviewed articles relevant to the service when furnished via telehealth. Our evidentiary standard of clinical benefit does not include minor or incidental benefits.

Historically, CMS has not proposed any permanent modifications to the definition of "interactive telecommunications system" to allow for use of audio-only communications technology due to our interpretation of the statutory requirements, as well as concerns over program integrity and quality of care. Specifically, CMS has been concerned that the use of audio-only communications technology for Medicare telehealth services could lead to inappropriate overutilization and we believed that video visualization of the patient generally was necessary to fulfill the full scope of service elements of the codes included on the Medicare telehealth list.

However, in 2020, Congress enacted the Consolidated Appropriations Act, 2021, which included a provision that removes the geographic restrictions for Medicare telehealth services for the diagnosis, evaluation, or treatment of a mental health disorder, and adds the patient's home as a permissible originating site for these telehealth services. Given considerations related to experience during the PHE and implementation of this provision, CMS believed it was appropriate to revisit our regulatory definition of "interactive telecommunications system" beyond the circumstances of the PHE to allow for the inclusion of audio-only services under certain circumstances. We also believe that mental health services are different from most other services on the Medicare telehealth services list in that many of the services primarily involve verbal conversation where visualization between the patient and furnishing physician or practitioner may be less critical to provision of the service.

Therefore, we finalized a change in the definition of interactive telecommunications system to include audio-only communications technology when used for telehealth services for the diagnosis, evaluation, or treatment of mental health disorders furnished to established patients when the originating site is the patient's home. Outside of the circumstances of the PHE, we continue to believe that our longstanding regulatory interpretation of the Medicare statute that "telecommunications system" generally precludes the use of audio-only technology for purposes of Medicare telehealth services with the exception under certain circumstances of telehealth services to diagnose, evaluate, or treat a mental health disorder (including treatment of a diagnosed SUD or co-occurring mental health disorder). We would be happy to provide technical assistance on any legislation that would update the statute to include coverage of audio-only E/M services.

Question. Direct supervision. Residents and other trainees should be exposed to telehealth, as this is now an essential component of clinical practice. There are successful models at academic medical centers and other training settings where clinicians provide direct supervision through virtual presence. I am discouraged that in its CY23 Physician Fee Schedule, CMS has chosen to terminate the supervision flexibilities granted during the public health emergency.

What is CMS's rationale for taking this stance regarding direct supervision?

What information could stakeholders provide CMS to demonstrate that this temporary exception should be made permanent in future rulemakings?

Answer. During the Public Health Emergency (PHE) for COVID–19, CMS temporarily modified the regulatory definition of direct supervision, which requires the supervising physician or practitioner to be "immediately available" to furnish assistance and direction during the service, to include "virtual presence" of the supervising clinician through the use of real-time audio and video technology. Under our currently finalized policies, CMS will continue to permit direct supervision through a virtual presence through the end of the year in which the PHE ends (through December 31, 2023). We continue to gather information on this topic, and we appreciate the information provided by commenters in the CY 2023 Physician Fee Schedule Rule. We believe allowing additional time to collect information and evidence for direct supervision through virtual presence will help us to better understand the potential circumstances in which this flexibility could be appropriate permanently, outside of the PHE for COVID–19.

Question. Protecting provider privacy. The architects of Medicare systems never envisioned that a provider would be practicing from their home. However, today it is commonplace and used as a strategy to reduce provider burnout. I am concerned that when providers furnish care from their homes, CMS will soon require that they publicly report their home address as the practice location.

How is CMS considering alternate strategies and changes to its systems so that providers can report practice locations, safeguard privacy, and ensure completeness of information to process claims?

What information could stakeholders provide CMS to demonstrate that it should alter its current systems?

Answer. During the Public Health Emergency (PHE) for COVID–19, CMS allowed practitioners to render telehealth services from their home without reporting their home address on their Medicare enrollment while continuing to bill from their currently enrolled location. This waiver will continue through December 31, 2023. CMS is open to receiving information from providers and other interested parties regarding the reporting of practice locations.

Question. Native Hawaiians and Pacific Islanders are underrepresented in all national health surveys. The limited data that are available demonstrate that NHPI people face persistent, disproportionate morbidity and mortality compared with other demographic groups. The paucity of data has restricted our understanding of the range and depth of health issues facing the NHPI population, and therefore curtailed the policies and programs that might mitigate these disparities. While the National Health Interview Study is fielded annually, it has been a decade since the sole Native Hawaiian and Pacific Islander National Interview Study was conducted. I believe it is past time to collect high- quality data on the NHPI population.

What novel insights were identified on NHPI health in the 2014 Native Hawaiian and Pacific Islander National Health Interview Study?

Answer. In 2014, to fill the Native Hawaiian and Pacific Islander (NHPI) health statistics data gap, the CDC's National Center for Health Statistics (NCHS) fielded the Native Hawaiian and Pacific Islander National Health Interview Survey (NHPI NHIS). The NHPI NHIS made it possible, for the first time, to calculate unprecedentedly reliable, precise, releasable statistics on the health conditions, health behaviors, and healthcare access and utilization for the U.S. NHPI population as a whole and for disaggregated NHPI groups. This survey yielded benefits in three key areas: comparison across race groups, creation of NHPI-focused chartbooks, and increased capacity for researchers.

Comparison Across Race Groups

The 2014 NHPI NHIS data were uniquely valuable because they were comparable to the 2014 NHIS data, which made it possible to compare outcomes among all five of the federally recognized race groups. Using 2014 NHPI NHIS data, it was possible to do the following:

—Clearly distinguish health disparities between NHPI and Asian populations, long obscured in combined "Asian and Pacific Islander" (API) statistics or unreliable NHPI statistics.

—Identify similarities of the NHPI population with the Black and African American population, long obscured by combined API statistics and unreliable NHPI statistics.

—Understand the differences among the disaggregated NHPI population groups, including Native Hawaiian, Samoan, and Guamanian or Chamorro populations.

—Identify the social determinants of health and healthcare access and utilization across the life course in the NHPI population.

NCHS NHPI NHIS Chartbooks: Thousands of unprecedented insights

NCHS created a set of visually oriented and estimate-dense reference chartbooks with disaggregated NHPI statistics for a broad range of health measures, as requested by the NHPI community stakeholders during the 2014 NHPI NHIS planning period. These chartbooks made it easy to compare statistics across Federal race groups and among disaggregated NHPI groups for over 50 health condition and health behavior measures and 15 healthcare access and utilization measures. Estimates were presented for single race and multiple race NHPI populations, and in some cases, by age group as well. The chartbooks include graphical charts with accompanying bullet-points that state what is shown in the chart. As a result, the chartbooks provide accessible insights for a variety of audiences.

Below are selected examples from the chartbooks. All statistics refer to the United States in 2014.

—*Asthma*

—*Ever, Children:* The percentage of Native Hawaiian children under age 18 who ever had diagnosed asthma was 24.3 percent, higher than the percentage among all Pacific Islander children (9.5 percent) and single-race Asian children (9.6 percent) and higher but not significantly different from single-race Black or African American children (18.4 percent).

—*Current, Adults:* The percentage of Native Hawaiian adults aged 18 and older who had asthma (13.3 percent) was higher than the percentage of all U.S. adults (7.4 percent) and single-race Asian adults (4.9 percent), and higher

than but not significantly different from the percentage among all Pacific Islander adults (5.8 percent).

—*Lower back pain:* Among all NHPI adults aged 18 and older, the percentage with lower back pain was 28.3 percent, which was similar to the percentages among all U.S. (28.1 percent, single-race white (28.7 percent), single-race Black or African American (28.5 percent), and single-race American Indian and Alaska Native (AIAN) (29.0 percent) adults, and higher than the percentage among single-race Asian adults (17.6 percent. The percentage of Samoan adults with lower back pain was 37.0 percent, which was higher than the percentages among Native Hawaiian (28.4 percent), Guamanian or Chamorro (23.6 percent), and Other Pacific Islander (24.2 percent) adults.

—*Cancer:* The percentage of NHPI adults aged 18 and older with any cancer was 5.7 percent, which was significantly higher than the percentage among single-race Asian adults (3.3 percent).

—*Help with personal care from other persons:* Among all NHPI adults aged 65 and over, the percentage who need help with personal care from other persons was 11.8 percent, which was higher than the percentage among all U.S. adults (6.6 percent), slightly more than double the percentage among white adults (5.8 percent), similar to the percentage among Black (11.1 percent) and Asian (10.4 percent) adults, and lower than but not significantly different from AIAN adults (15.6 percent).

—*Uninsured:* The percentage of Native Hawaiian adults aged 18—64 without health insurance coverage at the time of interview was 8.6 percent, which was lower than the percentages among all Pacific Islander (18.2 percent), Samoan (16.1 percent), Guamanian or Chamorro (15.1 percent), and Other Pacific Islander (21.3 percent) adults. It was also lower than the percentage among single-race Asian adults (12.8 percent) and single-race Black or African American adults (18 percent). The percentage of Pacific Islander adults 18–64 without health insurance was similar to the percentage among single-race Black or African American adults.

—*Unmet dental need due to cost:* Among adults, the percentage of all NHPI adults with an unmet dental need due to cost in the 12 months (12.3 percent) was higher than the percentage of single-race Asian adults with such unmet need (7.2 percent).

—*Pneumococcal Vaccination:* NHPI adults aged 65 and over were less likely to had ever received a pneumococcal vaccination (52.0 percent) compared with all U.S. adults aged 65 and over (62.3 percent). Native Hawaiian adults aged 65 and over were less likely to have ever received a pneumococcal vaccination (50.2 percent) compared with all Pacific Islander adults aged 65 and over (69.4 percent).

NHPI Health Research

The NHPI NHIS has also increased capacity for researchers, scientists, and other health professionals. Researchers have used the 2014 NHPI NHIS public use data set, the first publicly available, nationally representative single-year NHPI health dataset, to examine the distribution, inter-relationships, and sociodemographic correlates of a wide range of health outcomes. This research has appeared in over 100 peer review publications and conference presentations, including The American Journal of Public Health, Cancer, Sleep, and Obesity, and professional meetings of organizations such as the American Public Health Association, the Gerontological Society of America, and the Population Association of America. This work has increased awareness of NHPI health and health disparities.

Question. How would re-fielding the survey glean new information on NHPI health?

Answer. If the NHPI NHIS were to be fielded again, the new estimates produced would illuminate how NHPI health outcomes, health behaviors, healthcare access, and healthcare utilization have changed in the decade since the first NHPI NHIS. The resulting estimates, when compared with NHIS estimates for other race groups, would also illuminate what progress has been made in reducing health disparities between the NHPI population and other U.S. population groups, and reveal which disparities have stayed the same or increased. This information can inform policymakers efforts to target resources to improve the health of the NHPI population.

NCHS could produce chartbooks similar to those produced using the 2014 NHPI NHIS data. In addition, or instead, NCHS could produce interactive online dashboards with similar information.

Re-fielding the NHPI NHIS would make it possible to identify current risk and protective factors for the full range of health and healthcare outcomes in the NHPI population. Those insights can then be used to design evidence-based, successful

programs and policies, which can reduce illness and suffering, reduce health disparities, increase well-being, and ensure that limited health-related resources are used efficiently and effectively.

Question. What funding would be needed to re-field this survey, and for what activities?

Answer. CDC estimates that it would cost approximately $5.5 million to field a survey that would be comparable to the 2014 NHPI NHIS. This is a professional judgement, technical estimate. This estimate does not take into consideration competing budget priorities and constraints that must be considered when the President's Budget is developed. If additional resources were appropriated for this purpose, this funding could support the following activities:

Staff at Census Headquarters

—Identify the NHPI frame and sample, using the American Community Survey (ACS). The frame will consist of all people in the most recent available year of the ACS reported to have an NHPI racial identity, alone or in combination with one or more other racial identities.
—Update the addresses of the sample members who moved since their ACS participation.
—Modify the NHIS instrument in the limited ways necessary to implement the planned sample control logic and to meet the requirements of the authority governing follow-back surveys that use the ACS as a frame.
—Update the content and design of the outreach materials and respondent materials and print those materials.
—Hire extra Field Representatives (FRs) in areas of high NHPI population concentration. Note: The interviewers who would collect the NHPI NHIS data are called Census Field Representatives (FRs).
—Prior to data collection, update the NHPI NHIS FR training and conduct that training.
—Conduct focus groups with the FRs midway through the field period and provide a written refresher training midway through the field period. These efforts are designed to support culturally competent field work and to improve data quality.
—After data collection, produce the NHPI NHIS data sets and documentation, including the tools needed to calculate accurate estimates (weights and variance estimation variables).
—After data collection, conduct a data quality analysis and write a report on the results.

Census Field Staff

—Participate in the training and focus groups as required.
—Visit the homes of sample members, explain the survey, and gain informed consent.
—As necessary, work to encourage reluctant respondents to participate.
—Conduct the NHPI NHIS interviews.

Larger sample size translates into higher likelihood that the resulting estimates are reliable and releasable, and higher likelihood that results can be disaggregated to the level desired by the NHPI communities, including disaggregating NH from PI.

Question. How would the Center for National Health Statistics collaborate with the Office of Minority Health and the Census Bureau on this effort?

Answer. The team at the U.S. Census Bureau which works with NCHS to plan and collect the data for the annual NHIS, and who did the same for the 2014 NHPI NHIS, would work with NCHS on the next iteration of the NHPI NHIS. NCHS would work with that team to complete the tasks described in the answer to question 3.

In addition to collaboration with the Census Bureau and OMH, NCHS will work closely with the NHPI community. The NHPI communities devoted a remarkable level and diversity of support to the 2014 NHPI NHIS. NCHS is extremely grateful to the community members, organizations, and leaders who contributed their expertise, time, and effort during the development and outreach phases. In any future iterations of the survey, NCHS will again work closely with the communities, with respect, humility, and gratitude.

Question. What methodological approaches could be taken to ensure greater representation of NHPI populations in national health surveys moving forward, and at more frequent intervals?

Answer. The National Health Interview Survey (NHIS) is the United States' gold standard source for information on the health of the U.S. civilian noninstitutional-

ized population. The NHIS is one of the few sources of national NHPI health data. However, because NHPI sample sizes are so small, many NHPI health statistics are unreliable and are not released for public use. For example, the NHIS statistics for such important topics as cancer, chronic pain, mental health measures, and disability among NHPI adults are rarely releasable. Also, it is almost never possible to calculate reliable, releasable national health statistics for disaggregated NHPI groups such as Native Hawaiians and Samoans. To address this issue, in 2023, NHIS began producing some statistics for detailed race and ethnic populations using 3 years of NHIS data. While highly useful in many ways, these estimates obscure changes over time. In addition, because they are only estimates for single-race people, and more than half of the NHPI population also identifies as one or more other races, they only tell part of the story. This is why greater representation of NHPI populations in national health surveys is crucial. Obtaining greater representation of NHPI populations in the high quality, representative national surveys, which serve as the basis for evidence-based policy, such as the NHIS, is challenging. To understand why, it is necessary to note why the NHPI population is considered "hard-to-survey":

—First, the NHPI population is numerically small and geographically concentrated (a substantial fraction lives in certain states and areas, while the rest are widely dispersed across the country). Because the population is numerically small, in any given area of the country in which the NHPI population is not concentrated, there are very few NHPI people. Therefore, using traditional oversampling strategies would require a very large number of households to be screened to identify one household with one or more residents who identify as NHPI. This screening is a resource-intensive process.

—Second, on average, the NHPI population is even more reluctant to participate in Federal surveys than the rest of the U.S. population.

Methodological Options

The way to ensure larger NHPI sample sizes in national health surveys, at more frequent intervals, is to implement special sampling and surveying methods at regular intervals, with feasible options as follows:

—*Option 1:* The best method would be to establish permanent recurring the robust and high- quality survey methods employed in the 2014 NHPI NHIS and establish an agreement for NCHS to use the ACS at regular intervals to identify the NHPI sample for these surveys.

—*Option 2:* Another option, with more drawbacks, is a periodic NHPI oversample in areas with high density of NHPI population. Such a sample, designed to triple the NHPI annual sample size, would do nothing to increase the sample size of the NHPI population who live in non-concentrated regions. It also would likely yield a sample size inadequate for calculation of many NHPI health estimates. Both factors would limit the utility of the resulting dataset for identifying disparities between the NHPI population and other Federal race groups. In addition, the sample size obtained from this method would be inadequate for calculating single year Native Hawaiian estimates, single year Pacific Islander estimates, and disaggregated Pacific Islander population estimates, all of which are of great interest because of the diversity within the NHPI population. Most crucially, there is the chance that this method would not yield an adequate NHPI sample to calculate any reliable NHPI health estimates.

CDC collects data on certain small populations through sponsorship of survey questions, provided by other Federal agencies.

Adequate sample size is needed for all federally recognized race groups to calculate single year reliable and releasable statistics for all sub-populations.

Question. We are facing an acute children's mental health crisis in Hawaii, as the state has one of the highest rates of untreated depression among youth in the country. Contributing to these issues is a small workforce relative to the considerable need and too often, this results in delayed care.

In light of this crisis in Hawaii and nationwide, how does the proposed FY24 President's Budget redirect mental health resources to children and youth?

Answer. HRSA has several programs that provide mental health resources to children and youth, including expanding the mental health workforce. The FY 2024 President's Budget invests $387.4 million, an increase of $190.3 million above the FY 2023 Enacted level for Behavioral Health Workforce Development Programs, to support training for 18,000 providers. The increased resources will support the Behavioral Health Workforce Education and Training Programs for Professionals and Paraprofessionals, which include a focus on children, adolescents, and youth transitioning to adult care who are at risk for behavioral health disorders.

The FY 2024 President's Budget request also supports the Opioid-Impacted Family Support Program, which trains paraprofessionals to support children and families impacted by opioid use disorder and other substance use disorders in underserved areas.

The FY 2024 President's Budget includes $13 million for the Pediatric Mental Health Care Access Program (PMHCA) to support statewide or regional pediatric mental healthcare telehealth access programs. These resources, combined with American Rescue Plan Act and Bipartisan Safer Communities Act funding, will allow the program to fund up to 65 awards in states, jurisdictions, and Tribal organizations across the country.

HRSA's PMHCAP integrates behavioral health into pediatric primary care through state or regional networks of pediatric mental healthcare teams. These teams provide tele-consultation, training, technical assistance and care coordination. With this support, pediatric primary care providers can diagnose, treat and refer children to the care they need for behavioral health concerns. The telehealth technologies promote long-distance clinical healthcare, clinical consultation, and patient and provider education, helping to address challenges in accessing psychiatrists, developmental- behavioral pediatricians, and other behavioral health clinicians who treat behavioral concerns in children and adolescents.

The FY 2024 President's Budget also includes $40 million to integrate behavioral health support in non-traditional community settings. Grants will support communities that are traditionally underserved or are part of a Mental Health Professional Shortage Area to engage and train community-based organizations (CBOs) to identify and address the mental health and substance use disorder (SUD) care needs of mothers and children.

Th FY 2024 President's Budget also request resources to more than double the current Health Center Program investments in behavioral health services through a new $700 million behavioral health service expansion funding opportunity, and includes a legislative proposal to require all health centers provide mental health and substance use disorder services under Section 330 of the Public Health Service Act.

Question. What is HRSA's Bureau of Health Workforce plan to address increased demand for pediatric behavioral health services at a time of severe workforce shortages?

Answer. As noted above, the FY 2024 President's Budget invests $387.4 million, an increase of $190.3 million above the FY 2023 Enacted level, to grow the behavioral health workforce through Behavioral Health Workforce Development Programs. These programs have a particular focus on preparing a workforce to provide care to children, youth and youth transitioning to adult care.

In addition, in FY 2023, HRSA is implementing new Pediatric Specialty Loan Repayment Program (LRP) which will offer the repayment of education loans to support pediatric medical subspecialists and pediatric surgical specialists, and child and adolescent mental and behavioral healthcare providers working full-time in or serving a HPSA, medically underserved area (MUA), or medically underserved population (MUP).

Question. How does the FY24 President's Budget address the shortage of pediatric mental health beds at children's hospitals, and public and private hospitals?

Answer. HRSA supports important training at children's hospitals which expands their capacity to provide care. In FY 2022, the Children's Hospitals Graduate Medical Education (CHGME) Program issued a total of $356 million in funds to 59 freestanding children's teaching hospitals across 29 states, including DC and Puerto Rico.

This critical program is up for reauthorization in FY 2023. In FY 2024, the President's Budget requests $385 million to allow the CHGME Program to continue funding 59 awards to current eligible children's hospitals. The Budget Request will enable HRSA to continue to support approximately 8,000 physician FTEs by making payments for direct and indirect expenses associated with operating approved graduate medical residency training programs.

Question. Safety net providers (i.e., community health centers and rural health clinics) are the backbone of the U.S. healthcare system and serve as critical healthcare access points for vulnerable populations. Therefore, it is essential that these providers take full advantage of incentives, including those authorized by the Inflation Reduction Act, which can increase resiliency in the face of climate change-intensified extreme weather events.

How has HHS communicated with safety net providers to ensure that federally qualified health centers, lookalikes, rural health clinics, critical access hospitals, and disproportionate share hospitals are fully leveraging IRA tax credits to invest in upgrades that will improve climate resilience and prevent facility closure during extreme weather events?

Answer. HRSA regularly communicates with its safety net provider partners to share up-to-date information on a variety of resources to support their operations. The HRSA-supported National Training and Technical Assistance Partner (NTTAP) Capital Link is developing a publication and hosting a webinar for health centers to be released prior to June 30, 2023. The publication is titled "Financing Sources for Resilient federally Qualified Healthcare Facilities" which will include information about how health centers can utilize Inflation Reduction Act (IRA) tax credits in developing solar microgrids to remain operational during power outages. Upon the publication's release, a corresponding webinar will be hosted to elaborate on this topic, providing advice and insights from organizations that have successfully supported microgrid programs.

CMS recognizes the importance of safety net providers and protecting the vulnerable populations that they serve. To prepare for current and future disasters, CMS has developed an inventory of Medicaid and Children's Health Insurance Program (CHIP) flexibilities and authorities available to states in the event of a disaster to support Medicaid and CHIP operations and ensure continuity of coverage for people served through Medicaid and CHIP programs during times of crisis. CMS stands ready to assist with technical support and provide flexibilities with resources and waivers to ensure healthcare facilities can continue to operate and provide access to care to those impacted by extreme weather events.

Additionally, HHS has hit the ground running issuing initial guidance regarding implementation of provisions of the Inflation Reduction Act under its jurisdiction. The department prioritizes transparency and robust stakeholder engagement in our policy and operational activities and strives to communicate clearly to our safety net providers to ensure they are receiving the resources provided under the Act.

Question. What additional resources and incentives does HHS believe are needed to ensure safety net providers are equipped to respond to climate change in their communities, such as promoting care planning for individuals with complex care needs who are particularly susceptible during extreme weather events?

Answer. With healthcare delivery constituting roughly 20% of US GDP, I believe achieving extreme event resilience for the nation's health system, including community health and behavioral health centers, safety net hospitals, and other provider types beyond hospitals, will ultimately require investment for more direct technical assistance and further development of supports to meet the needs identified by safety net providers, support for health sector climate resilience work; training a sufficient workforce to lead such work; geospatial hazard forecasts integrated with population health information; and technical assistance for benchmarking high performers and identifying best practices for resilience planning. The HHS Office of Climate Change and Health Equity (OCCHE) is working all of these important issues. For FY23 and FY 24, the President's Budget requested $3 million for OCCHE, while the FY 24 President's Budget includes an additional $1.65 million for the Office of Environmental Justice.

Examples of OCCHE's ongoing projects include (1) working through partnerships to develop "resilience hubs" on the ground to support communities addressing health disparities year-round and also serve as resources in times of weather extremes and disasters and (2) supporting safety net providers in navigating the many opportunities created by the Inflation Reduction Act through webinars, meetings with provider organizations, application assistance, and the Office's "Quickfinder" resource on leveraging the historic legislation. OCCHE will also be introducing a new resilience resource for use in clinical and social services settings in the coming weeks.

Question. The Inflation Reduction Act included provisions that eliminated cost sharing for Medicare Part D and Medicaid vaccines. This went a long way to ensuring adults have access to recommended vaccines and I commend the department for the work to implement these important changes. The President's FY 2024 Budget includes a new proposal to provide access to recommended vaccines for adults who do not have insurance coverage.

Why is this program being proposed, and why is vaccine access for uninsured adults important?

Answer. The FY 2024 President's Budget proposes the establishment of a Vaccines for Adults (VFA) program to support high vaccination coverage among adults and reduce the spread of preventable disease by beginning to expand access to vaccines for uninsured adults. Ultimately, the program aims to reduce vaccination coverage disparities, improve outbreak control of vaccine-preventable diseases, and enhance and maintain the infrastructure needed for responding to future pandemics.

Adult vaccination coverage in the United States has remained relatively low for all recommended vaccines, with approximately 20 percent of adults 19 and older having received all Advisory Committee on Immunization Practices (ACIP)-recommended vaccines, based on a composite measure assessed using data from the

2018 National Health Interview Survey. Just 46.1 percent of those 19 and older received influenza vaccine, which is recommended annually for all persons 6 months of age and older. Income level, race, ethnicity, geographic location, and insurance status all influence vaccination uptake. Improving vaccine coverage overall, as well as among those experiencing health disparities, will require a comprehensive public health approach that includes a robust adult immunization infrastructure.

Vaccines are routinely recommended as preventative care across the lifespan. However, adults visit healthcare settings with less frequency than children and many times without a primary healthcare provider to provide continuity of care. Though insurance status alone does not predict adult vaccination rates, using influenza coverage as an indicator, only 16.2 percent of adults without health insurance received the influenza vaccine during the 2017–2018 influenza season, while 49.4 percent of adults with health insurance were vaccinated over the same period. A prior study suggested that adults with an out-of-pocket payment of $30 for the influenza vaccine are 58 percent less likely to get vaccinated than adults without any out-of-pocket payment.[3]

The Vaccines for Children (VFC) program was established in 1994 to ensure that all uninsured children under age 19 (along with children who are Medicaid-enrolled, underinsured, or American Indian or Alaska Native) have access to all vaccines recommended by ACIP. Following the introduction of VFC, vaccination rates for children under 19 years of age increased across all races, ethnicities, and income groups, and disparities among race and ethnic groups narrowed over time. No national counterpart to the VFC program exists for all uninsured adults. While CDC supports adult vaccination through the discretionary section 317 immunization program, to date, these activities have focused on rapid vaccination of uninsured adults in outbreak settings. Therefore, creating a separate Vaccines for Adults program for uninsured adults, would provide sustained support for immunizations from year to year.

The COVID–19 pandemic has highlighted the importance of a strong adult immunization program for uninsured adults. The VFA program has been proposed to provide vaccines for uninsured adults who might not otherwise be vaccinated because of an inability to pay. If authorized and funded by Congress, this initiative would cover ACIP recommended vaccines for uninsured adults, including the COVID–19 vaccine.

Question. How does the FY24 President's Budget seek to leverage and build on the state and local relationships established in response to COVID to improve access to routine vaccinations, particularly in this proposed program?

Answer. During the COVID–19 pandemic, the Federal Government has invested critical resources into vaccine data systems, vaccine safety, and vaccine equity partnerships, including adult providers, such as pharmacies. The proposed Vaccines for Adults program would build upon these relations to help improve access to ACIP-recommended vaccines for uninsured adults.

In addition, in 2020, CDC launched the Partnering for Vaccine Equity (P4VE) program to advance equity in adult immunization for racial and ethnic minority groups through partnerships that drive community-level action. While the program initially focused on urgent disparities in COVID–19 and influenza vaccination rates, it has built a far-reaching network of national, state, and local partners that are improving equity by reaching people directly in their communities, equipping ambassadors and influential messengers, and engaging people online and though social media.

Since its launch, the program has provided over $156 million in funding to approximately 500 partners at the national, state, and local levels working in over 225 cities and all 50 states.

The FY 24 President's Budget for CDC's discretionary immunization programs would be a critical investment to strengthen and expand immunization programs at the state, local, and jurisdictional level, particularly as it relates to vaccine confidence and equity. Improving vaccine confidence will require sustained and tailored approaches so that funded partners can address the full range of vaccine confidence and demand activities. Vaccine confidence and demand activities are also explicitly tied and prioritized to improve adult immunization rates; therefore, investments in vaccine confidence will contribute to successes in adult vaccination coverage and access, including the proposed VFA program.

The FY 24 President's Budget for CDC's discretionary immunization programs would also be used to increase overall base grantee awards to sustain and modernize other critical areas of immunization infrastructure. These investments are all tied to strengthening immunization access and increasing coverage of routine vac-

[3] https://www.cdc.gov/vaccines/imz-managers/coverage/adultvaxview/pubs-resources/NHIS–2017.html.

cination, including modernizing Immunization Information Systems, increasing the jurisdictional immunization workforce to respond to increasing demands in outbreak preparedness, health equity, and communications, and supporting routine immunization "catch-up" work and campaigns, primarily for routine childhood immunizations.

Question. How can state and local partners and community stakeholders help with catch-up activities for routine immunizations?

Answer. To more effectively address declines in routine immunizations resulting from the COVID–19 pandemic, CDC launched the Let's RISE (Routine Immunizations on-Schedule for Everyone) initiative in January 2023. Let's RISE supports vaccination catch-up across the lifespan and focuses on developing a framework and working with healthcare personnel, health departments, public health and community partners, schools, and day care centers to address pandemic-related declines in vaccinations. The Let's RISE initiative focuses on prioritizing and targeting existing resources and activities to communities/schools that have fell behind on their vaccinations. The Let's RISE campaign is designed to equip partners and healthcare providers with actionable strategies, resources, and data to support getting all Americans back on schedule with their routine immunizations.

CDC also continues to publish reports and hold regular meetings with partners, including state and local health departments and community partners, to share strategies for preventing and addressing vaccine misinformation. Achieving rapid vaccination catch-up is only possible with the continued coordination efforts between public and private public health partners at the local, state, and Federal levels.

During the COVID Response, community-based organizations played a critical role in educating and assisting individuals overcome barriers to getting the vaccination. In part through American Rescue Plan Act funding, these organizations were able to hire outreach workers from their community. This includes events such as pop-up, school-based, and/or family vaccination clinics supported enhance access to COVID–19 vaccination sites.

Question. How would this proposed program increase routine vaccinations in rural and underserved areas?

Answer. Adults aged 18–64 living in rural communities are more likely to be uninsured and less likely to have private insurance compared to those in metropolitan communities (58 percent vs. 73 percent). The Vaccines for Adults program is critical to improving vaccine access and equity, particularly for rural Americans. The program would include enrolled providers, which could include pharmacies and other trusted healthcare providers. Pharmacies are readily accessible in communities—with most Americans living within five miles of a pharmacy. Recognizing this, the Federal Government made pharmacies a key part of its COVID–19 vaccination strategy. As of April 13, 2023, more than 301.9 million doses of COVID–19 vaccine have been administered and reported by Federal Retail Pharmacy Program participants in the United States. This includes eight million doses administered onsite to residents and staff of long-term care facilities in the early days of the COVID–19 vaccination program.

Building upon this successful public-private partnership, the Vaccines for Adults program would continue to use the enrolled provider model, leveraging the 64 state, local, and territorial existing immunization awardees to recruit providers, which could include community health centers, rural health clinics, local public health departments, private healthcare providers, and pharmacies.

A Vaccines for Adults Program could be administered in a similar manner as CDC's Vaccines for Children (VFC) program. The VFC federally funded program provides vaccines at no cost to eligible children (i.e., Medicaid-enrolled, uninsured, underinsured, and American Indians/Alaska Natives through age 18 years) who might not otherwise be vaccinated because of inability to pay. Such capacity could support uninsured adults from rural and underserved areas in the same manner.

There are considerable opportunities in rural areas in particular to expand vaccine access and uptake through trusted providers in the community like FQHCs and rural health clinics.

QUESTIONS SUBMITTED BY SENATOR JOE MANCHIN III

Question. West Virginia has the second highest rate of Medicare beneficiaries in the country, with almost 25 percent of the state's population on Medicare. Ensuring that this program is stable and able to cover benefits for our seniors is paramount to keeping the promise we made—that after a lifetime of hard work, seniors deserve to retire with dignity and peace of mind. The Congressional Budget Office predicts that the Medicare Hospital Insurance Trust Fund will be insolvent by 2033, the

Medicare Trustees had previously predicted it could be as soon as 2028. I was proud to support the Inflation Reduction Act, to finally allow Medicare to negotiate the price of drugs. Your budget proposes utilizing the savings from these negotiations to help shore up the Medicare Hospital Insurance Trust Fund.

Can you describe what would happen if the Medicare Hospital Insurance Trust Fund were to become insolvent?

By using the savings produced from the Inflation Reduction Act, how many years do you expect to extend solvency by?

Answer. Medicare is a key pillar of our healthcare system and we are committed to strengthening the program both now and in the future. Thanks to our efforts, this year's Medicare Trustees Report estimated that the solvency of the Medicare Hospital Insurance (HI) Trust Fund has been extended by 3 years—until 2031—since last year's report. If the HI Trust Fund's assets are depleted, Medicare could pay health plans and providers of Part A services only to the extent allowed by ongoing tax revenues—and these revenues would be inadequate to fully cover costs. The percentage of expenditures covered by non-interest income is projected to be 89 percent in 2031. Adoption of the proposals in the President's FY 2024 Budget would extend Medicare solvency by at least 25 years, without cutting benefits or raising costs for people with Medicare. These proposals include modifying the Net Investment Income Tax and dedicating its revenues to the HI Trust Fund and including key reforms to the tax code to ensure high-income individuals pay their fair share into the Medicare HI Trust Fund. Furthermore, the Budget builds on the Inflation Reduction Act's new Medicare Drug Price Negotiation Program by increasing the number of drugs subject to negotiation and making drugs eligible for negotiation sooner after their launch. The savings from this proposal, which are $160 billion over 10 years, are credited to the HI Trust Fund.

Question. West Virginia, and the country, continue to face workforce shortages across the healthcare industry. This is especially true in rural areas of the state that already face significant issues with access to care. These shortages span across the healthcare spectrum: nurses, behavioral healthcare workers, EMS, direct care workers, and so many others. Your budget requests an increase of $190 million for workforce development programs.

Can you describe how your budget would not just train, but also help rural providers recruit and retain health providers?

Answer. HRSA's loan repayment programs are valuable tools in distributing the health workforce to high needs areas. The NHSC and Nurse Corps provide loan repayment to providers in exchange for their service in high need communities and therefore helps attract and retain providers to work in rural communities.

The FY 2024 President's Budget invests $965.6 million in the NHSC, an increase of $547.7 million. The request will maintain the field strength of over 20,000. Approximately 37 percent of NHSC clinicians work in rural areas.

The FY 2024 President's Budget invests $92.6 million in the Nurse Corps program. As of September 30, 2022, more than 800 Nurse Corps members are serving in rural communities. Out of the Nurse Corps members that HRSA continues to track following their service commitment, 18 percent currently work in a rural community.

HRSA also helps rural communities recruit clinicians by hosting NHSC job fairs to connect clinicians with sites and by supporting the National Rural Recruitment Retention Network (3RNet) which links together practice sites and tribal partners with providers who want to practice in rural areas.

The FY 2024 President's Budget also invests $28 million for a new program to address growing concerns around healthcare workforce shortages— this initiative would stimulate and develop innovative approaches to recruiting, supporting, and training new providers, with an emphasis on meeting the needs of underserved and rural communities. The Health Care Workforce Innovation Program will help grow the healthcare workforce by funding new, leading edge health profession education and training models that will expand the supply of healthcare professionals in underserved and rural areas. New approaches funded through this competitive initiative will aim to combat systemic barriers to educational opportunity, while also advancing innovative solutions to increase matriculation in and graduation from health professionals training programs, as well as the number of individuals who chose to provide clinical care upon graduation.

In addition, the FY 2024 President's Budget invests a total of $416 million for the HRSA Federal Office of Rural Health Policy (FORHP), which is $63 million above FY 2023 Enacted, for grants to increase healthcare access, strengthen healthcare networks, and focus on quality- of-care improvements for Critical Access Hospitals, small rural hospitals, and Rural Emergency Hospitals. This includes a request of $13 million for the Rural Residency Planning and Development Program to fund an

additional 15 new awards and increased technical assistance to support creation of new rural residency programs that recruit and retain new physicians in rural areas. Additionally, the FY 2024 President's Budget for rural health includes $10 million for a new Rural Health Clinic Behavioral Health Initiative to expand access and increase workforce for behavioral health and mental health services in rural communities.

Question. What can the Department do to help ensure rural hospitals and healthcare professionals in places like West Virginia can access rural healthcare workforce development and training programs?

Answer. HRSA's FORHP supports technical assistance to support the establishment and operation of rural residency training programs. The Rural Residency Planning and Development Technical Assistance (RRPD–TA) Program provides webinars, Technical Assistance advisors, and toolkits to RRPD grantees. Limited free resources are available via the HRSA funded RuralGME.org portal to other organizations interested in rural residency development, such as the new and improved Rural GME Hospital Analyzer tool.

In addition, several of the HRSA workforce training programs include funding priorities for grant applicants who will benefit rural communities. The Primary Care Training and Enhancement (PCTE) Program aims to strengthen the primary care workforce by supporting training for future primary care clinicians and faculty and promoting primary care practice, particularly in rural and underserved areas. Through the PCTE Program, HRSA provided direct financial support to almost 12,000 individuals who received training in medically underserved/rural areas.

Many of HRSA's nursing workforce programs also include a particular focus on rural service. For example, the Advanced Nursing Education Programs increase the number of qualified nurses in the primary care workforce by funding enhancements of training and practice of advanced nurses and traineeships for nursing students. Grant applications with projects that substantially benefit rural or underserved populations or help public health nursing needs in state or local health departments receive a funding preference. Another example is the Nurse Education, Practice, Quality and Retention (NEPQR) Programs, which aim to increase the number of nursing students exposed to meaningful clinical experiences and training in medically underserved and rural communities, who will then be more likely to choose to work in these settings upon graduation.

Additionally, the NHSC and Nurse Corps programs improve the distribution of health professionals to underserved areas. Of the more than 20,000 NHSC participants, 36.8 percent serve in a rural community, and of the more than 3,900 Nurse Corps participants, 21.3 percent are currently serving in a rural community. The NHSC program also includes the NHSC Rural Community Loan Repayment Program, which supports those working to combat the opioid epidemic in rural communities. The total number of NHSC clinicians serving in rural communities has increased by 59 percent between FY 2017 and FY 2020.

Participants in HRSA's workforce programs who choose to serve at HRSA-funded Health Centers, Rural Health Clinics and small rural hospitals often decide to continue to serve in these communities after their service obligation ends.

Question. The Health Resources and Services Administration (HRSA), which administers these programs, does not recognize several Critical Access Hospitals in West Virginia as rural, what is your Department doing to ensure rural hospitals and health centers are accurately recognized and made eligible for this funding?

Answer. FORHP uses the Office of Management and Budget (OMB)'s list of counties designated as part of a Metropolitan Statistical Area (MSA) as the basis for determining whether an area is considered rural for purposes of its rural health grant programs. FORHP also designates census tracts within MSAs as rural for grant purposes using Rural-Urban Commuting Area (RUCA) codes from the Economic Research Service (ERS) of the U.S. Department of Agriculture (USDA).

Beginning with FY 2022 Rural Health grants, FORHP expanded its existing rural definition by adding outlying MSA counties with no Urbanized Area (UA) population to its list of areas considered rural.

We continue to collaborate with our Federal partners, including the USDA's ERS, to find ways to improve the definitions we use. Currently, of the 55 counties in West Virginia, we recognize 52 counties as rural or partially rural. For those CAHs in West Virginia that lie outside of FORHP-delineated rural areas, we would note the recent eligibility expansion for FORHP's rural healthcare services outreach grants. Now entities outside of FORHP-delineated rural areas, including all WV CAHs, are eligible to receive these grants.

Question. The drug epidemic continues to ravage our country, in particular my home state of West Virginia. The national average of drug overdose rate is roughly 31 deaths per 100,000 persons with West Virginia ranking number one with over

90 deaths per 100,000 persons. We know we need to do more. I have continually fought for a set aside in funding to go to states with the highest rate of overdose, like West Virginia, where it is desperately needed. This epidemic is continually changing, from prescription opioids, to heroin, and now fentanyl. Fentanyl is a particularly deadly synthetic opioid, up to 50 times stronger than heroin and 100 times stronger than morphine. And now we're finding counterfeit pills, like Adderall or Percocet, laced with fentanyl in lethal doses.

What is your department doing to address the rise in illicit fentanyl?

Answer. The Department of Health and Human Services (HHS)'s Substance Abuse and Mental Health Services Administration (SAMHSA) is focused on using evidence-based strategies to save lives, including distribution and training for how to administer naloxone and distribution of fentanyl test strips (FTS) as well as expanding medications for opioid use disorder (MOUD) to the most under resourced communities, to address this crisis and prevent further overdose deaths. One key policy change directly related to addressing the rise in illicit fentanyl was that the CDC and SAMHSA announced on April 7, 2021, that certain Federal funding could be used to purchase fentanyl test strips to help address the overdose crisis.[4]

SAMHSA's Fiscal Year 2024 Budget request includes several noteworthy programs intended to address this issue. The first program is the Strategic Prevention Framework for Prescription Drugs (SPF-Rx). SAMHSA requested an additional $5 million, which will be used to reach more underserved populations, ensuring that they receive important technical support for decreasing prescription drug misuse. In our FY24 budget request, SAMHSA also requested $50 million for a new Community Harm Reduction and Engagement Initiative, which will help support services such as distribution of FTS, to 330,000 people.

Additionally, SAMHSA funds the First Responders—Comprehensive Addiction and Recovery Act (FR–CARA) program that trains and equips firefighters, law enforcement officers, paramedics, emergency medical technicians, and volunteers in other organizations to respond to adverse overdose-related incidents, including how to administer naloxone. During the program's recent project period, each state developed a strategic action plan for combatting opioid misuse and deaths related to heroin and illicit fentanyl.

Another program that SAMHSA administers is the Grants to Prevent Prescription Drug/Opioid Overdose-Related Deaths (PDO), which supports training for first responders and other key community sectors on the prevention of prescription drug/opioid overdose-related deaths and teaches participants how to implement secondary prevention strategies, including the purchase and distribution of naloxone to first responders. Since the program began, PDO grantees have conducted 48,975 trainings, and has trained 167,683 individuals on naloxone usage and administration. Collectively, PDO grantees have distributed 323,286 naloxone kits with grant funds and administered naloxone 36,925 times.

SAMHSA's Medication-Assisted Treatment-Prescription Drugs and Opioid Addiction (MAT-PDOA) grants provide resources to help expand and enhance access to medications for opioid use disorder (MOUD). Access to MOUD is key to decreasing illicit opioid use and prescription opioid misuse, including the use of illicit fentanyl or substances laced with fentanyl. Evidence has demonstrated that MOUD, in the form of buprenorphine and methadone, is associated with significant reductions in overdose mortality by over 50%.[5] There are currently two active MAT-PDOA cohorts of grantees totaling $93,897,952 for 156 grantee organizations.

Finally, SAMHSA's State Opioid Response (SOR) program addresses the opioid crisis by increasing access to MOUD including the three FDA-approved medications for the treatment of opioid use disorder (OUD), reducing unmet treatment need, and reducing opioid overdose related deaths through the provision of prevention, treatment, and recovery activities for OUD (including prescription opioids, heroin and illicit fentanyl and fentanyl analogs). These grants are awarded to states and territories via formula. The SOR program also includes a set-aside for states with the highest mortality rate related to drug overdose deaths. The most recent SOR application, also required states to develop a naloxone saturation plan, to aid in the distribution and saturation of naloxone in the community.

Question. I appreciate the Department's efforts towards implementing the Jessica Grubb's Legacy Act. The Legacy Act was passed as part of the CARES Act in March 2020. This law reduces barriers for treating persons with substance use disorder

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[4] Federal Grantees May Now Use Funds to Purchase Fentanyl Test Strips, SAMHSA (Apr. 7, 2021), https://www.samhsa.gov/newsroom/press-announcements/202104070200.

[5] Wakeman SE, Larochelle MR, Ameli O, et al. Comparative Effectiveness of Different Treatment Pathways for Opioid Use Disorder. JAMA Netw Open. 2020;3(2):e1920622. doi:10.1001/jamanetworkopen.2019.20622.

and allows medical professionals to access the vital information they need to properly coordinate the care of their patients with substance use disorder. I was pleased to see the Department issue proposed regulations last fall to finally implement this law, and improve care coordination for patients with substance use disorder.

What is the Department's timeline to implement the final rule of the Legacy Act?

Answer. HHS anticipates publishing a final rule on the proposed modifications to the confidentiality of substance use disorder records (42 CFR part 2), as required by section 3221 of the Coronavirus Aid, Relief, and Economic Security (CARES) Act, in the last quarter of 2023.

Question. Vaccines are vital to protecting and preserving the health and economic well-being of older adults, the chronically ill, and entire communities. Every year, thousands of turn to their trusted community pharmacists to receive their vaccinations. Community pharmacists are often the only health provider in rural areas, making them an important part of the healthcare system, and ensuring our seniors receiving their vaccines. Under the Public Readiness and Emergency Preparedness Act or PREP Act—pharmacists were given the authority to provide recommended vaccinations for children ages 3–18. The PREP Act declarations made it clear that these authorities would continue until October 1, 2024.

Mr. Secretary, can you please confirm that you plan to keep this public health authorization for pharmacists to provide childhood vaccinations for ages 3–18, in place until October 1, 2024?

Answer. As HHS Secretary, my role is to implement the law. The Department will follow all applicable laws as they relate to any issue.

Question. Osteopathic medicine is the fastest growing medical field in the country according to the U.S. Bureau of Health Professions. Osteopathic medical schools currently educate more than 35,000 physicians —25% of all U.S. medical students. Osteopathic medicine provides all of the benefits of modern medicine including prescription drugs, surgery, and the use of technology to diagnose disease and evaluate injury. It also offers the added benefit of hands-on diagnosis and treatment through a system of treatment known as osteopathic manipulative treatment. Do students gain significant experience training in diverse healthcare settings, such as community hospitals and other health facilities. In many schools, a community-based primary care rotation in a rural or underserved area is a fourth-year training requirement.

What HHS programs or initiatives address the services provided by Doctors of Osteopathic Medicine (DOs) or Colleges of Osteopathic Medicine

Answer. All of HRSA's Bureau of Health Workforce programs that support medical training are available to Colleges of Osteopathic Medicine. Similarly, DOs are eligible to participate in all HRSA programs available to physicians, such as the NHSC.

HRSA funds the Rural Residency Planning and Development Program (RRPD) to support creation of new rural residency programs. For the purposes of this funding, rural residencies are allopathic and osteopathic physician residency programs. A number of grantees past and present have developed or are developing partnerships with Colleges of Osteopathic Medicine. One RRPD grantee, the Cherokee Nation Family Medicine Rural Residency Program in Tahlequah, Oklahoma, has also achieved Osteopathic Recognition from the Accreditation Council for Graduate Medical Education.

The FY 2024 President's Budget request also includes $5 million for the Maternal and Child Heath Bureau to support a new Training for Health Care Providers program to fund up to 10 training grants to institutions of higher learning, which include accredited schools of osteopathic medicine. The program aims to:

—Develop and provide evidence-informed training and curricula to support maternal health providers in addressing bias through both experiential and instructor-led learning;

—Engage faculty and trainees in research to expand the evidence base on strategies to address bias among maternal health providers; and

—Engage community-based organizations and individuals with lived experience in the development, implementation and evaluation of training and research activities.

QUESTIONS SUBMITTED BY SENATOR SHELLEY MOORE CAPITO

Implementation of the Technical Reset to Advance the Instruction of Nurses (TRAIN) Act (Section 4143 of the Consolidated Appropriations Act (CAA) for fiscal year 2023)

Question. The TRAIN Act ensures eligible hospital-based nursing schools and other allied health training programs be held harmless for excess funds inadvertently disbursed by the Centers for Medicare & Medicaid Services as part of Medicare Advantage Nursing and Allied Health Professional Education Payments in past years. CMS recently issued a Transmittal Notice (number 11904/change request 13122) that lays out a very complicated formula that describes how the nursing and allied health schools will be repaid. My office and Senator Brown's office worked closely with CMS on the language that is now section 4143 of the CAA to ensure full reimbursement of the clawed back funds for the impacted schools. Why is this full reimbursement not occurring? What will CMS do to correct and ensure these schools are made whole?

Answer. CMS is working to clarify any confusion and is committed to implementing this provision of the CAA, 2023 correctly. CMS commits to engaging with interested Congressional offices upon implementation.

Infant Formula Shortage

Question. With the knowledge that only four companies make up approximately 90% of the infant formula market, what is the Administration doing to diversify the market?

Answer. FDA is a food safety agency and works to support improved nutrition, including for our youngest consumers, and we have very limited authority and ability to impact market concentration and monitor supply chains in real time. FDA is committed to doing everything within our authorities to ensure the safety and availability of infant formula. For instance, when the shortage became apparent, FDA sought to help increase the availability of safe and nutritious infant formula in the U.S. market by temporarily exercising enforcement discretion, on a case-by-case basis, for certain requirements that apply to infant formula. Twelve manufacturers brought their infant formula products into the U.S. market under this flexibility. Recently, in order to facilitate longer-term availability of such infant formula and help diversify manufacturers providing infant formula in the U.S. market, FDA issued a Transition Plan guidance that outlines a path for interested firms marketing infant formula in the U.S. under the exercise of enforcement discretion to bring those products into compliance with all U.S. requirements. As a result, the number of manufacturers providing formula to the U.S. market has doubled, and in-stock rates have generally returned to pre-recall levels. Further, on March 28, 2023, FDA released its Immediate Strategy to Increase the Resiliency of the U.S. Infant Formula Market, detailing the Agency's plans for improving the resiliency of the supply.

FDA is also committed to reviewing new infant formula submissions, recognizing that new infant formula entrants are able to help increase the diversity of the infant formula market. In 2022, there were a total of 152 complete submissions for FDA review, of which 44 were new infant formula submissions and 81 were before first processing reviews (involving only minor changes in formula or processing).

While FDA is doing what we can within our authorities, preventing future shortages will likely require attention from other Federal agencies, including those with responsibility over market concentration, as well as those that have tremendous purchasing power in the market. Currently, the Federal Trade Commission is conducting a review of the market in which FDA has provided additional information, as has the U.S. Department of Agriculture regarding the Special Supplemental Nutrition Program for Women, Infants and Children. Most recently, the Food and Drug Omnibus Reform Act of 2022 required manufacturers to provide notification regarding certain events that may cause supply disruptions and to create risk redundancy plans to ensure increased resiliency in the event of future disruptions. Effectively diversifying this market requires a whole of government approach because FDA has limited charge over supply chain issues.

Question. Can you tell us what the Administration is doing to equalize treatment between foreign and new domestic entrants? Moreover, how quickly can this occur?

Answer. Foreign and new domestic entrants are treated the same, regardless of the manufacturer's location. FDA will continue to work with all manufacturers currently marketing infant formula in the U.S. market, including infant formulas subject to FDA's enforcement discretion, as well as with manufacturers who seek to enter the U.S. market, to ensure timely and thorough review of submissions. Any

product new to the U.S. marketplace receives a detailed review so Americans can be assured that these products are safe and nutritionally adequate.

In each case where FDA has exercised enforcement discretion, FDA has conducted a careful review of information pertaining to safety and nutritional adequacy of an infant formula product prior to its entrance into U.S. commerce. Under a guidance [6] issued in September 2022, FDA provided a pathway for manufacturers of infant formula products that received a letter of enforcement discretion based on the May 2022 guidance,[7] which outlined flexibilities to market certain infant formula products including via importation, to continue marketing these products while they work toward meeting all applicable FDA requirements. Under the September 2022 guidance, the period of enforcement discretion for these products was extended for firms that express interest in and take steps toward remaining on the U.S. market.

FDA will also continue to regularly inspect infant formula manufacturing facilities to ensure appropriate oversight of infant formula manufacturing and fulfill the new requirement for annual inspection of registered infant formula facilities. The Agency believes these efforts are essential to increasing production, both domestic and foreign, in support of a consistent, safe, and nutritionally adequate infant formula supply with a diversity of manufacturers. FDA typically conducts routine surveillance inspections of infant formula facilities on an annual basis, and the Agency is committed to continuing this for all infant formula facilities, both domestic and foreign. In circumstances where inspectional observations warrant or compliance follow-up is needed, a re-inspection may be conducted within a shorter interval. In 2022, FDA conducted inspections at all 24 domestic infant formula facilities scheduled for inspection, as well as all 6 foreign infant formula facilities that served the U.S. market. These efforts would be further buoyed in the years ahead by additional funding FDA is requesting in the FY 2024 President's Budget.

Question. Can you address what other measures are actively being taken to ensure that a tragedy such as this never happens again?

Answer. FDA has taken a great number of measures to reduce the potential of a similar incident occurring in the future. However, it should be noted that it is not possible to completely prevent another outbreak and industry remains concentrated in the U.S. Further, the infant formula industry ultimately has the primary responsibility to produce safe, nutritious, and high-quality infant formula.

Since February 2022, the Agency has had ongoing and extensive engagement with the infant formula industry to identify and implement opportunities to strengthen preventive control practices and engage on the development and refinement of the FDA's Strategy to Help Prevent Cronobacter sakazakii Illnesses Associated with Consumption of Powdered Infant Formula (released November 15, 2022). FDA food safety experts have engaged with industry, state, international, and other partners to: explore environmental factors that may contribute to contamination in facilities; review issues related to specific foodborne hazards to identify potential mitigation measures or knowledge gaps; review regulations to identify provisions that may be strengthened; identify prevention measures that can be taken to reduce future incidences of foodborne illness; and identify knowledge gaps to expand our understanding of food safety issues and limit recurrences of underlying root causes responsible for contamination.

Already, the Agency is seeing actions advanced through the prevention strategy that will help to prevent recurrence of contamination. FDA food safety experts have advanced a charge through the National Advisory Committee on Microbiological Criteria for Foods (NACMCF) to gain scientific insight on possible industry and public health interventions to address Cronobacter infections associated with powdered infant formula. The Agency has engaged with the National Academy of Science, Engineering and Medicine (NASEM) to examine and report on challenges in the supply, market competition, and regulation of infant formula in the U.S.

Furthermore, on March 28, 2023, FDA released its Immediate Strategy to Increase the Resiliency of the U.S. Infant Formula Market detailing the Agency's plans for improving the resiliency of the supply. This is the first step toward issuing, with input from the NASEM, a long-term strategy in 2024 to improve preparedness and explore new approaches to help facilitate entry of new manufacturers to increase supply and mitigate future shortages.

FDA will continue to build on these efforts throughout FY 2023 as a result of $7.5 million in additional funding provided by Congress for infant formula-related activities. This is enabling the Agency to hire 16 new full-time equivalents (FTE) in the

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[6] https://www.fda.gov/regulatory-information/search-fda-guidance-documents/guidance-industry-infant-formula-transition-plan-exercise-enforcement-discretion.

[7] https://www.fda.gov/regulatory-information/search-fda-guidance-documents/guidance-industry-infant-formula-enforcement-discretion-policy.

Center for Food Safety and Applied Nutrition. FDA's FY 2024 request contains an additional $21 million to further expand its work in this area.

However, the infant formula industry needs to take its responsibility to produce safe food more seriously. FDA has reviewed conditions during recent inspections of powdered infant formula manufacturers and has identified numerous areas for improvement across the infant formula industry. The Agency outlined these areas for improvement in a March 8, 2023, letter, which was a call to action for all members of the infant formula industry to help protect our most vulnerable population by, among other things, evaluating established systems of production and in-process controls and ensuring that appropriate controls are implemented at any point, step, or stage in the production process where control is necessary to prevent adulteration of infant formula. In addition, the infant formula industry is now required to establish and implement risk redundancy plans, to minimize the impact of any future disruptions in production. Industry must ensure they are producing formula consistent with high U.S. food safety standards and maintaining their facilities so recalls and shutdowns are minimized.

Tardive Dyskinesia (TD)

Question. The Fiscal Year (FY) 2022 Consolidated Appropriations Act included report language encouraging HHS to prioritize the importance of screening for, diagnosing, and treating TD and to report to Congress outlining resources. Could you please provide an update on what steps HHS has taken to fulfill this request from Congress, which agency or office is leading this effort, and when the report to Congress should be expected?

Answer. 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.[8] 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.

Access to Care for Obesity

Question. The Committee previously encouraged CMS to ensure beneficiary access to care for obesity if it was determined to be clinically appropriate by a patient's physician. How has CMS addressed this issue to ensure access to therapies, including anti-obesity medications, for Medicare beneficiaries who struggle with obesity and comorbid chronic conditions?

Answer. As detailed by the White House National Strategy of Hunger, Nutrition, and Health,[9] the Administration set a goal of ending hunger and increasing healthy eating and physical activity by 2030 so fewer Americans experience diet-related diseases—while reducing related health disparities. Integrating nutrition and health can optimize Americans' well-being and reduce healthcare costs. Currently, only a limited number of Medicare beneficiaries are seeking nutrition and obesity counseling services. The President's FY 2024 Budget includes a proposal to expand access to additional beneficiaries with nutrition or obesity-related chronic diseases and make additional providers eligible to furnish services.

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[8] rarediseases.org/rare-diseases/tardive-dyskinesia/?filter=complete-report.

[9] https://www.whitehouse.gov/wp-content/uploads/2022/09/White-House-National-Strategy-on-Hunger-Nutrition-and-Health-FINAL.pdf.

Currently, Medicare covers an array of services that aim to address obesity. For example, obesity screenings, intensive behavioral therapy for obesity for the prevention or early detection of illness or disability, bariatric surgical procedures, and diabetes screenings and participation in a diabetes prevention program are covered under Medicare in certain cases.

Under current law, the Medicare statute excludes "agents when used for anorexia, weight loss, or weight gain" from the definition of a Part D drug in section 1860D–2(e) of the Social Security Act. Despite this statutory exclusion, Part D sponsors wishing to provide coverage of prescription weight loss agents may do so as a supplemental benefit to enhanced alternative Part D plans, as they can with other prescription drugs that are excluded from the definition of a Part D drug.

Mental Health/988 Lifeline

Question. This Subcommittee has made great investments in suicide prevention activities and has supported, at every turn, the effort to launch the three-digit, 988 Lifeline that started last summer. In fact, Congress provided a four-fold increase of nearly $400 million in FY2023 to support these critical activities, on top of roughly $270 million provided through emergency supplemental and mandatory funding across the last few years. The budget requests yet another substantial increase of nearly $334 million without much detail. What is the true driver of these increased costs? Please provide a breakdown of requested increase by activity.

Answer. The 988 Suicide and Crisis Lifeline's successful launch in July 2022 has generated a significant increase in month-to month contacts to the Lifeline. Moving to an easy-to-remember number provided an easier way to access a strengthened and expanded network of crisis call centers. The 988 Lifeline data for March 2023 showed an increase in overall volume compared to March 2022. The 988 Lifeline answered 164,337 more contacts (calls, chats and texts) and significantly improved how quickly contacts were answered. The average speed to answer across all contacts decreased from 168 seconds to 36 seconds. In March 2023 vs. March 2022, calls answered increased by 47%, chats answered increased by 136%, and texts answered increased by 1299%.

In FY 2023, Lifeline volume is expected to continue to increase to 6 million contacts. Further, national data indicate an alarming trend of increased suicidality in adults and youth. Provisional data from CDC's National Center for Health Statistics indicate that the number and the rate of suicides in the United States increased by 4% from 2020 to 2021, after two consecutive years of decline in 2019 and 2020. In addition, results from SAMHSA's 2021 National Survey on Drug Use and Health (NSDUH) indicate that approximately 12.3 million adults aged 18 or older had serious thoughts of suicide in the past year, and 1.7 million attempted suicide. Data from the NSDUH also indicated that approximately 3.3 million youth aged 12 to 17 had serious thoughts of suicide, and nearly 900,000 youth attempted suicide. In sum, the need for the Lifeline, suicide prevention, and crisis care services continues to rise nationwide, hence the need for more resources to combat it.

The requested FY24 Lifeline increase will fund local crisis call centers, support network operations, enable critical media campaigns, and maintain the 988 Behavioral Health Crisis Coordinating Office operations. Additionally, funds within the network operations budget will be invested in services for specialized populations, including people who are LGBTQI+, and services for Spanish speakers. The FY24 President's Budget request for the Lifeline is detailed by activity below:

—An increase of $3 million for the 988 Behavioral Health Crisis Coordinating Office.

—An increase of $287.9 million for 988 network crisis centers and back-up centers to respond to calls, texts, and chats; provide referrals to crisis care services; and to enhance regional and local response capacity tailored for diverse communities. This funding also supports specialized services, technical assistance, and administrative overhead costs.

—An increase of $43.5 million to support a national public awareness and behavior change communications campaign focused on populations known to be at high risk of suicide, building upon formative research launched earlier in FY 2022, including targeted national campaigns focused on promoting help seeking behavior.

Question. How much of the FY2023 appropriation for the 988 Lifeline is staying within SAMHSA for administration, beyond the $10 million set aside for the 988 Coordinating Office, and how much of the FY2023 appropriation is funding state and local crisis centers versus the contractor administering the system? Please provide a breakdown of FY2023 988 Lifeline obligations by activity.

Answer. For FY 2023, the $501,618,000 appropriated for the 988 Lifeline will be obligated as follows:

—$348,118,000 for to support the capacity of 988 network crisis centers and back-up centers to respond to calls, texts, and chats and provide referrals to crisis care services. This funding also supports specialized services, technical assistance, and administrative overhead costs.
—$140,000,000 for administering and overseeing network operations, training, and infrastructure. This funding will be directed toward the 988 administrators.
—$7,000,000 is for the 988 & Behavioral Health (BH) Crisis Coordination Office to provide technical assistance to states, and crisis centers; strategic planning, performance management, evaluation, and oversight; and will be allocated to support formal partnerships, convenings, and cross-entity coordination.
—$6,500,000 will be allocated to support a national public awareness and behavior change communications campaign to conduct targeted, foundational work to better understand the needs of populations at high risk of suicide and to continue other critical communication efforts supporting public awareness and education on 988.

QUESTIONS SUBMITTED BY SENATOR JERRY MORAN

Question. Mr. Secretary, COVID revealed the inadequacies of our domestic capacities and supply chains, particularly relating to the development and production of biological products such as vaccines. I was pleased that the Department created a new industrial base expansion office and that BARDA issued a request for information last year about creating a biomanufacturing surge capacity rapid response network in response to this issue. Can you tell the Subcommittee the status of these efforts, and particularly how much funding has been allocated?

Answer. Using over $16 billion provided across COVID–19 emergency supplementals, ASPR's Industrial Base Management and Supply Chain (IBMSC) Office has awarded over 87 contracts to support manufacturing domestic supplies, including masks, gloves, gowns, diagnostics, and advanced manufacturing of drug substances and drug products. We are currently manufacturing much more PPE domestically than previous capacity allowed; however, continued sustainment of these capacities, as requested in the FY 2024 Budget, is required to ensure these manufacturing capacities remain. This includes capacity for PPE final products as well as some of the raw materials, such as Nitrile Butadiene Rubber (NBR) and other key chemicals necessary for manufacturing the nitrile gloves. This also includes manufacturing capacities for diagnostics and drug products. These efforts support the Make PPE in America Act portion of the Infrastructure Investment and Jobs Act, which requires that all raw materials for PPE purchased by HHS, VA, and DHS be made in the United States. These efforts to streamline and clarify Federal Government demand signals mentioned above will also help manufacturers achieve economies of scale, thus narrowing cost differentials while promoting supply chain resilience.

The SNS is also working to ensure compliance with the Make PPE in America Act. Purchasing critical MCMs and PPEs domestically reduces the risk of relying on international partners. We learned during the COVID–19 pandemic that the supply chain can fail; having an SNS that relies on foreign manufacturing and production of critical products is not the best choice for national security. When and where possible, the SNS looks to domestic sourcing for products to include in the stockpile. The FY 2024 Budget requests funding for SNS to implement requirements outlined in the Make PPE in America Act. While domestic material is generally more expensive than internationally sourced product due to manufacturing protocols, requirements, and to adhere to production policies and regulations, relying on foreign sourcing is not the best preparedness posture and we experienced this first hand during the COVID–19 response. CMS recognizes that hospitals may incur additional costs when purchasing domestic NIOSH-approved surgical N95 respirators. Therefore, CMS finalized our FY 2023 proposal to provide payment adjustments under the IPPS and OPPS that would reflect, and offset, the additional marginal resource costs that hospitals face in procuring domestically made NIOSH-approved surgical N95 respirators. Under this policy, these payments would be provided biweekly as interim lump-sum payments to the hospital and would be reconciled at cost report settlement. The rule also outlines the information that would be collected on the cost report to determine payments under this policy, which would apply to cost reporting periods beginning on or after January 1, 2023.

The $400 million requested in FY 2024 for Pandemic Preparedness and Biodefense will support continued investments to strengthen and maintain domestic manufacturing capacity. In addition, the FY 2024 Budget requests authority for acquisition, construction, or alteration of non-federally owned facilities that would

allow ASPR to continue to onshore and build domestic manufacturing capacity for critical components of the medical supply chain in partnership with the private sector. COVID–19 emergency supplemental legislation provided similar authorities which ASPR has used to support the construction of new factories nationwide for COVID–19 related medical supplies.

This authority is requested as part of a suite of legislative proposals to provide the authorities HHS needs to enhance early detection and response to public health threats and supply disruptions; build domestic manufacturing capacity for and otherwise advance safe, effective supplies and medical countermeasures; facilitate a response-ready workforce; and enhance recovery.

Question. Will any of the increase for ASPR or BARDA provided in the FY2023 Omnibus be used for these efforts?

Answer. It is important to note that the increase in FY 2023 Omnibus funding for BARDA will not be used to support domestic manufacturing efforts. The additional funding will advance the development of medical countermeasures (MCMs) across BARDA's threat areas, support transformative science and technology to strengthen national and global health security through BARDA Ventures, and help the program maintain a world-class workforce that continues to respond to the COVID–19 pandemic as well as numerous other PHEs and outbreaks caused by CBRN and pandemic influenza threats.

Related to investments in domestic manufacturing, BARDA was able to respond swiftly to the COVID–19 pandemic, awarding 27 capacity expansion efforts during FY20—FY22 to mitigate bottlenecks in the domestic supply chain and reduce our dependence on foreign suppliers of the ingredients, raw materials, and consumables required during vaccine manufacturing. These efforts, including expanding domestic capacity or onshoring production of critical raw materials, manufacturing consumables, and expansion of fill/finish manufacturing, increased capacity for sterilization of components, vials, and needles and syringes. To meet the requirement of achieving domestic capacity expansions to support 600 million vaccine doses in six to 9 months, BARDA awarded 11 Technology Investment Agreements, 14 Cooperative Agreements, and two FAR-based contracts that allow for cost-sharing between the USG and industry partners. Most awards include a negotiated 10-year priority access period post-construction that allows the USG access during future public health emergencies (PHEs).

Question. What funding requested in the FY2024 budget will be used for these efforts?

Answer. ASPR is investing in securing a strong domestic manufacturing base infrastructure to produce essential products such as medical devices, pharmaceuticals, and personal protective equipment. With the reorganization in February 2022, ASPR established the IBMSC Office and is requesting funds in the FY 2024 President's Budget to support this office and its important work.

The $400 million requested in the FY24 President's Budget will also ensure we are able to maintain the capabilities built and used extensively during the COVID–19 pandemic to strengthen development and manufacturing of medical countermeasures and other critical medical products. Funds could also support purchasing domestically made product for inclusion in the SNS, as well as other actions to sustain demand for domestically manufactured products, thus reducing reliance on foreign production. The $400 million Pandemic Preparedness and Biodefense request will ensure BARDA has ready resources to immediately scale up manufacturing of vaccine, diagnostic, and therapeutic prototypes at the first indication of an outbreak. The requested funding would also accelerate advanced development and additional manufacturing of medical countermeasures for clinical trials and, when appropriate, patient care as part of an emergency response.

Approximately $50 million is requested as part of BARDA's FY24 Advanced Research and Development funding, which will allow some initial effort to begin to address the gap in domestic, commercial-scale MCM production capabilities by supporting nominal access to domestic commercial-scale fill/finish capabilities. Furthermore, under ASPR, the 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. The FY 2024 President's Budget requests $995 million for the SNS, an increase of $30 million above FY 2023 enacted. 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. These funds will ensure the SNS's assets are available and ready to protect America from 21st century health threats in FY 2024. In addition, when and where possible, the SNS is seeking to award contracts with

domestic manufacturers, to reduce reliance on foreign production. Funds could be used for some of these investments in FY24 and beyond. While domestic material is generally more expensive than internationally sourced product due to manufacturing protocols, requirements, and to adhere to production policies and regulations, relying on foreign sourcing is not the best preparedness posture and we experienced this first hand during the COVID–19 response.

Question. The budget request includes $400 million in new funding for ASPR to rapidly respond to future pandemics, and support just-in-time development, manufacturing, and procurement of innovative medical countermeasures, as well as to make investments to expand and sustain the domestic manufacturing capacity of the medical supply chain. Can you discuss how this funding would be allocated in FY2024?

What is the Department's implementation plan for advancing research and development partnerships with the private sector to ensure we have the tools necessary to respond to the next outbreak?

Answer. The $400 million requested in the FY24 President's Budget will also ensure we are able to maintain the capabilities built and used extensively during the COVID–19 pandemic to strengthen medical countermeasure development and manufacturing. Funds could also support purchasing domestically made product for inclusion in the SNS, reducing reliance on foreign production. The $400 million Pandemic Preparedness and Biodefense request will ensure BARDA has ready resources to immediately scale up manufacturing of vaccine, diagnostic, and therapeutic prototypes at the first indication of an outbreak. The requested funding would also accelerate advanced development and additional manufacturing of medical countermeasures for clinical trials and, when appropriate, patient care as part of an emergency response.

Within ASPR, BARDA has partnered with private industry since 2006 to advance the development of MCMs across its chemical, biological, radiological, and nuclear (CBRN) threats, pandemic influenza, and emerging infectious disease portfolio. BARDA has partnered with more than 400 different academic and industry partners, which has resulted in 71 FDA-approved vaccines, therapeutics, and diagnostics supported by BARDA. In addition to providing funding, BARDA has subject matter experts with decades of experience that work hand in hand with industry partners to help expedite MCM development. Should additional funding be provided to support pandemic preparedness, this same model would be leveraged.

If you have constituents interested in speaking with BARDA or IBMSC, please know that we have two programs called TechWatch and IBx Connect that can facilitate conversations about their product, technology, or capabilities and explore potential partnering opportunities.

TechWatch meetings include representatives from across the Federal Government, allow companies to get insight on how their solution could fit within the Federal Government, and better prepare them for a formal proposal submission.

For more information, please visit https://medicalcountermeasures.gov/Request-BARDA-TechWatch-Meeting/. Or https://aspr.hhs.gov/IBxConnect/Pages/default.aspx.

Question. How much FY2023 funding has been devoted to these efforts?

Answer. Funding in FY23 will generally support ongoing MCM development. Going forward into FY24, the $400 million requested in the FY24 President's Budget will ensure we are able to maintain the capabilities built and used extensively during the COVID–19 pandemic to strengthen the domestic manufacturing base. In addition, the $400 million Pandemic Preparedness and Biodefense request will ensure HHS has ready resources to immediately scale up manufacturing of vaccine and therapeutic prototypes at the first indication of an outbreak. The requested funding would also accelerate advanced development and additional manufacturing of medical countermeasures for clinical trials and, when appropriate, patient care as part of an emergency response.

Question. Secretary Becerra, while we may not know what the next outbreak will be, the Department can be developing disease-agnostic tools and platforms now to be ready for whatever may come. Will any of the $2.5 billion NIH increase or $205 million BARDA increase provided by this Subcommittee last year be used for such activities?

Will any of the new $400 million proposed in the budget request within ASPR be used for platform-based, threat agonistic activities? Please describe in detail.

Answer. BARDA will continue to support threat-agnostic medical countermeasures to achieve its mission to make available MCMs that address CBRN threats, pandemic influenza, and emerging infectious diseases. FY23 funding will support the development of novel host-based therapeutic approaches that are agnostic to pathogen and address severe forms of disease and sepsis. Novel host-based diagnostic ap-

proaches to address disease severity and identify health deterioration in a number of clinical settings (pre-hospital, hospital, post-discharge) and threat-agnostic diagnostics for use in the early days of novel disease outbreak will also be supported. More than $25 million is expected to be utilized for these efforts in FY23 using annual funding.

Question. Mr. Secretary, since the bipartisan Orphan Drug Act was enacted 40 years ago, rare disease and cancer patients have benefitted from the development of over 600 new treatments. This is a tremendous achievement, though there's more work to be done. Too many patients living with rare diseases and cancers still have no treatments available to them. Unfortunately, Democrats' so-called Inflation Reduction Act threatens the continued success of the Orphan Drug Act. Specifically, it does not protect from the law's price-setting scheme therapies that treat two or more orphan diseases. As a result, we already know of two companies that have cited the IRA as a reason not to continue rare disease drug development.

Will you commit to doing what you can via guidance and rulemaking to ensure that the pipeline of life-altering therapies continues for patients living with rare diseases and cancers?

Answer. FDA remains strongly committed to doing what we can via guidance for industry and stakeholder engagement activities to maintain and promote the robustness of the development pipeline for safe and effective drugs and biological products to treat patients with rare diseases, including rare cancers. FDA has published more than 18 guidances since 2018 on topics that are highly relevant to drug and biological product development for rare diseases, including rare cancers. Some recent examples include:

—2023 Draft Guidance for Industry: Clinical Trial Considerations to Support Accelerated Approval of Oncology Therapeutics [10]

—2023 Draft Guidance for Industry: Considerations for the Design and Conduct of Externally Controlled Trials for Drug and Biological Products [11]

—2022 Guidance for Industry: Human Gene Therapy for Neurodegenerative Diseases [12]

—2022 Draft Guidance for Industry: Tissue Agnostic Drug Development in Oncology [13]

Question. Nearly 800,000 people in the United States have End Stage Renal Disease, with over 550,000 needing dialysis, a procedure to remove waste products and excess fluid from the blood, to live. This process must take place several times a week, and cannot be missed, even in times of national emergency.

Since inclusion of dialysis machines in the SNS can help prepare the U.S. to care for patients needing dialysis during future emergencies, what steps are you taking to ensure these devices are included in the SNS or that the Administration for Strategic Preparedness and Response is prepared to provide dialysis care during disasters and public health emergencies?

Answer. The SNS makes stockpiling decisions based on the Department of Homeland Security's (DHS) material threat determinations, the ASPR requirements process, and available funding. There is not currently a material threat determination related to dialysis.

However, ASPR does have a program, the HHS emPOWER Program (emPOWER), that is at the forefront of innovating and harnessing the power of Federal health data, artificial intelligence (AI), and Federal-to-community level partnerships to protect health and save lives, including aiding those individuals who are dependent on dialysis machines and in-facility dialysis treatments. emPOWER is a partnership between ASPR and the Centers for Medicare & Medicaid Services (CMS) that provides Federal data, mapping, and AI tools to help communities protect the health of at-risk Medicare beneficiaries, including individuals who rely on electricity-dependent durable medical and assistive equipment devices, or essential healthcare services (i.e., facility-based dialysis, home oxygen tank services, home healthcare services, and at-home hospice services).

In a disaster or emergency, authorized state or territorial public health authorities that meet certain requirements may submit a disclosure request for official review and approval of a minimum necessary HHS emPOWER Emergency Response

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[10] https://www.fda.gov/regulatory-information/search-fda-guidance-documents/clinical-trial-considerations-support-accelerated-approval-oncology-therapeutics.

[11] https://www.fda.gov/regulatory-information/search-fda-guidance-documents/considerations-design-and-conduct-externally-controlled-trials-drug-and-biological-products.

[12] https://www.fda.gov/regulatory-information/search-fda-guidance-documents/human-gene-therapy-neurodegenerative-diseases.

[13] https://www.fda.gov/regulatory-information/search-fda-guidance-documents/tissue-agnostic-drug-development-oncology.

Outreach Individual Dataset to support critical life-saving assistance and response outreach public health activities. The dataset includes limited individual level data and healthcare provider and supplier information for Medicare beneficiaries who have a claim for one or more types of electricity-dependent durable medical equipment and certain cardiac implantable devices, or one or more of the above-mentioned types of essential healthcare services. The dataset has been used by public health authorities to activate emergency plans and communications, deploy response assets and resources, and conduct life-saving outreach with authorized partners in the event of emergencies and disasters.

QUESTIONS SUBMITTED BY SENATOR JOHN KENNEDY

Question. The Coronavirus Aid, Relief, and Economic Security (CARES) Act established this $178 billion fund to reimburse eligible healthcare providers for increased expenses or lost revenue attributable to COVID–19. According to a report published by the Government Accountability Office (GAO), providers began returning unused funds, with most returns stemming from automatically issued payments based on eligibility determination rather than on their necessity-based applications. As of February 28, 2022, GAO reported that $9.8 billion from previous disbursement from both general and targeted distributions had been returned to the Health Resources and Services Administration (HRSA). In addition to this, HRSA has begun their own payment integrity oversight including post-payment reviews, recovery of overpayments and audits. As of February 2022, nearly $27.4 million had been identified for recovery from ineligible providers.

How much has been returned as of March 2023?

Where are these returned funds now?

If these returned funds have already been used, where did they go?

Answer. As of February 1, 2023, approximately $11.3 billion in PRF payments have been returned by providers. All of the returned funds have been re-allocated—for example, for additional provider payments.

Question. Congress created the 340B program over 30 years ago to help low-income and other vulnerable patients access more affordable medicines. The goal of the program is to enable safety-net providers (Disproportionate Share Hospitals (DSH) Hospitals, Community Health Centers, federally Qualified Health Centers, ect) to help low-income and other vulnerable patients access more affordable medicines and healthcare services. Participating entities, such as large, well-resourced hospitals, have taken advantage of the program's lack of clarity and reporting requirements at the expense of the patients that the program is meant to serve.

What are the current reporting requirements for participating entities in terms of how they spend the money they receive through the program?

Answer. The FY 2024 President's Budget includes a proposal to require covered entities to report to HRSA how the savings achieved through the Program benefit the eligible patients they serve and provide HRSA regulatory authority to implement this requirement.

While the current 340B Program statute does not include specific authority to require covered entities to report on how 340B Program savings are used, many covered entities are HHS grantees and have specific requirements under the terms of their grants for how to use savings generated from the 340B Program.

HRSA employs a number of approaches to oversee covered entity compliance of the 340B Program including annual recertification to ensure compliance, program audits and maintaining auditable records.

Finally, HRSA's strategy includes quarterly DSH checks, review of contracts with State/local government for eligibility, contract pharmacy agreement requirements, and a self-disclosure process for reporting potential violations of 340B Program requirements.

Question. If none, how do you ensure that these funds are actually being spent on low- income patients as the program intended?

Answer. See response to 30a above.

Question. What are your recommendations for improving the 340B program to ensure low income individuals are actually benefitting?

Answer. As discussed above, The FY 2024 President's Budget proposes to require covered entities to annually report to HRSA how savings achieved through the Program benefit the communities they serve and provide HRSA with 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.

Question. In February CMS released a 2024 Medicare Advanced Notice that proposed changes to the Medicare Advantage risk adjustment model by removing up to 2,000 codes for conditions like depression, cardiovascular disease, rheumatoid arthritis, and diabetes. The proposed policies included in the notice would reduce payments to Medicare Advantage, raise costs, and reduce benefits for beneficiaries. 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 CMS and therefore will have to make a terrible choice between increasing beneficiary premiums, reducing supplemental benefits, such as dental coverage, or doing both. Estimates are that premiums could increase $45 a month. 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.

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?

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?

Answer. 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.

QUESTIONS SUBMITTED BY SENATOR CINDY HYDE-SMITH

Question. More than 550,000 kidney patients in the United States receive dialysis to remain alive, including more than 7,600 people in Mississippi. Approximately 85% of dialysis care takes place "in center," meaning that kidney failure patients must travel to a dialysis clinic three times a week, for 3–4 hours at a time, just to survive. This interferes with patients' ability to hold down employment or spend time with their families, it requires patients to abide by strict dietary restrictions, and is a very physically draining experience that leaves patients fatigued, washed-out, and at-risk for a series of serious complications including cardiovascular disease and death. Home dialysis, however, allows patients more flexibility in when and how often they dialyze. With proper training and support, patients can dialyze every day, at nighttime when they sleep, or really whatever time works best for them. More frequent dialysis means patients have fewer dietary restrictions, allowing higher quality of life. It can also be gentler on the body and reduce the highs and lows that leave in-center patients feeling so wiped out all the time.

Despite this, fewer than 15% of U.S. kidney patients utilize home dialysis. Many patients do not even have this choice, as only 54% of dialysis facilities are certified to offer home dialysis.

Access to home dialysis is rife with racial and ethnic inequalities as well, with home dialysis ranging from 18% for White patients, 11% for Hispanic/Latinos, and 10% of Black/African Americans. The ESRD Conditions for Coverage (or CfCs, as they're known) contribute to low patient access to home dialysis. These burdensome and outdated regulations require that registered nurses conduct home dialysis training, even as there's a universal shortage of trained nurses. The regulations also have significant "bricks and mortar" requirements that make it challenging for companies who want to deliver home dialysis to enter the marketplace. Given the ongoing nurse staffing shortage and recent innovations in dialysis technology, it is imperative that the CfCs—which haven't been updated since 2008—be reopened to provide more innovation and options for patients, including patients in rural communities like those in Mississippi, while still ensuring patient safety, which I believe the newer technology would permit.

What is your administration planning to do to amend these outdated and archaic rules and to expand access to home dialysis?

Answer. At the beginning of the COVID–19 Public Health Emergency (PHE), CMS used emergency waiver authorities and various regulatory authorities to enable flexibilities so providers could rapidly respond to people impacted by COVID–19, as

well as limit exposure to and spread of the virus. In recognition of the critical importance of maintaining access to dialysis treatment, CMS utilized a number of these regulatory authorities during the PHE, including reducing administrative burden for providers, bolstering the dialysis workforce, expanding Medicare telehealth for End Stage Renal Disease (ESRD) patients and providers, and establishing Special Purpose Renal Dialysis Facilities (SPRDF) to address access to care issues.

Additionally, CMS has assessed which flexibilities would be most useful in a future PHE, such as natural and man-made disasters and other emergencies, to ensure a rapid response to future emergencies, both locally and nationally, or to address the unique needs of communities that may experience barriers to accessing healthcare. CMS is continuing to collaborate with Federal partners and the healthcare industry to ensure that the healthcare system is holistically prepared for addressing future emergencies.

Finally, the Innovation Center's ESRD Treatment Choices (ETC) Model is an innovative payment model that aims to test whether greater use of home dialysis and kidney transplantation for Medicare beneficiaries with ESRD will reduce Medicare expenditures, while preserving or enhancing the quality of care furnished to beneficiaries with ESRD. The ETC Model uses payment adjustments to offer the incentive to participating ESRD facilities and Managing Clinicians to work with beneficiaries and caregivers in the choice of treatment modality, and to provide additional resources to support greater utilization of home dialysis and kidney transplantation. The Model began on January 1, 2021 and is scheduled to run through June 30, 2027. In the Model's first year (2021), 2,434 ESRD facilities and 3,641 Managing Clinicians participated, with nearly 100,000 beneficiaries attributed to ETC Participants. Results from that year showed that 81 percent of ESRD facilities and 72 percent of Managing Clinicians improved their home dialysis rate compared to the first benchmark year (July 2019–June 2020).

Question. About half a million Americans rely on dialysis, and about 13 percent of these patients rely on home hemodialysis Studies show that patients are highly satisfied with their home dialysis, and that home dialysis can lead to better outcomes for patients, including improved survival rates. Because so many Americans rely on dialysis, an innovative home dialysis system was included as part of the Strategic National Stockpile (SNS) in 2020. SNS is the supply of drugs, vaccines, medical products, and related accessories that can be deployed during a public health event.

Since inclusion of home dialysis machines in the SNS can help prepare the U.S. care for patients needing dialysis during future emergencies?

What steps are you taking to ensure these devices are included in the SNS?

Answer. The SNS makes stockpiling decisions based on DHS's material threat determinations, the ASPR requirements process, and available funding. There is not currently a material threat determination related to dialysis.

However, ASPR does have a program, the HHS emPOWER Program (emPOWER), that is at the forefront of innovating and harnessing the power of Federal health data, artificial intelligence (AI), and Federal-to-community level partnerships to protect health and save lives, including aiding those individuals who are dependent on dialysis machines and in-facility dialysis treatments. emPOWER is a partnership between ASPR and CMS that provides Federal data, mapping, and AI tools to help communities protect the health of at-risk Medicare beneficiaries, including individuals who rely on electricity-dependent durable medical and assistive equipment devices, or essential healthcare services (i.e., facility-based dialysis, home oxygen tank services, home healthcare services, and at- home hospice services).

In a disaster or emergency, authorized state or territorial public health authorities that meet certain requirements may submit a disclosure request for official review and approval of a minimum necessary HHS emPOWER Emergency Response Outreach Individual Dataset to support critical life-saving assistance and response outreach public health activities. The dataset includes limited individual level data and healthcare provider and supplier information for Medicare beneficiaries who have a claim for one or more types of electricity-dependent durable medical equipment and certain cardiac implantable devices, or one or more of the above-mentioned types of essential healthcare services. The dataset has been used by public health authorities to activate emergency plans and communications, deploy response assets and resources, and conduct life-saving outreach with authorized partners in the event of emergencies and disasters.

Question. CMS reimbursement needs to keep up with inflation: The latest consumer price index measure showed that healthcare experienced a 7.7% increase in overall cost, primarily driven by increased wages. In rural areas, this margin grew significantly more due to the demand for nurses and the lack of supply. On the reimbursement side, CMS has not increased its rate of provider pay to match this in-

crease to inflation, resulting in an overall reduction in provider reimbursement while meeting an all-time high number of compliance measures as required by CMS and other insurers.

What can be done to increase CMS payments to physicians to help them to overcome the financial devastation that inflation has caused in healthcare?

Answer. Annual Medicare physician payment updates have been set in statute since 2015. CMS does not have the authority to use a different update. For CY 2024, the update in physician payments set by Congress is an increase of 1.25 percent over CY 2023. If Congress wants to change the law, we would be happy to provide technical assistance.

Question. Much attention has come recently to issues with provider burnout, but little has been done to address the underlying issue. Most of provider burnout is due to an overwhelming number of non-critical tasks required of medical staff while they still care for the sick. Such tasks include entering social determinants of health codes, meeting compliance measures in the clinic or hospital, meeting value-based outcome measures, attending cybersecurity trainings, handling downloads and denials of services, fighting Medicare and private insurance audits, and much more. They are doing this while fewer available providers are eligible to provide support and more patients are needing care. The burnout we are facing is not something that will be resolved with 'more meetings' or even 'more time off.' Rather, it will be solved with allowing providers to care for patients in a more flexible way without the concern of meeting arbitrary benchmarks and requirements and without having to constantly defend themselves against payers attempting to pay them less than what is owed for the services provided.

What steps can be taken to decrease the regulatory burden of healthcare policy as well as to eliminate the reduction of provider payments through downcodes, denials, audits and prior authorization requirements?

Answer. In addition to these Centers for Medicare & Medicaid Services (CMS) activities, the Office of the National Coordinator for Health Information Technology (ONC) is working to better enable providers to interact with healthcare plans and other payers for the automated, electronic completion of prior authorization tasks.[14] Further, ONC recently proposed rulemaking to advance interoperability, improve transparency, support the access, exchange, and use of electronic health information, enhance health IT certification, and reduce burden and costs.[15] In 2020, the U.S. Department of Health and Human Services (HHS) released a comprehensive Strategy on Reducing Regulatory and Administrative Burdens Relating to the Use of Health IT and EHRs[16] to reduce the regulatory and administrative burden related to the use of health IT, including EHRs. The report's strategies, recommendations, and policy shifts aim to give clinicians more time to focus on what matters—caring for their patients. ONC, CMS, and HHS as a whole are working to implement strategies identified within the report to reduce burden and advance interoperable health IT.

CMS is committed to reducing unnecessary administrative burden by advancing interoperability and national standards, and its Office of Burden Reduction & Health Informatics serves as a focal point for burden reduction, national standards and interoperability, and to engage our stakeholders to inform solutions. CMS has continued to seek public input on barriers to accessing healthcare and related challenges to inform our work and better support the populations we serve.

Prior authorization has a role in healthcare, in that it can ensure that covered items and services are medically necessary and covered by the payer. However, patients, providers, and payers alike have experienced burden from the process. It has also been identified as a major source of provider burnout, and can become a health risk for patients if inefficiencies in the process cause care to be delayed. In the Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Advancing Interoperability and Improving Prior Authorization Processes for Medicare Advantage Organizations, Medicaid Managed Care Plans, State Medicaid Agencies, Children's Health Insurance Program (CHIP) Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the federally-Facilitated Exchanges, Merit-Based Incentive Payment System (MIPS) Eligible Clinicians, and Eligible Hospitals and Critical Access Hospitals in the Medicare Promoting Interoperability Program proposed rule (87 FR 76238) issued last December, CMS proposed a num-

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[14] https://www.healthit.gov/topic/laws-regulation-and-policy/request-information-electronic-prior-authorization-standards-implementation-specifications.

[15] https://www.govinfo.gov/content/pkg/FR-2023-04-18/pdf/2023-07229.pdf.

[16] https://www.healthit.gov/topic/usability-and-provider-burden/strategy-reducing-burden-relating-use-health-it-and-ehrs.

ber of policies to help make the prior authorization process more efficient and transparent.

CMS proposed requiring impacted payers to build and maintain a Prior Authorization Requirements, Documentation, and Decision Application Programming Interface (PARDD API) that would automate the process for providers to determine whether a prior authorization is required, identify prior authorization information and documentation requirements, as well as facilitate the exchange of prior authorization requests and decisions from their electronic health records (EHRs) or practice management system. CMS proposed requiring impacted payers to include a specific reason when they deny a prior authorization request. CMS proposed requiring certain impacted payers to send prior authorization decisions within 72 hours for expedited (i.e., urgent) requests and seven calendar days for standard (i.e., non-urgent) requests. CMS also proposed requiring impacted payers to publicly report certain prior authorization metrics by posting them directly on the payer's website or via publicly accessible hyperlink(s) on an annual basis. The comment period for this proposed rule closed on March 13, 2023, and CMS is considering comments received for final decisionmaking.

Question. The rate of Medicare beneficiaries that have moved to Medicare Advantage has grown each year since the inception of the program. As of January, 2023, 46% of Medicare beneficiaries have signed-up for a Medicare Advantage (MA) Plan. The challenge with these plans is that they are not subject to the value-based care promoted through CMS, as they are a private plan funded with Medicare dollars. Although possibly beneficial in theory, 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. This is ultimately hurting both providers and patients, while primarily only proving to be an 'advantage' to the companies providing the policies. Although reversing course on MA plans would be very difficult given the number of patients using them, a strict requirement of guarantees payment, reduction of downcodes and denials, and significant patient education is needed in order to allow for a positive outcome. Otherwise, all of the work from CMS with Medicare will become secondary to the wishes of the private system using CMS dollars to fund what is largely an inferior product.

Is there a process in place to better educate the public on the pros and cons of Medicare Advantage plans?

Answer. On December 27, 2022, CMS published the Contract Year (CY) 2024 Medicare Advantage and Part D proposed rule. As part of this proposed rule, CMS took critical steps to protect Medicare beneficiaries from confusing and potentially misleading marketing while also ensuring they have accurate and necessary information to make coverage choices that best meet their needs. The proliferation of certain television advertisements generically promoting enrollment in MA plans has been a specific topic of concern. To address these concerns, CMS proposed to prohibit marketing that does not mention a specific plan name. In addition, CMS proposed to prohibit plans from using, in communications activities and materials, the Medicare name, CMS logos, or products and information from the Federal Government in a way that is misleading. In the rule, CMS also proposed reinstating important protections that prevent predatory behavior and finalized changes that strengthen the role of plans in monitoring agent and broker activity. CMS also proposed requirements to further protect Medicare beneficiaries by ensuring they receive accurate information about Medicare coverage and are aware of how to access accurate information from other available sources. The comment period for the proposed rule closed on February 13, 2023. CMS is taking into consideration comments received for final decisionmaking.

Question. Is there a plan in place to ensure that Medicare Advantage plans provide the same or greater level of benefits to patients while providing the same or greater benefits to providers for service, in comparison to original Medicare?

Answer. Under the statute, Medicare Advantage plans are required to cover the same benefits available under Original Medicare (with some exceptions), referred to as "basic benefits." The CY 2024 Medicare Advantage and Part D proposed rule proposes clarifications for clinical criteria guidelines to ensure people with Medicare Advantage receive access to the same medically necessary care they would receive in Original Medicare. CMS proposes clarifying rules related to acceptable coverage criteria for basic benefits by proposing to require that Medicare Advantage plans must comply with national coverage determinations (NCD), local coverage determinations (LCD), and general coverage and benefit conditions included in Original Medicare regulations. CMS also proposes that when coverage criteria are not fully established, Medicare Advantage organizations may create internal coverage criteria based on current evidence in widely used treatment guidelines or clinical literature made publicly available to CMS, enrollees, and providers.

Question. One in three seniors die from Alzheimer's or a related form of dementia. Bi-partisan groups of members in Congress have written to the Administration about concerns over 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. CMS has declined to open the National Coverage Determination to start the process for access so these changes are not forced to jump through all these CMS requirements after FDA determines that they should be approved.

What is your agency doing for these patients with life threatening conditions?

Why are patients with Alzheimers having to jump through hurdles to access life-saving drugs?

Answer. 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. Moreover, in the final National Coverage Determination, we do not restrict the setting of approved clinical trials 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.

Question. Dialysis is a procedure that removes waste products and excess fluid from the blood and it is critically important to the over 550,000 people with kidney failure in the U.S. These patients need to dialyze several times per week. Roughly 14% do so at home, but the remainder dialyze in centers, sitting next to other patients and attended to by healthcare staff. Studies show that patients who are able to undergo dialysis at home rather than in a center are able to spend more time with loved ones, spend less time traveling and waiting for appointments, participate more in work and other activities, and experience improved health outcomes. Individuals receiving maintenance dialysis are particularly vulnerable to COVID–19 and sadly, the COVID pandemic was the first time since 1980 that the population of people with End Stage Renal Disease declined, with mortality up by 17% among dialysis patients. In the event of future emergencies there should be improved access to home dialysis units to help these vulnerable individuals protect their health from infection.

What actions is the Department taking to ensure patient's continued access to their dialysis during emergencies, and to home hemodialysis to keep them safe from infections?

Answer. At the beginning of the COVID–19 Public Health Emergency (PHE), CMS used emergency waiver authorities and various regulatory authorities to enable flexibilities so providers could rapidly respond to people impacted by COVID–19, as well as limit exposure to and spread of the virus. In recognition of the critical importance of maintaining access to dialysis treatment, CMS utilized a number of these regulatory authorities during the PHE, including reducing administrative burden for providers, bolstering the dialysis workforce, expanding Medicare telehealth for End Stage Renal Disease (ESRD) patients and providers, and establishing Special Purpose Renal Dialysis Facilities to address access to care issues.

Additionally, CMS has assessed which flexibilities would be most useful in a future PHE, such as natural and man-made disasters and other emergencies, to ensure a rapid response to future emergencies, both locally and nationally, or to address the unique needs of communities that may experience barriers to accessing healthcare. CMS is continuing to collaborate with Federal partners and the healthcare industry to ensure that the healthcare system is holistically prepared for addressing future emergencies.

QUESTIONS SUBMITTED BY SENATOR JOHN BOOZMAN

Question. As you know, the healthcare workforce is essential to maintaining access to high-quality, safe, and equitable care. However, the healthcare workforce is faced with shortages across the board. Arkansas ranks among the lowest in the number of available physicians per capita and more than 500,000 Arkansans live in an area lacking an adequate number of health professionals to serve the population. Furthermore, an aging population presents an even greater future challenge. In 2017, the majority of the nursing workforce was close to retirement, with more than half aged 50 and older, and almost 30% aged 60 and older. Hospitals faced similar demographic trends for physicians, with data from the Association of Amer-

ican Medical Colleges indicating that one-third of practicing physicians will reach retirement age over the next decade.

Can you talk about the Administration's views with respect to the need to fund various healthcare workforce programs to address current and future workforce needs?

Answer. Healthcare workforce needs are a pressing challenge across the country and the Budget makes a number of important investments to help grow the healthcare workforce. The FY 2024 President's Budget invests $2.7 billion for workforce programs, which includes $947 million in mandatory funding to expand workforce capacity across the country.

Highlights include:

—$965.6 million, an increase of $547.7 million, for the NHSC to maintain a field strength of over 20,000 clinicians practicing in rural and underserved communities in return for scholarships and loan repayment.

—$387.4 million, an increase of $190.3 million, for Behavioral Health Workforce Development Programs to support training for 18,000 providers.

—$112.6 million for Advanced Nursing Education, an increase of $17 million, to grow and diversify the maternal and perinatal health nursing workforce.

—$28 million for a new program to address modernizing health workforce training to address healthcare workforce shortages

—$91.9 million, an increase of $32.5 million to expand, enhance, and modernize nursing education programs.

—$157 million in mandatory funding for FY 2024 for the Teaching Health Center Graduate Medical Education program to support over 1,400 resident full-time equivalent slots in community -based ambulatory settings.

With respect to workforce programs in rural areas specifically, the FY 2024 Budget includes a request of $13 million for the Rural Residency Planning and Development (RRPD) Program to support creation of new rural residency programs to recruit and retain new physicians in rural areas. Recognizing the issue of workforce shortages you raised in Arkansas, HRSA has provided roughly $2.25 million through the RRPD program to expand rural residency training programs in the state.*Question.* According to the CDC, rates of suicide among farmers are 1.5 times higher than the national average. Farming communities are essential in Arkansas with almost 50,000 farms across the state. I appreciate Congress and the Administration's support for expanding access to mental healthcare. However, I fear that farmers are often left out of the conversation.

How is the Administration tailoring its mental health response to ALL Americans, especially the farmers that are core to our nation's agricultural mission?

Answer. On July 16, 2022, the U.S. transitioned to the 988 Suicide & Crisis Lifeline, which is a new, easier way to reach the service formally known as the National Suicide Prevention Lifeline. 988 offers 24/7 access to trained crisis counselors who can help people experiencing mental health-related distress, including suicidal ideation. People can call or text 988 or chat 988lifeline.org for themselves or if they are worried about a loved one who may need crisis support. 988 serves as a universal entry point so that no matter where an individual lives in the U.S., they can reach a trained crisis counselor who can help.

In addition, SAMHSA also administers multiple suicide prevention grant programs focused on youth and adults. SAMHSA administers the Garrett Lee Smith (GLS) State/Tribal Youth Suicide Prevention and Early Intervention Program, which is available to states or Tribes, and the GLS Campus Suicide Prevention Grant Program, which is available to institutions of higher education. GLS State/Tribal grantees, most recently Michigan and Tennessee, have included a focus on agriculture community youth as part of their population of focus. For adults, SAMHSA administers the National Strategy for Suicide Prevention (NSSP) grant program and the Zero Suicide program. The NSSP grant program supports the implementation of the 2021 Surgeon General's Call to Action to Implement the National Strategy for Suicide Prevention, with an emphasis on older adults, adults in rural areas, and American Indian and Alaska Native adults. The program supports a broad-based public health approach to suicide prevention and aims to raise awareness of the resources available to prevent suicide. The program also promotes help seeking behavior; establishes referral processes and improves outcomes for individuals at risk for suicide; and enhances collaboration with key community stakeholders. The Zero Suicide program supports health systems to implement the Zero Suicide intervention and prevention model, a comprehensive, multi-setting approach to suicide prevention in health systems.

Further, SAMHSA funds the Suicide Prevention Resource Center (SPRC), which advances suicide prevention infrastructure and capacity building through consulta-

tion, training, and resource development. The SPRC website has a dedicated page for resources focused on rural communities.

SAMHSA also administers the Rural Emergency Medical Services (EMS) Training grant program. The purpose of this program is to recruit and train EMS personnel in rural areas with a particular focus on addressing substance use disorders (SUD) and co-occurring disorders (COD) when a person has both substance use and mental disorders. Recipients are expected to train EMS personnel on SUD and COD, trauma-informed, recovery-based care for people with such disorders in emergency situations and, as appropriate, to maintain licenses and certifications relevant to serve in an EMS agency. In 2023, SAMHSA is requiring the grant recipients to train EMS personnel on the use of motivational interviewing to engage those individuals who use substances, and/or who suffer mental health conditions, and to provide referrals to treatment and harm reduction services.

SAMHSA also funds the Mental Health Technology Transfer Center (MHTTC) program. This program has developed several resources to support mental health in rural communities. For example, the MHTTC developed the Depression, Alcohol and Farm Stress: Addressing Co- Occurring Disorders in Rural America practical guide. This guide offers resources specific to screening for co-occurring disorders experienced by farmers, farmworkers and farm families in rural communities. The guide uses a case scenario to illustrate the most common barriers encountered in identifying co-occurring disorders and underscores the unique needs of rural communities that are home to agricultural producers.

In addition, the MHTTC created the Addressing Suicide Disparity in Rural Communities webinar. The 4-hour seminar gave providers and anyone providing mental health support to individuals a working knowledge, resources, and community-based solutions for addressing suicide in rural communities. Participants learned about the signs and symptoms of suicide, the impact of stigma on seeking and maintaining treatment, the role of harm reduction, and suicide postvention for providers and families.

Finally, the MHTCC also has produced a collection of resources specifically aimed at addressing mental health conditions caused by farm stress called Farm Stress and Mental Health Resources and a webinar called Improving Mental Health Care by Understanding the Culture of Farming and Rural Communities, which aimed at addressing the mental health crisis and unique stressors caused by the COVID–19 pandemic within the farming and rural/frontier communities.

Question. I am very concerned about infant mortality. Unfortunately, Arkansas struggles with a high infant mortality rate. Arkansas—7.38 infant deaths per 1k live births. Overall US—5.4 infant deaths per 1k live births. And the overall U.S. infant mortality rate is much higher compared to countries with a similar GDP.

How does the Administration plan on addressing these alarmingly high rates of infant mortality?

Answer. HRSA advances infant health in its broader investments such as the Title V Maternal and Child Health Services Block Grant Program, which supports or partners with fetal-infant mortality reviews (FIMRs) and Child Death Reviews (CDRs) to reduce fetal and infant mortality.

Community and state CDR and FIMR teams are supported by the HRSA-supported National Fetal, Infant, and Child Death Review Center Program, which aims to increase their capacity to collect high-quality uniform data, translate data into action at the community, state, and national levels, and expand fetal, infant, and child death reviews to additional states, territories and tribes.

The Maternal, Infant and Early Childhood Home Visiting Program also helps reduce infant mortality by linking families to appropriate newborn healthcare, providing education and support to new parents on caring for infants, facilitating connections with health, social services and child development professionals, and preventing child abuse and neglect.

In addition, HRSA has targeted investments to address infant mortality, including:

—The Healthy Start Program, which provides grants to high-risk communities with infant mortality rates at least 1.5 times the U.S. national average, as well as high rates of other poor perinatal outcomes (e.g., low birthweight and preterm birth). Healthy Start provides and/or facilitates access to care and needed services to improve the health of mothers and children through the first 18 months after birth. In FY 2022, the program provided 101 grants to community-based projects.

—The Catalyst for Infant Health Equity Program, which aims to reduce disparities in infant mortality and support action plans that focus on improving community systems and services that influence health outcomes. In FY 2022, HRSA awarded $4.5 million to counties with high disparities in infant death rates.

—A new Enhanced Healthy Start grant program that will award up to $13.1 million to communities who are not already covered under the Healthy Start program with the highest rates of perinatal health disparities in the country.

Healthcare workforce needs are a pressing challenge across the country and the Budget makes a number of important investments to help grow the healthcare workforce. The FY 2024 Budget invests $2.7 billion for workforce programs, which includes $947 million in mandatory funding to expand workforce capacity across the country.

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—$112.6 million for Advanced Nursing Education, with an increase of $17 million, to grow and diversify the maternal and perinatal health nursing workforce.
—$28 million for a new program to address modernizing health workforce training to address healthcare workforce shortages
—$91.9 million, an increase of $32.5 million to expand, enhance, and modernize nursing education programs.
—$157 million in mandatory funding for FY 2024 for the Teaching Health Center Graduate Medical Education program to support over 1,400 resident full-time equivalent slots in community-based ambulatory settings.

Lastly, supporting working families is a priority for this Administration. On December 29, 2022, the President signed the Providing Urgent Maternal Protections (PUMP) for Nursing Mothers Act into law, extending the Fair Labor Standards Act's reasonable break time and space protections to pump breast milk at work to an estimated 9 million workers. Our partners at the Department of Labor's Wage and Hour Division are working hard to ensure that nursing employees receive these pump at work protections.

In FY 2024, The National Institutes of Health (NIH) will provide an estimated $111 million to support research aimed at reducing infant mortality. The Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD) supports a Maternal-Fetal Medicine Units (MFMU) Network that performs randomized controlled trials and observational studies to investigate the safety and efficacy of obstetric treatments and management strategies. Studies focus on high-risk pregnancies to reduce maternal, fetal, and infant mortality and morbidity, especially preterm births, fetal growth abnormalities, and maternal complications.

NICHD's Neonatal Research Network (NRN), founded in 1986, conducts collaborative, multi-site clinical trials and observational studies involving newborns and lactating people, providing evidence to guide clinical practice. Its purpose is to improve healthcare and outcomes for newborns. This includes finding ways to increase survival chances without neurodevelopmental impairment for infants born premature, low-birth weight, or with other serious conditions.

Additionally, NICHD's Safe to Sleep© program educates caregivers about ways to reduce the risk of Sudden Infant Death Syndrome (SIDS) and other sleep-related causes of infant death.

Question. In relation to developing Dietary Guidelines for Americans (DGA) for 2025–2030, HHS recently stated that alcohol "will be examined in a separate effort, led by HHS that supports work on this topic."

What process will HHS employ to ensure its "separate effort" will operate in a fully transparent manner?

Answer. The Interagency Coordinating Committee on the Prevention of Underage Drinking (ICCPUD) led by the Substance Abuse and Mental Health Services (SAMHSA) will support a technical subcommittee to review evidence on alcohol intake and health and make recommendations on adult alcohol consumption to be included in the Dietary Guidelines for Americans. A subcommittee report will be published and available to the public.

QUESTIONS SUBMITTED BY SENATOR MARCO RUBIO

Question. As a parent, I send my children to school each day to learn how to read, how to write, how to do math—in short, I want them to learn critical skills for their future. Today, however, woke activists are infiltrating our classrooms and preying on our children through the promotion of so-called "gender-affirming care." It is no longer enough for an adolescent to self-describe as gay or lesbian of their own ac-

cord. Activists are now brainwashing vulnerable youth—particularly those struggling with gender dysphoria— into thinking that in order to be happy, they need to consider dangerous treatments like puberty blockers and irreversible surgeries. The vast majority of individuals with gender dysphoria eventually lose their desire to identify with another sex. Moreover, a young adult's brain development does not stop until approximately 25 years old. Taking all this into consideration, I have serious concerns with your department's decision to use taxpayer dollars and manipulate Federal laws to support crazy practices under the guise of "gender-affirming care" for children.

Can you explain "the science" behind what happens when an 11-year old takes puberty blockers, particularly when these drugs are not approved by the FDA for the purposes of gender transition?

How does "the science" justify imposing the negative social, psychological, and physical consequences of failed "gender-affirming" procedures—which include an increased risk of depression and cancer—on children?

Answer. The Department of Health and Human Services (HHS or Department) is committed to supporting the health and well-being of all families and children of all beliefs and backgrounds. HHS believes that all children and adults should be afforded life-saving, medically necessary care, including youth who identify as Lesbian, Gay, Bisexual, Transgender, Queer, Intersex (LGBTQI+).

Major medical associations in the United States, including the American Medical Association, the American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry, the Pediatric Endocrine Society, and the Society for Adolescent Health and Medicine, have found that gender-affirming care is medically necessary, safe, and effective care for transgender and nonbinary people.[17] Gender-affirming care is life-saving care, it includes counseling and mental healthcare. It is also suicide-prevention care.[18] Gender-affirming care is a specialized model of care, tailored to the specific needs of the patient. Gender affirming care is in line with current standards of care, and healthcare providers make individualized medical judgments about what evidence-based treatments are appropriate for a particular patient.

Question. Secretary Becerra, earlier this year, under your supervision, the FDA removed a crucial protection requiring women to consult with a doctor before receiving a prescription for the chemical abortion drug mifepristone. The serious medical risks of mifepristone are well-documented. More than a third of women who take this drug show up to the emergency room due to serious complications. Under the guide of "expanding access," the FDA is allowing profit-hungry online pharmacies to push the drug on women without first consulting with a doctor. In-person visits are essential for physicians to rule out extremely dangerous factors like an ectopic pregnancy or a Rh-negative blood type. For decades, Democrats have purported to help women decide whether to have an abortion with their doctor. Now, the FDA proposes to remove doctors from the equation.

Is the Biden Administration more concerned with increasing abortion or protecting women's health as it weighs decisions over the regulation of chemical abortion pills?

Answer. FDA stands behind its determination that mifepristone is safe and effective under its approved conditions of use for medical termination of early pregnancy, and believes patients should have access to medications that FDA has determined to be safe and effective for their intended uses. Under FDA's approved conditions of use, mifepristone may only be dispensed by or under the supervision of a certified prescriber, or by a certified pharmacy on a prescription issued by a certified prescriber. As part of its Congressionally-mandated role to approve and regulate medications, FDA has made an independent, evidence-based determination that mifepristone may be safely dispensed in person or by mail on a prescription issued by a certified prescriber.

Question. How does the Department of Health and Human Services (HHS) justify removal of the in-person distribution requirement for mifepristone given the substantial medical evidence on the drug's health risks?

Answer. FDA stands behind its determination that mifepristone is safe and effective under its approved conditions of use for medical termination of early pregnancy, and believes patients should have access to medications that FDA has determined

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[17] Transgender Legal Defense and Education Fund Trans Health Project. Medical Organization Statements. (2023.) Available at: https://transhealthproject.org/resources/medical-organization-statements/.

[18] Tordoff, Diana M., Jonathon W. Wanta, Arin Collin, Cesalie Stepney, David J. Inwards-Breland, and Kym Ahrens. "Mental health outcomes in transgender and nonbinary youths receiving gender-affirming care." JAMA network open 5, no. 2 (2022): e220978-e220978.

to be safe and effective for their intended uses. Under FDA's approved conditions of use, mifepristone may only be dispensed by or under the supervision of a certified prescriber, or by a certified pharmacy on a prescription issued by a certified prescriber. As part of its Congressionally-mandated role to approve and regulate medications, FDA has made an independent, evidence-based determination that mifepristone may be safely dispensed in person or by mail on a prescription issued by a certified prescriber.

Question. How does HHS justify permitting mail-in pharmacies to distribute mifepristone on legal grounds given that Federal law bars the United States Postal Service and private carriers from mailing abortion drugs (18 U.S.C. §§ 1461—1462)?

Answer. FDA stands behind its determination that mifepristone is safe and effective under its approved conditions of use for medical termination of early pregnancy, and believes patients should have access to medications that FDA has determined to be safe and effective for their intended uses. Under FDA's approved conditions of use, mifepristone may only be dispensed by or under the supervision of a certified prescriber, or by a certified pharmacy on a prescription issued by a certified prescriber. As part of its Congressionally-mandated role to approve and regulate medications, FDA has made an independent, evidence-based determination that mifepristone may be safely dispensed in person or by mail on a prescription issued by a certified prescriber.

Question. The failure to include the Hyde Amendment in HHS' FY24 proposed budget is incredibly alarming. This is the third time President Biden has excluded this critical bipartisan protection against taxpayer-funded abortions with more than 40 years of precedent. The 80 percent increase in Title X family planning funding is also concerning when Democrats and the Biden Administration have made it clear those dollars would fund abortion providers. There is no human right more fundamental or more sacred than the right to life, and funding Planned Parenthood and other abortion clinics is a blatant attack on the right to life.

Does the Biden Administration support taxpayer-funded abortion?

When Congress rejects the President's radical proposal and includes the Hyde Amendment in future spending bills, will you follow the law and ensure that Federal Medicaid dollars are not used to finance abortion?

Answer. As HHS Secretary, my role is to implement the law. The Department will follow all applicable laws as they relate to abortion and any other issue.

SUBCOMMITTEE RECESS

Senator BALDWIN. And with that this hearing is adjourned.

[Whereupon, at 4:19 p.m., Wednesday, March 22, the subcommittee was recessed, to reconvene subject to the call of the Chair.]

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

THURSDAY, MAY 4, 2023

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

The subcommittee met, at 10 a.m., in room SD–192, Dirksen Senate Office Building, Hon. Tammy Baldwin (chairwoman) presiding.

Present: Senators Baldwin, Murray, Durbin, Shaheen, Schatz, Capito, Moran, Kennedy, Boozman, Britt, and Collins.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

NATIONAL INSTITUTES OF HEALTH

STATEMENT OF DR. LAWRENCE TABAK, ACTING DIRECTOR

ACCOMPANIED BY:

DR. DOUGLAS LOWY, PRINCIPAL DEPUTY DIRECTOR, NATIONAL CANCER INSTITUTE

DR. JOSHUA GORDON, DIRECTOR, NATIONAL INSTITUTES OF MENTAL HEALTH

DR. RICHARD HODES, DIRECTOR, NATIONAL INSTITUTE ON AGING

DR. NORA VOLKOW, DIRECTOR, NATIONAL INSTITUTE ON DRUG ABUSE

OPENING STATEMENT OF SENATOR TAMMY BALDWIN

Senator BALDWIN. Good morning. I want to welcome everyone to the Senate Appropriations Subcommittee on Labor, Health, and Human Services, Education, and Related Agencies hearing on fiscal year 2024 budget request for the National Institutes of Health, and today I am happy to welcome Acting Director Tabak and his colleagues and I will introduce you all before the testimony begins.

These hearings are essential for our subcommittee to assess our country's needs for the coming year. For NIH (National Institutes of Health), this means providing our scientists with what they need to conduct cutting edge research, to discover and develop treatments to help patients fighting disease.

As I happen to be the granddaughter of an NIH-funded scientist, my grandparents raised me and I understand what an important role biomedical research plays not just in treating and curing dis-

ease but also in bolstering our economic growth and ensuring that America is a global leader in innovation.

We cannot afford to have NIH's potential limited or even worse have its legs cut out from under it. Yet that is precisely what the House Republicans have proposed to do with their fiscal year 2024 budget caps in the bill that they passed last week.

Cutting spending as they have proposed would mean slashing approximately 22 percent from programs next year that support a range of programs, including supporting our veterans, keeping our communities safe and healthy, and doing vital research to find cures for illnesses and diseases.

It would mean a cut of over $10 billion in fiscal year 2024 alone for life-saving medical research at NIH. An extreme cut like that would mean NIH could fund 5,000 fewer grants and would shutter hundreds of labs across the country. It would stall training for the next generation of researchers and result in fewer drugs being developed for cancer, Alzheimer's disease, diabetes, serious mental illness, and other devastating conditions.

This would slow progress to find treatments for disease and weaken America's competitiveness, particularly against China, and increase our reliance on foreign countries for clinical trials and drug development.

Fortunately, here in the Senate, Ranking Member Capito and I are focused on writing a bipartisan Labor/HHS (Health and Human Services) spending bill to move our country forward. We are committed to working together to find compromise.

Our communities are depending on us to continue providing the support needed to combat the opioid epidemic, the mental health crisis, and so many other challenges.

Every day across Wisconsin researchers at world-class institutions, like Marquette University, the Medical College of Wisconsin, and the University of Wisconsin System, are working around the clock and making ground-breaking discoveries.

I'm pleased to say this subcommittee has a proven track record of recognizing the tremendous importance of supporting our Nation's biomedical research community.

Acting Director Tabak, I'm pleased to see that the Administration's budget request for NIH would increase funding for the Cancer Moonshot and Mental Health Research, and I look forward to learning about the agency's plans to deliver new cancer treatments with fewer side effects and develop a precision psychiatric initiative, but I'm disappointed to see programs that aim to address maternal mortality, the opioid epidemic, Alzheimer's disease, and health disparities and develop a universal flu vaccine to name just a few, that those programs remain flat or are actually cut in the proposal.

I look forward to working with my colleagues to ensure NIH has the resources it needs across its 27 institutes and centers to continue the progress of recent years.

I have been glad to see NIH working to examine barriers to diversity among its researchers and within its clinical trials and increased career opportunities for groups that are underrepresented in biomedical research, but there is still a long way to go, and in

the meantime, these remain real problems with real consequences for research.

Finally, before I turn it over to Senator Capito, I want to mention an article published last week in Science revealing NIH's failure to discipline an investigator with a known documented history of sexual harassment.

In March of 2022, after years of urging NIH to take decisive action, this subcommittee wrote policy into law requiring institutions to inform NIH of disciplinary actions taken against harassers to ensure accountability.Yet, following a far-reaching investigation at Florida State University that resulted in a 131-page report detailing years of severe pervasive sexual harassment, NIH approved the transfer of an investigator from FSU (Florida State University) to San Diego Biomedical Research Institute and awarded him a new $2.5 million grant. Unsurprisingly, the abuse continued, driving at least one trainee out of the institution.

It is outrageous that NIH is complicit in this case of pass the harasser and I want to know what you're doing to hold the researcher and institutions accountable and how you will prevent incidents like this from happening again in the future.

So, Acting Director Tabak, I look forward to your testimony and appreciate your being here today.

In a moment, I will turn it over to Ranking Member Capito for her opening remarks. Following Senator Capito's opening statement, we will hear from Acting Director Tabak and after that Senators will each have 5 minutes for the first round of questions.

Senator Capito.

STATEMENT OF SENATOR SHELLEY MOORE CAPITO

Senator CAPITO. Thank you. Thank you, Madam Chair, and I agree with you. We need to do this together, work together. We have the Vice Chair here. So, she's riding hard on all of us as she is with the Chair. So, we are hopeful that we have a successful result.

Dr. Tabak, thank you for being here and for your role in performing the functions as NIH Director, really appreciate this. You've done it since December 2021 and have helped steer NIH through some interesting times. Maybe you'll write a book or something.

Dr. Volkow, thank you. Dr. Hodes, thank you. Dr. Gordon and Dr. Lowy, thank you for being here today to discuss some of the biggest health issues facing our Nation.

This is an important opportunity for us to hear about the NIH budget proposal and better understand the priorities for fiscal year 2024.

I've mentioned before that our jobs will be more challenging this year given the debt ceiling and fiscal challenges that face our Nation. Supported funding for biomedical research at NIH has long been a bicameral, bipartisan priority.

The budget proposes $48.8 billion in discretionary spending for NIH, including 21st Century cures and ARPA–H (Advanced Research Project Agency for Health). NIH funding has seen almost a 60 percent increase for the last 8 years and these investments are

for good reasons since NIH research affects every American in every way.

As I look through the dais, I think of all the people that I know in my home State who are affected by your different disciplines.

In West Virginia, NIH supports 952 jobs and a $142 million in economic activity during 2022 alone through the $49 million that were received in grants and contracts.

This year we need to prioritize areas of agreement, such as funding to find cures and treatment for cancer, including childhood cancer, and funding for our academic research institutions.

For example, in the fiscal year 2023 Omnibus, we reauthorized the Childhood Cancer Star Act, which I led with Senator Jack Reed and included in there $30 million to continue to implement it.

The Cancer Star Act directs the National Cancer Institute to advance childhood cancer research to better understand and track the disease and enhance support for survivors and those affected by childhood cancer. Childhood cancers are different than adults and this specialized research is very important.

West Virginia ranks above the national average both in new cancer diagnoses and deaths. So, I'm pleased that the budget devotes increases to the Cancer Moonshot and significant resources to the Advanced Research Project Agency for Health or ARPA–H to focus on finding cures and treatments for cancer.

Another area I greatly support is for the NIH Institutional Development Award or the IDEA Program. There have been few programs as impactful to my State as the IDEA Program and I'm disappointed that these awards are flat funded in the President's budget.

West Virginia University is one of 17 research institutions nationwide to participate in an IDEA, an Echo Program that was started in 2016. The collaboration between WVU (West Virginia University) establishes pediatric clinical trials throughout the entire State of West Virginia so that doctors and patients have access to the same treatments that are available at WVU's hospital in Morgantown.

WVU is also a leader in NIH COVID research. Dr. Sally Hotter with WVU is co-leading an IEDEA States Consortium Initiative to better understand the long-term effects of COVID.

The research capabilities at West Virginia University continue to prove that our West Virginia institutions can compete with any other institution in the country.

I'm disappointed in some of the overall funding levels in the NIH proposed budget. First, there are no new resources specifically for Alzheimer's research at NIH which Dr. Hodes knows is a great passion of mine. An estimated 6.7 million people 65 or older are currently living with Alzheimer's in our country and the national cost of caring for those Alzheimer's and other dementias is estimated to reach $345 billion, not to mention the emotional cost on our families and care-givers.

There's a lot of exciting research going on in this area. Alzheimer's and dementia-related research must remain a national priority.

Also, substance abuse challenges facing the Nation basically are receiving just lip service in this budget as the National Institute on Drug Abuse is receiving flat funding.

In 2021, fatal overdoses claimed nearly a 107,000 Americans. Dr. Volkow has visited my State and has seen firsthand how we are in the crosshairs of the opioid and addiction crisis.

Dr. Hodes, I know we are anxious to have you back in West Virginia and, frankly, I'd welcome all of you to visit West Virginia not just to see and learn but also to enjoy the State, as well, and meet the dedicated professionals.

I know we're dealing with a tight budget year this year, but investments in biomedical research are so important for the future of our country.

Listen. I want to thank all of you for what you do. I should have started with that because you're in an exciting time for research and exciting time for break-throughs, and we want to support you as well as we can.

So, thank you.

Senator BALDWIN. Thank you, Senator Capito, and I will now introduce our witnesses.

Dr. Lawrence Tabak is the Acting Director of the National Institutes of Health.

Dr. Joshua Gordon is the Director of the National Institute of Mental Health.

Dr. Richard Hodes is the Director of the National Institute on Aging.

Dr. Douglas Lowy is the Principal Deputy Director of the National Cancer Institute.

Dr. Nora Volkow is the Director of the National Institute on Drug Abuse.

I want to thank you all for joining us and underscore what Senator Capito just said. Thank you for what you do and how you have devoted your careers.

Acting Director Tabak, you may deliver your opening remarks.

SUMMARY STATEMENT OF DR. LAWRENCE TABAK

Dr. TABAK. Thank you, Chair Baldwin, Ranking Member Capito, and Distinguished Subcommittee Members.

I'm 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 to 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 or how gene activity is controlled doesn't often improve human health immediately, but fundamental research is essential to making breakthrough discoveries that lead to treatments and cures.

A paper published last Friday in the Journal of the American Medical Association indicated that NIH funding contributed to the development of 354 out of 356 new drugs approved by the U.S. FDA (Food and Drug Administration) from 2010 to 2019.

NIH supported the foundational evidence that pharmaceutical companies leveraged to develop life-saving drugs and many thousands of patents.

I've spoken to this subcommittee previously about how fundamental research from NIH supported scientists and collaborators positioned the United States 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 tissue plasminagen activator or TPA that resulted from decades of work conducted across biological disciplines. Researchers first found the enzyme on cells that line blood vessels in 1946. Three decades later, certain cancer cells were found to secrete TPA in large quantities and once purified the purifying enzyme dissolved clots in animal models.

A decade after that, using recombinant DNA technology NIH-supported clinical trials led to the approval of TPA to treat heart attacks and then in the 1990s TPA transformed the treatment of stroke, allowing most patients who are treated within 3 hours to make a full recovery with far reduced health costs.

Many of our most important advances have come when we were not even thinking about a direct application. Decades ago, NIH-funded research on how bacteria protect themselves from viruses, for example. No one involved could have predicted that this research would lead to tools that have revolutionized all of medicine.

Because of research on recombinant DNA in the 1960s, it became possible to produce drugs like human insulin and TPA for widespread use starting in the 1980s.

Continued investments led to the transformative approaches for gene editing, such as CRISPR. This highly-versatile technology has revolutionized how basic research is conducted and how diseases may be treated, including such things as sickle cell and antibiotic resistant urinary tract infections.

Discoveries build upon each other in ways that we cannot necessarily predict. 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 collaborate with industry to advance crucial interventions for the public.

As most of you know, Naloxone is a life-saving treatment that can quickly restore normal breathing when somebody overdoses on opioids. This drug is an essential tool in the fight against the opioid overdose crisis which claims 188 lives in the U.S. 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 the pivotal data to support FDA approval of Narcan in 2015, and just a few weeks ago the FDA approved Narcan for use without a prescription.

NIH-supported discoveries have affected nearly all of our lives from research studies that lay the foundation for future advances to clinical trials that evaluate potentially life-saving interventions.

Your continued support of our mission to help people live longer and healthier lives is crucial.

I thank you for your time and I welcome your questions.

[The statement follows:]

PREPARED STATEMENT OF LAWRENCE A. TABAK, D.D.S., PH.D.

Good morning, Chair Baldwin, Ranking Member Capito, 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,℠ 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 3 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 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.

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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.

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 healthcare 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.

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 healthcare, 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 healthcare utilization; the effectiveness of digital health apps like Headspace as a just-in-time approach to immediate, personalized behavioral healthcare; 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.

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

[3] wisqars.cdc.gov/data/explore-data/explore.
[4] nimh.nih.gov/health/statistics/mental-illness.
[5] covid19.nih.gov/news-and-stories/covid19-ripple-effects.
[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.

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 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 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 fa-

[9] https://nida.nih.gov/research-topics/comorbidity/covid-19-substance-use.
[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.

cility, 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.

Senator BALDWIN. Thank you, Dr. Tabak.

We will now begin our round, first round of questions. I have several questions that I want to get to, but first, as I noted in my opening statement, the House Republicans last week passed a bill that would have devastating impacts on biomedical research.

HOUSE BUDGET CUTS

What they have proposed would require deep cuts to the NIH and would lock in those cuts over the next decade. I outlined a list of impacts I believed it might have on NIH.

Very briefly, is there anything that you would like to add about what a more than $10 billion cut would mean for NIH research, including if those cuts were sustained over the next decade?

Dr. TABAK. In addition to the numbers that you provided, Chair Baldwin, it would be a chilling effect on the entire biomedical research enterprise. It'll decrease interest in research careers and, as you well know in times of fiscal stress, disproportionately young investigators are the ones who suffer the most.

It really bodes poorly for the future of biomedical science.

Senator BALDWIN. Thank you.

BIOSAFETY INCIDENTS

Dr. Tabak, research that involves enhanced potential pandemic pathogens must be accompanied by safeguards and conducted under strict biosafety and biosecurity measures.

There have been two biosafety incidents involving the H5N1 virus at the University of Wisconsin, Madison, campus. The CDC (Centers for Disease Control and Prevention) considered a 2013 incident a serious exposure that required a researcher to quarantine for a week, which they ended up doing at home rather than at a dedicated quarantine facility.

NIH officials didn't find out about an incident in 2019 until 10 days after a trainee had been exposed. In March, the National Science Advisory Board for Biosecurity published a report recommending the U.S. expand the scope and impose stricter oversight of federally-funded research on dangerous pathogens. This includes NIH-funded studies overseas.

Dr. Tabak, how will the NIH increase its oversight of this research and ensure institutions are held accountable when incidents happen?

Dr. TABAK. So, as you know, the NSABB (National Science Advisory Board for Biosecurity) recently provided its report to HHS and this is informing ongoing discussions across the USG.

I can't presume what those discussions will yield but I can speak to what NIH is doing in the meantime.

First, we are considering how best to elevate the transparency and oversight of the decision process that we use at NIH that feeds into the HHS oversight function.

We are also developing approaches to partner more effectively with our applicant organizations by developing new materials which will clarify both institutional and NIH responsibilities in the process.

We're also performing a comprehensive review to our resisting recombinant DNA and synthetic molecules policies to ensure that we capture biosafety considerations related to emerging technologies, like CRISPR.

Senator BALDWIN. I appreciate your answer.

I just want to comment also that when we look at this oversight, we want to make sure that we don't prompt scientists to move their experiments to countries where there are less stringent requirements. It's a balance that we must reach.

Dr. Volkow, I'm concerned that this budget request leaves opioid research flat footed. Our communities continue to struggle with an opioid crisis and fentanyl is making it so much worse.

Fentanyl is 50 times stronger than heroin and a hundred times stronger than morphine and it has become the leading cause of death for people 18 to 45. In my home State of Wisconsin, synthetic opioids, primarily fentanyl, were identified in 91 percent of opioid overdose deaths from 2021 to 2022.

I've heard from families across Wisconsin of lost loved ones to fentanyl poisonings and overdoses. We have to utilize every tool in our toolbox, from stopping it from coming into our country to preventing its use to bringing an end to this national crisis.

Last October, the Wisconsin Department of Health Services distributed a 120,600 fentanyl test strips to organizations across the State to help prevent drug overdose deaths.

Doctor, what does research show about how effective fentanyl test strips are in a real-world setting?

Dr. VOLKOW. The data is actually showing that they are effective in changing the practices of people that are intending to use drugs when these come back negative and research is ongoing to actually strengthen the guidelines that can then inform the users on how to take these drugs in a more safe way and how to test them.

Senator BALDWIN. Thank you.

I see my time has ended. I'm going to turn it to Senator Capito.

Senator CAPITO. Thank you.

CHILDHOOD CANCER

Dr. Lowy, I wanted to talk a little bit about the childhood cancer that I spoke about in my opening statement. I talked about the Star Act, but I guess what I would ask you is where are you seeing the most promising advances in terms of being able to make advances in this pediatric cancer space and what are some of the differences or the top challenges that you have?

Dr. LOWY. Senator Capito, I really want to thank you and Senator Reed for the initial passage of the Star Act and its reauthorization this year and as you know, we are able as a result to support areas for cancer survivors, for improving our biospecimens, and then for collaborating with the Childhood Cancer Initiative to develop molecular characterization in more detail.

We hope that these and other advances will be able to improve the lives of children who develop cancer, both with improved treatment as well as with less toxicity. There have been several FDA approvals over the last few years but it's not enough.

Children who get cancer, as you know, terrible. Children who die from cancer, even worse. We are working hard at the NCI (National Cancer Institute) to support research that is specifically targeted to molecules that are able to interfere with specific abnormalities in a wide range of childhood cancers.

As you said in your opening statement, childhood cancers are not adult cancers in children but they are qualitatively different and we take advantage of that.

Thank you very much.

Senator CAPITO. Thank you. Thank you.

ALZHEIMER'S AND PARKINSON'S RESEARCH

Dr. Hodes, I want to ask you about the flat funding in Alzheimer's which makes absolutely no sense to me when we see the raging numbers. We know there have been a lot of breakthroughs recently, but I also wanted to ask you about Parkinson's disease because I think—I don't know that it's related to Alzheimer's, but it's a neurodegenerative disease.

Senator Murphy and I have just put a bill in that's leading legislation, National Plan to End Parkinson's Act, which would coordinate the research across the Federal Government and other ways.

So can you first talk about Alzheimer's and then the Parkinson's issue, on the Alzheimer's, the budgeting issue and then on the Parkinson's, what breakthrough kind of things are you anticipating, are you seeing within your research?

Dr. HODES. In terms of Alzheimer's disease research, we're clearly at a very exciting juncture, as many of you all have seen in the news, which, to be perfectly clear, the outcome of congressional support and NIH-funded research has led from translation of basic practice into clinical trials which are now showing effects for the first time.

The necessary funds to continue research in this area are important as we recognize it from the brains in people with Alzheimer's is really a very diverse disease. No one treatment is likely to be sufficient for all and promising reflection of what we have been able to accomplish, for example, are now some 59 early stage Phase 1 and Phase 2 clinical trials, only eight of which are targeted to amyloid. The other 51 are towards other diverse targets, such as inflammation, protein folding, and ultimately it's going to be the ability to personalize which of these is most effective for individuals.

So your question about budget and momentum reflects on the fact that if there were a limit in resources, we'd, of course, do our best to ration them appropriately but it would mean a slowing of

this whole and very successful pipeline from basic discovery for clinical trials research.

I'd also add that as we are seeing a time when clinical trial results are going to be translated into common practice in the communities, we are going to have to look very carefully at what happens when treatment reaches the community. Which individuals profit most? Who is most at risk for side effects? This is going to mean monitoring these outcomes in a way that we haven't done before.

To touch briefly perhaps on Parkinson's disease, the potential for a national plan equivalent to what has happened in Alzheimer's disease, I can only project could be as extraordinarily valuable as it has been for Alzheimer's disease.

I think you may be referring in fact to one particular discovery of a new sensitive means for a biomarker accomplishment in Parkinson's that shows the promise of detecting disease even before clinical symptoms and biomarkers as they have been in Alzheimer's disease are very critical to identification early to monitor the effects of clinical trials and to making the appropriate interventions available to the broadest diverse populations.

Senator CAPITO. Well, thank you. Just as a comment, thank you very much. I would agree now is not the time for us to take the foot off the pedal when we're starting to see these early breakthroughs that affect so many families across the country. Thank you.

Senator BALDWIN. Chair Murray.

Senator MURRAY. Well, thank you very much, Chair Baldwin, and Ranking Member Capito.

As Senator Collins and I have said from the start of these hearings, we are very determined to get back to regular order and make sure we pass the funding necessary to keep our families safe and healthy and keep our Nation competitive and that simply has to include providing robust funding for the National Institutes of Health.

If we want to continue to lead on the world stage, we have to continue our global dominance in biomedical research. Our Nation is the leading light here. I should know. I come from Washington State. We have many world-class institutions, and I couldn't disagree more with the House Republicans whose proposal to slash NIH funding would mean we will fall behind and fail to keep investing in these breakthroughs that have truly made a world of difference for patients across our country and across the globe.

We've got to build on that critical progress we've been making and ensure that our investments keep pace, not slash them as House Republicans voted to do.

You know, after a global pandemic that brought the world economy to a grinding halt and cost more than one million American lives, House Republicans are seriously suggesting that we slash funding for life-saving research.

So if we truly care about protecting families, we need to understand that this funding is just as critical as the investments we make in our military and we cannot forget the millions of families who are fighting cancer and Alzheimer's, substance use disorders, long COVID, and so much more.

We have to make sure that our investments reflect the reality that illness is one of our Nation's deadliest adversaries and biggest economic and national security threats.

As I mentioned, we saw that all too clearly during the COVID pandemic, but we also saw the incredible pace of discovery with COVID vaccines. It was no accident. It was made possible by our investments in research into mRNA vaccines in response to Ebola and other viruses and by a premier biomedical research enterprise that we have strategically built over decades and in the bipartisan pandemic response bill that I got signed into law last Congress, I'm glad that we were able to establish ARPA–H to continue strengthening our capacity for cutting edge research.

So I look forward to hearing from the witnesses today about the resources we need across NIH to continue supporting this life-saving work because at the end of the day, what we get for these investments are really important discoveries that keep our Nation competitive, that prepare us for pandemics and other health crises, and give families more time with their loved ones, and give patients hope for the future. That's not just worth the cost, it is priceless.

So I hope we all remember that as House Republicans have now voted for deeply serious and deeply dangerous cuts to cutting edge life-saving research, in the Senate we need to make sure that we are continuing to fund these important and critical investments.

So I'm glad to be here today and speak to our witnesses and, Dr. Tabak, I am a huge supporter of NIH but I have to ask you a tough question today.

HARASSMENT

I have been pressing NIH for years about how to ensure that Federal dollars are not flowing to researchers who harass or bully or retaliate against or even create a hostile environment for their colleagues and for their students and how to ensure NIH workers themselves are not continuing to experience harassment.

So I have to say I am really appalled by recent reporting that an NIH-funded scientist who faced institutional disciplinary action because he was found to have sexually harassed colleagues was simply able to transfer his award from one university to another research institute where he then harassed a trainee in his new lab and, even worse, NIH awarded him a new $2.5 million grant.

That happened despite the fact that Congress directed NIH to make it mandatory for institutions to inform NIH when scientists or key staff are removed or otherwise disciplined due to harassment, bullying, retaliation, or hostile working conditions.

Despite NIH posting publicly that you require notification from all of your award recipients, despite NIH's knowledge of the investigation's finding, and I just have to say it is completely unacceptable.

So I need to ask you today what is NIH doing to fully implement the requirement under last year's law that such actions must be reported to the agency and how are you using that requirement to enforce workplace protections against harassment?

Dr. TABAK. Chair Murray, I want to assure you that we take this issue very, very seriously. We've handled over 650 allegations of

harassment, discrimination, and hostile work environments. We have dedicated staff addressing these allegations and about 30 percent of those allegations have been substantiated and in dozens of cases principal investigators were removed from grants.

The issue that you point out this morning of so-called pass the harasser problem, we, of course, are well aware of that and the specific case. Unfortunately, the original institution was not completely forthcoming about the extent of the investigator's behavior and it was only after the individual's grant was allowed to transfer to the second institution that we became aware of the greater severity of what the issues were.

We are now working with the second institution to understand what the most recent allegations are and I can assure you that if these allegations are sustained, we will take immediate action as required.

Senator MURRAY. Okay. Well, I want to follow up with you. I'm out of time, but I want to find out how you are making clear to these institutions and your grantees that these behaviors are not being accepted and what you're doing to make sure that our NIH workers themselves are not experiencing harassment because at the end of the day, innovation isn't just driven by programs, it is driven by people, and we need the best and the brightest, and if this is what they see around them, we are going to lose them. So this is critical.

Thank you.

Senator BALDWIN. Vice Chair Collins.

Senator COLLINS. Thank you very much, Chair Baldwin.

Before I turn to my questions, I'm going to make a few comments.

First, I want to thank each of you for your extraordinary work. In my judgment, there is no investment that pays greater dividends to American families than our investment in biomedical research and that is why I've been such a strong supporter of NIH and I will continue to be one.

I think we're very fortunate that all of those who are on this committee share that view, including the Chair and the Vice Chair of this subcommittee.

ALZHEIMER'S FUNDING

That is why I am puzzled at the flat funding for Alzheimer's research. We have made real investments to help the 6.7 million Americans aged 65 and older who are currently living with Alzheimer's and those who care for them and we know that this number is on a trajectory to double by 2060.

Alzheimer's is also one of our Nation's most costly diseases and it's one of the leading causes of death among seniors. As the Senator representing the oldest State in the Nation, this is of particular concern to me and as a person who lost her father, her grandfather, and two uncles to this devastating disease, I know personally what this means to American families. So I hope that we can correct the flat funding and continue the trajectory that we have been on.

Now let me turn to my questions. First, Dr. Hodes, I want to commend the National Institute of Aging. You have been essential

in your institute in sustaining the progress that we have been making and we've seen an exciting new class of treatments, one announced just yesterday that is similar to another that has been approved under the accelerated process of FDA that could delay or slow the onset of Alzheimer symptoms.

In a statement last year following the release of Phase 3 lecanemab data, NIH said, "Although NIH did not fund this study, our decades of research paved the way for this Alzheimer's trial that notably met its primary and secondary endpoints." I agree.

That's why I'm so frustrated that these new therapies based on sound science approved by the FDA are not reaching patients because of CMS's (Centers for Medicare and Medicaid Services) inexplicable determination that they are not reasonable and necessary for seniors and here's my real concern.

While this is being finally sorted out, it is so sad because these treatments are most effective when they're given early when people are in the early stages of Alzheimer's. So the patients who would benefit the most are not receiving access to this medication.

Dr. Hodes, in your view, what would broader access now to these disease-modifying therapies mean for patients?

Dr. HODES. Well, thank you for the question, and, of course, the FDA and CMS have the regulatory authorities that are distinct from NIH, but from an NIH perspective, as you said, the therapies that have become available now are the clear outcome result of research supported by NIH.

In fact, lecanemab, one of the drugs, is now being studied in three trials directly funded by NIA (National Institute on Aging), one of which, for example, is treating individuals before any symptoms, so an even earlier stage than before a so-called secondary prevention trial.

Through these, we're trying to work for exposure to more diverse populations and in terms of what this could mean to the public, we are preparing for when final FDA approvals and CMS coverage occurs so we can monitor and ensure that we understand in populations that are diverse, rural, urban, racial, ethnic, which are likely to differ and just which treatment, what time is best, that we have the infrastructure and the trials in place to optimize their impact on society.

This is the next stage, having first found successful interventions to learn from these first leads and to optimize them. So I agree with you the impact on the broad population can be huge and it's our research commitment to make sure that we are prepared to assess this.

Senator COLLINS. Thank you.

EFFECTS OF CANNABIS

Dr. Volkow, I am very concerned about the widespread use of extremely potent cannabis by our young people whose brains are still developing.

NIH research has sought to better understand the relationship between marijuana use and psychiatric disorders. Given recent trends in recreational cannabis use and increased potency, is more research needed to better understand the short- and long-term ef-

fects of cannabis use on mental health and is NIH or its grantees investigating cannabis-induced psychosis?

Dr. VOLKOW. Thanks very much for that question.

Yes, indeed, we are very concerned about the increased use of cannabis with very high content of THC (Delta-9-tetrahydrocannabinol) and also by the increased in regular use. So what we are seeing in the United States is an increase in the number of people that are using cannabis regularly at very high doses. This is particularly important because it is the high doses that are associated with psychosis.

It's a very important area of research to try to understand under what conditions the use of marijuana can result in psychosis and importantly chronic psychosis. So, yes, we are prioritizing this as an area of research to try to unequivocally determine if there's a causal link between the use of cannabis and psychosis.

Researchers are also investigating the potential role that cannabis use can have in suicidal behavior. So we need to understand what may be consequence or not of the use of cannabis, but from what we know, we should be concerned and certainly be monitoring the trends.

Senator COLLINS. Thank you.

Senator BALDWIN. Senator Durbin.

Senator DURBIN. Thank you, Madam Chair. It's an honor to be here and want to thank all of you for your work.

BREACHING THE BRAIN BLOOD BARRIER

I would like to address an announcement this week in Chicago from Northwestern University. It was a breakthrough in their research related to the brain and it has a personal element to it. We lost two of the pillars of the United States Senate to glioblastoma, brain cancer, Senator McCain and Senator Kennedy.

I understand the treatment of this terrible disease is limited by and large to surgical intervention because of the blood-brain barrier.

Now I'm going to stop trying to sound like I've ever attended medical school or even got close to one, but in reading the news account of this Northwestern University breakthrough, it appears that they have now opened the blood-brain barrier to allow drugs to pass through to the brain, meaning that unusable chemotherapy drugs can now reach brain tumors. So there's an option beyond surgery or could be soon.

The process they created is known as Sonication and I won't go any further to try to describe it, but it also said in the article that this could have an application on Parkinson's as well as Alzheimer's.

Would someone please comment as to whether this was an NIH-funded research project and what the prospects may be?

Dr. TABAK. Senator, I don't know the answer to that and will have to get back to you for the record.

Senator DURBIN. Well,——

Dr. TABAK. It certainly is a breakthrough and unless one of my colleagues knows specifically. No. We'll get back to you for the record, sir.

MENTAL HEALTH FUNDING

Senator DURBIN. Second point I'd like to raise is a number of people said to me if you ever get NIH in front of you, ask them why they aren't putting more money into mental health research.

I noticed in your opening statement, you talk about precision medicine, but when we look at the scourge of mental illness in this country, particularly as it affects young people now in extraordinary numbers and percentages, could you give me some kind of point of reference as to how much is being invested in mental health or mental illness as opposed to physical illness?

Dr. TABAK. Dr. Josh Gordon could answer that question, sir.

Dr. GORDON. When we're talking strictly dollars here, we're talking that the National Institute of Mental Health's budget is about two billion. There's a couple billion dollars more in NIDA (National Institute on Drug Abuse) and NIAAA (National Institute on Alcohol Abuse and Alcoholism).

But, of course, the crisis isn't about dollars, it's about people. We are in the midst of a national mental health crisis and we have to respond.

You noted in particular two priorities that we are highlighting in our research response and are highlighted by the President's agenda: precision psychiatry and youth mental health.

On the precision psychiatry space, we know that we need to do a better job in psychiatry in matching patients with treatments and we also know that we're on the cusp of being able to do for mental health, at least for some parts of mental health, like depression and schizophrenia, what the NIA has done for Alzheimer's, that is, develop and prove biomarkers can work and can be used in the clinic to help guide clinical decisionmaking and to innovate treatments and so we are spearheading—in the President's budget, we are proposing two large initiatives in precision psychiatry, one aimed more generally at mental health and one aimed at depression.

On the youth mental health space, again we know from a lot of different studies what to do, but we need to do a better job of figuring out how to implement things like suicide prevention programs and mental health prevention programs and early detection and early prevention treatments for psychosis in youth, in schools, and through digital health and through other settings that we know can reach children. So those are two of our priorities in those areas.

Senator DURBIN. Many any of the cities across America face what Chicago faces with gun violence, particularly from young people. I went to the Cook County Juvenile Facility where teenagers are being held waiting for trial, many of them accused of murder. They spend 1 to 3 years in this building. They've created a high school in the building for these teenagers. It looks like a regular high school inside, gymnasium, cafeteria, classrooms, and such, and when I asked the counselors what do you find when you sit down and talk to these young people who are on trial for murder and accused of gun violence, they said, well, we find the full menu of mental illness, but the one recurring theme is trauma. They've

been exposed to trauma in their lives and it's really changed the way they look at the world.

Senator Capito and I have a bill on this issue looking at trauma, ACEs (Adverse Childhood Experiences). It just seems to me that when we talk about youth mental illness, this is the most obvious frontline challenge that we face.

What should we be doing now that we're not doing when it comes to trauma exposure?

Dr. GORDON. You're a hundred percent correct that trauma is at the root of much mental illness not only in childhood but in adulthood, as well.

We know we need to do a better job of building resilience to trauma. One of the earliest findings in trauma research was that successful navigation of trauma in childhood can lead to resilience to a range of mental health consequences later in life.

So that's really been the focus of much research at NIMH (National Institute of Mental Health) and really needs to be the focus of implementation moving forward.

Senator DURBIN. I would just say in closing that I've been proud of this subcommittee and what it's achieved in terms of funding for NIH research. The 2 percent figure sent to us by the Administration is a true disappointment. I mean to tell the President as much.

The idea that the Republicans have suggested in the House of a 20–25 percent cut in NIH funding is scandalous.

Thank you, Madam Chair.

Senator BALDWIN. Thank you.

Senator Moran.

Senator MORAN. Chairman, thank you. I wish you and the Ranking Member well and will pledge to be a good member of this subcommittee to see that we achieve good results for NIH and other things.

Impact of Increased Funding

One of the examples of not in every instance if you spend money do you necessarily get a better result, but there is plenty of evidence that at NIH that does occur.

Dr. Hodes, I would highlight particularly the increasing total amount of money.

Dr. Tabak, I highlight that to you and what has happened, but in the area of Alzheimer's, I think we've seen significant difference and perhaps you could tie it to the additional resources that this subcommittee, this Congress has provided to NIH. I would be happy if you'd like to confirm that more resources do make a difference, Dr. Hodes.

Dr. HODES. I'd be happy to confirm that they have made a difference. The enormous progress we've seen could not have happened at this pace without the increased support and investment in research and similarly we'll do our best to continue the momentum of this with whatever resources are available.

Senator MORAN. Could you put that in personal terms what it might mean for a family or an individual who has been diagnosed with Alzheimer's?

Dr. HODES. Well, I think with the reduction and limitation in resources, we do our best, of course, to be good stewards of what resources we have, but inevitably it would slow the progression from

most basic discovery to the identification of new diagnostic, therapeutic, and preventive measures. We haven't spoken as much about prevention as we have treatment but that's another one of the very high priorities in which we've made great progress, the continuation of which is going to be dependent upon resources.

Senator MORAN. Thank you for the reminder about prevention.

DOWN'S SYNDROME

I chair the Down Syndrome Caucus in the Senate and one of the things that I appreciate is the opportunity. We have one of the institutes that have a role to play in that research. The relationship between Down Syndrome and Alzheimer's is still being developed and understood and hopefully providing information and a path forward.

Anything that I ought to know maybe, Dr. Tabak, about what's going on in the realm of Down Syndrome and how our caucus and my colleagues and I can be helpful in not only the research that's going on but in assistance to individuals and families?

Dr. TABAK. Well, with the continued leadership and support of the Congress, we have expanded our work with individuals with Down Syndrome. For example, the INCLUDE Initiative, which stands for Investigation of Co-Occurring Conditions.

As you know, people with Down Syndrome are more susceptible to certain types of disease and are less susceptible to others and so there's something to be learned for the general population as well as those with Down Syndrome.

We are in particular trying to enroll more people with Down Syndrome in typical clinical trials so that we have a better understanding of what interventions that we use for the general population would have on individuals with Down Syndrome.

We've already alluded to the intersection between Down Syndrome and Alzheimer's disease and, of course, Dr. Hodes is best prepared to speak to that specific point if you are interested.

Senator MORAN. Dr. Tabak, let me suggest to you that if NIH would provide me with information about how to encourage additional individuals with Down Syndrome to participate, we'd be glad to take that on as a project in educating our constituents. It's beneficial to them and beneficial to NIH.

Dr. TABAK. Thank you. We really appreciate that.

Senator MORAN. And we may suggest that we have a Down Syndrome Caucus meeting in which we pursue that and other issues that are going on.

Dr. TABAK. Thank you.

CANCER FUNDING

Senator MORAN. Dr. Lowy, I raised this issue a year ago with Dr. Tabak and I want to highlight this again.

I'm concerned about the competition that will occur for cancer research funding. So we have funding at the Advanced Research Project Agency, ARPAA, and I want to make sure that it doesn't come at the expense of basic clinical research at NCI.

We also have ARPA–H and the Cancer Moonshot Initiative, and I'm looking for a commitment by you and by NIH that there will

be a prioritization that NCI competitive cancer grants will be funded in fiscal year 2024.

Dr. LOWY. Senator Moran, thanks to you and the committee and the long-term strong support, we were able in fiscal year 2023 to increase the pay line for our large awards from the 11th percentile to the 12th percentile. This will mean more than a hundred additional grants than we were able to do in 2022.

It is still not enough. As you know, there has been tremendous opportunities for cancer research and so researchers are flocking to the NCI in large numbers, larger than in other areas, and therefore although we're supporting many more investigators than we did previously, our pay lines or success rates are not where they should be.

Turning to your specific question about these other entities, I can assure you that we interact regularly with them. For example, with ARPA–H, Dr. Bertagnolli and Dr. Wegrzyn, who is the head of ARPA–H, meet regularly, but we also are communicating directly with various possibilities of research that could be conducted by ARPA–H versus research that will be more appropriate for NCI and to work collaboratively and together to make this a reality.

Senator MORAN. Thank you.

Chairman, I wish that Dr. Collins was here to hear Dr. Lowy say that researchers are flocking, flocking to the NCI and I would look at that photograph of this young lady whose grant wasn't adopted and she was ending her career in research. It was something that captured me a long time ago on this topic about individuals that we lose when the money's not there.

Thank you.

Senator BALDWIN. Senator Shaheen.

Senator SHAHEEN. Thank you, Madam Chair and Senator Capito, for holding this hearing, and thank you to all of you for your work every day and for being here.

OPIOID EPIDEMIC

Dr. Volkow, you've been to New Hampshire. You know what a challenge we've had in my State of dealing with the opioid epidemic. 2022 was the worst year for overdose deaths since 2017 in our State, and I understand that in your testimony you discussed the important work of the Heal Initiative.

Can you talk about what's being done to address vaccinating individuals against substance use disorders and what other promising medications you're seeing?

Dr. VOLKOW. Yes, thank you very much, and, indeed, the funds from the Heal Initiative have enabled us one thing. For example, to expand very much the medication development pipeline and that includes development and research on vaccines and monoclonal antibodies.

So there is ongoing research on different strategies to develop vaccines that are targeting fentanyl, oxycodone, heroin, or multiple drugs at the same time. In parallel, we are investing also significant amount of resources to get monoclonal antibodies because those will be able to deliver higher titers.

These interventions are targeted to monoclonals to help prevent and reverse overdoses from fentanyl as well as with other drugs.

In terms of investments, we have a whole pipeline that goes from repurposing of medications that may be useful to result in better outcomes for the treatment of opioid disease disorders as well as completely novel targets that will be able to help people that are addicted not just to opioids but to multiple substances. That is a goal at the basis of the molecular mechanisms linked with addiction.

Also, an area that I think extraordinarily exciting is the utilization of narrow modelization by which we can actually strengthen or weaken certain sequence or hobs in the brain that are found to be associated with addictive behaviors and there many of the developments that have enabled us to go increasingly more precisely are part of the Brain Initiative which is another brain fundamental.

METHAMPHETAMINES

Senator SHAHEEN. How about methamphetamines?

Dr. VOLKOW. Methamphetamines, we don't have any medications that have been approved by the FDA. So it is a major priority for us. It can be very exciting.

Currently, we are doing clinical trials Phase 1 and Phase 4 monoclonal antibodies against methamphetamines because we don't have anything to reverse an overdose, but we're also working on vaccines for methamphetamines.

We are also doing research in terms of clinical trials taking advantage of medications that when combined have already shown to be beneficial in reducing craving and withdrawal. So this is an area that requires again investment of research and partnerships with industry so that we can bring these developments and translate them into the clinic.

Senator SHAHEEN. And are we talking about 5 years, 10 years, beyond that in terms of having something that we think is going to actually be marketable?

Dr. VOLKOW. I would actually like to say that there are so many lower hanging fruit, like the repurposing of medications. What I would hope that we could have them in the clinic if the FDA approves the indications, say, within 5 years.

For the issue of monoclonal antibodies or vaccines, this is a completely new adventure and there is no antecedent of approval by the FDA of vaccines or monoclonals which is likely again to result in a longer trajectory to get them from the research. Now they are in humans, some of these toys, into the clinic, but I predict this is going to be longer-lasting, but there's also an area where we are investing and that is the use of devices and that enables us to translate problems much faster because the level of safety that the FDA requires is much lower.

So we are investing on multiple roads to get more rapid and then also in the long term things that can be transformative.

Senator SHAHEEN. Well, thank you, very much appreciate your work.

DIABETES

Dr. Tabak, I'd like to switch to another illness. Senator Collins and I have been—we chair the Diabetes Caucus in the Senate and we've been looking at how we can continue to support the research

to address diabetes, and I understand that right now we have beta cell- and stem cell-derived islet replacement therapies that are actually showing promise for cures.

My daughter told me she had been to a conference where she met a man who had benefited from that therapy. He had been diabetes-free for 3 years.

Can you talk about what NIH is doing to support that and any challenges? I understand also that FDA has been an obstacle in getting approvals. Can you speak to that and what we need to see from FDA in order to see this research actually bear fruit?

Dr. TABAK. We don't view them as being an obstacle, but it's certainly——

Senator SHAHEEN. That's my term. You don't——

Dr. TABAK. But certainly, we need to partner with them.

Senator SHAHEEN. Thank you.

Dr. TABAK. The challenges are to protect the newly-transplanted islet cells, regardless of what their origins were, from attack from the human immune system, and so we're using different approaches.

For example, we're encapsulating them as a barrier. We're also trying to genetically engineer the islet cells so that they're not recognized as being foreign. These are the types of approaches that will take things to the next level, but as you point out, the findings are very, very promising.

Senator SHAHEEN. So that we could actually see a cure in the foreseeable future for diabetes?

Dr. TABAK. The results are very promising.

Senator SHAHEEN. That's okay. You don't have to repeat that. I can use that. Thank you.

Thank you, Madam Chair.

Senator BALDWIN. Thank you.

Senator Schatz.

Senator SCHATZ. Scientists and their hedging. Thank you very much, all of you, for being here.

Social Media Use

Dr. Gordon, I don't have to tell you that we're facing a youth mental health crisis. The Surgeon General has called out a link between this crisis and social media use and said that 13-year-olds are too young to join social media.

Last week I introduced a bipartisan bill with Senators Cotton and Britt and Murphy to empower parents and protect kids on social media.

NIH has recognized these risks, too, and you are requesting an additional $20 million to continue to study the impact of social media on children.

Dr. Gordon, I know that correlation and causation are not the same thing, but does a spike in mental health challenges in kids correspond with increased social media use?

Dr. GORDON. First, there has been a spike. I actually wouldn't call it a spike. I would call it a mountain with a slope that really started 5 years ago or more increased rates of suicide deaths in children, increases rates of depression and anxiety.

So it's there, no question, and certainly the COVID pandemic has played a role, and there is evidence to suggest that social media

can be a harm for children's mental health. There's been a number of studies funded by NIH, including NIDA, NIMH, and the Eunice Kennedy Shriver National Institute of Child Health and Human Development, which have shown some of these negative impacts. Adolescents, for example, who discussed self-injurious behaviors through social media were more likely to have a suicide attempt, adolescents who place higher levels of importance on social media use and self-image report higher levels of depression symptoms. The list of findings goes on and on.

It is important to recognize, though, that social media can also be leveraged for positive impacts on mental health. For example, customized moderated social media platforms have been used to effectively deliver a wide variety of social supports and mental health treatments.

Senator SCHATZ. Because my time is limited, first of all, I agree with everything you said and thank you for that.

I'm going to reduce one question for the record, which is how you're going to use the $20 million in the President's budget.

But I'd just point out that, yes, there are plenty of beneficial uses of social media, especially for kids who are feeling alienated, but there are, in my view, no beneficial uses of the predictive algorithm that boosts content into people's brains, especially children's forming brains, and let's just take one moment to understand the business model.

The business model is engagement equals revenue and the algorithm has discovered that the way to get engagement is to upset kids.

So publicly-traded companies have a fiduciary obligation to run an algorithm that is systematically upsetting generations of children and so we shouldn't wonder why this is happening. This is happening. It is true that kids can find affinity groups and learn things and, you know, my kids certainly learn to do arts and crafts and fix bikes and there's all kinds of cool stuff on social media but none of that is coming from the predictive algorithm. All of that is coming from the search function. So I just wanted to make that kind of technical point.

Dr. Tabak, one of your priorities is to reduce health disparities and to build a diverse workforce. I was disappointed to see that the budget request makes no mention of the Native Hawaiian community, even as Native Hawaiians face 14 fewer years of healthy life than other groups.

What can NIH do to increase the representation of Native Hawaiians as investigators in community-based research?

Dr. TABAK. Well, one of the approaches, of course, is to launch studies that seek to understand the nature of these disparities in the health communities.

We recently announced a funding opportunity announcement for Native Hawaiians, Pacific Islanders, that collaboration, to support a population-based study to look at the key health gaps and we're committing about $44 million over the next several years.

Getting studies of this type into the communities often will attract people from those communities to participate and that's sort of an on-ramp, if you will, into health-based careers. So that's one approach.

Senator SCHATZ. Thank you. Thank you.

PSYCHEDELIC THERAPY

Dr. Volkow, 60 years ago the United States was producing research on psychedelics as therapy for addiction, chronic pain, and mental illness. This, as you know, research was cut off as a matter of public policy as part of the War on Drugs, and I know that there has been a pivot to sort of relook at these not to make an assumption that any of these things are medicines.

There's a process for that determination, but I think all of your agencies are now starting to relook at the potential therapeutic benefits of some of these pharmaceutical substances that have now been made contraband and used almost exclusively, you know, as very illegal recreational drugs.

Can you provide us an update on where we are on psychedelics research?

Dr. VOLKOW. Yes, thanks very much for this question on psychedelic research effectivity halted for many years, and as the evidence is starting to emerge that shows significant potential in terms of therapeutics for certain conditions, like severe depression or post-traumatic stress disorder and also preliminary research showing benefits for the treatment of addiction, we're actually engaging the scientific community to try to understand how basically psychedelic drugs can be potentially utilized for the treatment, how they affect the brain, and also how to deploy them in ways that are going to be safe and very effective.

So this is an area of great interest. Both NIMH and NIDA are partnering and trying to expand and accelerate.

Senator SCHATZ. Thank you.

Senator BALDWIN. Senator Boozman.

Senator BOOZMAN. Thank you, Madam Chair and Senator Capito, for this really important hearing, and thank all of you all for being here and just the great work that you do and the remarkable careers that you've had through the years.

NCI DESIGNATED CANCER CENTER

Dr. Lowy, the University of Arkansas for Medical Sciences, UMS, in Little Rock has been doing incredible work expanding its Cancer Institute and working towards applying for NCI designation.

As you know, there are 71 NCI-designated cancer centers in 36 States across the country with the closest to Arkansas being in Memphis, pediatrics only, Dallas, and Oklahoma City.

NCI-designated centers receive the large majority of the available NCI funding for research in clinical trials, giving them a unique advantage over non-designated centers. It's critical for all areas of the country to have access to quality cancer research and clinical trials.

What are the NCI's plans for supporting NCI-designated cancer centers in areas in the country where there are none, such as Arkansas?

Dr. LOWY. Senator Boozman, thank you very much for this question.

As you point out, there are 14 States that do not yet have NCI-designated cancer centers. To some degree, this is compensated for

by some of the NCI-designated cancer centers having outreach beyond their States. For example, the University of Utah and Wyoming just as an example, but Arkansas is one area where it would be wonderful if the University of Arkansas Cancer Center were able to meet the requirements that NCI has for NCI designation and our Office of Cancer Centers has interacted with the Cancer Center as recently as a couple of months ago to—we would really welcome the possibility of the Arkansas Cancer Center coming in for this important area.

While waiting for that, it's important to recognize that NCI supports other parts of the cancer research enterprise, such as the Community Oncology Research Program, which has more than 2,000 areas or places where people can enter clinical trials, including in Arkansas.

Thank you.

Senator BOOZMAN. We appreciate that and we do appreciate your help and you all have been really good in helping in getting us where we need to go.

CLINICAL TRIALS ENROLLMENT

One of the problems that we've got is with the finding enrollment for clinical trials. Arkansas, 41 percent of the population is rural and so that makes it just that much more difficult.

The budget request includes a $500 million increase for the Cancer Moonshot with one of the goals of the funding being to boost recruitment in clinical trials that NCI sponsors and/or supports.

What can we do to do a better job of accessing cancer trials in Rural America? How can we help you?

Dr. LOWY. Senator Boozman, this is a very important issue because there are so many parts of the United States, not just Arkansas, where rural populations are even at higher risk of developing cancer and unfortunately over the last 20 years, although mortality rates for cancer has gone down for people in rural areas as well as in urban, the rate of decrease now is slower for people in rural areas compared with urban.

NCI has had a number of meetings. In the very near future we are going to be providing research awards for areas of chronic poverty which are one of the potentially rural areas which have particular high incidence of mortality from cancer.

One of the good news, one of the few areas of good news for the pandemic has been the expansion of telemedicine and also the streamlining of clinical trials to make it easier for people in rural areas to enter and participate in those trials.

Thank you, sir.

Senator BOOZMAN. Well, thank you, and we do appreciate those efforts, and anything we can do to help you, we would be pleased to do. So we look forward to visiting with you.

Thank you all again very much. Thank you, Madam Chair.

Senator BALDWIN. Thank you.

Senator Kennedy.

Senator KENNEDY. Thank you, Madam Chair.

Dr. Tabak, nice seeing you.

Dr. TABAK. That's fine. Thank you, sir. Tabak.

Senator KENNEDY. By the way, I think the NIH is an extraordinary institution. You and your colleagues, your work is breathtaking.

DIVERSITY AND INCLUSION

But I want to ask you about one of your programs, Doctor. In 2020, you created a program called The Faculty Institutional Recruitment for Sustainable Transformation, and basically under the program, you gave 12 institutions $241 million, a lot of jack in anybody's book, and you directed the grant applicants to use the money to demonstrate a strong commitment to promoting diversity and inclusive excellence when you hire people. Okay?

Two of the institutions to which you gave money, one was University of South Carolina to hire faculty members and public health and nursing and the other one was University of New Mexico to hire faculty members in neuro-science and data science, two great institutions.

South Carolina and New Mexico issued rules to administer the money that you gave them and they both said that we are going to punish candidates who apply for jobs with us with this money that you gave them who espouse "race neutrality."

In other words, both of those institutions said we're going to give a very low score for anyone who states, "An intention to ignore the varying backgrounds of their students and treat everyone the same."

So they took your money and they said we're hiring faculty members and any applicant who says we don't believe in racial prejudice. We think everybody ought to be treated the same gets an F.

Did you know that?

Dr. TABAK. I'm not familiar with the specifics like you are mentioning, Senator.

Senator KENNEDY. Would you look into it?

Dr. TABAK. I certainly will. This program is an important effort by NIH to create a more highly diverse workforce.

Senator KENNEDY. I agree with that. It's a good idea. Do you know anybody against diversity?

Dr. TABAK. Well, unfortunately, sir,——

Senator KENNEDY. I don't.

Dr. TABAK [continuing]. I have run across a few over the years, but——

Senator KENNEDY. I'm sure there's some out there, but I think most fair-minded people agree with diversity.

Dr. TABAK [continuing]. Our effort is to create an environment where people from all backgrounds in every different dimension will be safe and welcomed to conduct high-quality biomedical research.

Senator KENNEDY. And I agree with that, but here's what I'm getting at. Do you think it's fair for the University of New Mexico and the University of South Carolina, two extraordinary schools, to say to an applicant who's borrowed hundreds of thousands of dollars to get her Ph.D. and who comes forward and they say how do you feel about race and they say I believe in racial equality, I believe everybody should be treated the same. They get an F. They're

dismissed summarily. Do you think that's fair to do that with your money, with taxpayer money?

Dr. TABAK. Again, sir, I can't speak to the specifics of these institutions. I will look into it.

Senator KENNEDY. Well, would you—if it's true, do you support that?

Dr. TABAK. Again, I'd have to see what exactly it is——

Senator KENNEDY. But if it's true, do you support it?

Dr. TABAK. What we are trying to do, sir, is create inclusive environments because unfortunately far too often certain individuals do not succeed in obtaining faculty level positions at universities.

Senator KENNEDY. But if I hire somebody—suppose—can I as an American legally, constitutionally, morally say I'm only going to hire Asian Americans? Anybody else of any different ethnic background need not apply. Is that moral? Is that constitutional?

Dr. TABAK. Well, God knows I'm not a lawyer, but, sir,——

Senator KENNEDY. Well, but you're a human being.

Dr. TABAK. [continuing.] To get to a faculty level position is a multistep process and very often highly-qualified candidates are never even considered because of where they train, where they're from, or what they look like.

Senator KENNEDY. Yes. But do you think——

Dr. TABAK. And none of that is fair.

Senator KENNEDY. Do you think—I don't think you're answering my question. Do you think it's right for an institution using money that you gave them to say if you believe in racial equality and you say you want to treat everybody the same, say a big old hook comes out around their neck and pulls them off the stage and they say I'm not going to be hired? Do you think that's right?

Dr. TABAK. I just don't—I would need to understand the context, sir, and I really don't know what these institutions are saying to candidates and I will certainly find out.

Senator KENNEDY. Well, I'm going to follow up. I want to know.

Dr. TABAK. Fair enough.

Senator KENNEDY. I mean, that's how they spent taxpayer money that you gave them and I'm going to follow up and I wish you would, too. This disturbs me.

Because I don't think that's lawful.

Dr. TABAK. We will certainly get back to you, sir, with what we find.

Senator BALDWIN. Thank you, Senator Kennedy.

Senator Britt.

Senator BRITT. Thank you, Madam Chairman.

DIGITAL PLATFORMS AND MENTAL HEALTH

I wanted to talk today obviously about the crisis in this Nation with regards to mental health.

Mr. Tabak, when you look at what is happening, it's clear that NIH has also identified this crisis as being one that is plaguing communities across this great Nation.

The White House in 2023, the Mental Health Research Priorities, those even showed they speak to digital platforms in terms of their effectiveness to treat mental and behavioral health outcomes.

However, there are plenty of NIH studies that show how social media and screen time likely have a negative effect on mental health, particularly youth mental health.

Now let me tell you something. As a momma of a 13- and a 14-year-old, this is something that is particularly important to me. I look at how young people are having to grow up right now. I know as someone who went through middle school and high school as a young woman that it's tough. I can't even imagine the additional pressures that they feel given having a screen at their fingertips all of the time.

I think the reports are shocking and I don't think the numbers lie. Last year, one in three high school girls said that they seriously considered suicide and actually one in nine or almost nine percent, one in 10 high school students reported actually attempting suicide in the last 12 months.

Folks, I ran for the Senate as a momma on a mission. I said that my children and other people's children and grandchildren should be able to achieve the American dream. If we do not take a hold of what is happening right now with social media and our youth, it is going to be so far gone we cannot get it back.

My question to you is what is the NIH doing to address the damage of social media and what effect it is having on our children and our children's mental health?

Dr. TABAK. So, Senator, on a personal level, I have a grandson who's the same age as your children. So I completely understand.

Senator BRITT. Thank you.

Dr. TABAK. If I may turn this to Dr. Josh Gordon, who's the Director of NIMH, to answer you specifically.

Senator BRITT. Absolutely. Thank you.

Dr. GORDON. To add to that personal, I have children who are 20 and 25 who grew up with social media. I saw them wrestle with it and the challenges they are in, and I can absolutely from that personal perspective understand the situation.

Senator BRITT. And I think if you look at the correlation, so from 2011 to 2019 the CDC says that depression amongst our children, our high school kids more than doubled. It is no coincidence that that actually coincides with the exact time where we had a rise in social media.

Dr. GORDON. For that matter, not just depression but suicide deaths have been dramatically increasing in children and children who are even younger than used to typically die. So we're seeing dramatic increases in the rates in pre-teens which is incredibly disturbing.

So what are we doing about social media and mental health? We and the National Institute of Child Health and Human Development both have programs in understanding the impacts of social media and, importantly, looking specifically at what aspects of social media use correspond with negative outcomes from the mental health perspective and trying to figure out how we might intervene and especially trying to support families and parents in working with children to figure out how to avoid the negative consequences of social media and how to regulate social media use at the family level.

So we have a range of different programs in this research that we've been supporting with specific dollars appropriated by this subcommittee in the past and we will continue to support that work.

Senator BRITT. I hope that you will all continue to work on this, to pay close attention. Our children are counting on us.

I want to follow up on what Senator Schatz said earlier. We have introduced a piece of legislation along with Senator Cotton and Senator Murphy to help with this. It's bipartisan. It prohibits children from under the age of 13 from using social media, which is consistent with what social media companies say that they already do. It requires a parent or guardian's permission for children ages 13 to 17 to create an account, so very simple, and the last thing is it requires social media companies to verify that quickly but it also does not allow them to utilize algorithms against our children.

So between 13 and 17, when they're on social media, they would not be able to be targeted by algorithms pushing them into what we know to be so many deep dark holes and so I am hopeful that this body will act. I am hopeful that we will come together and actually do something to put parents back in the driver's seat and to protect our children. I will tell you they are counting on us.

Thank you. I yield my time.

Senator BALDWIN. Thank you.

We will begin a second round, hopefully quick and painless.

XYLAZINE

So I wanted to start where I left off with you, Dr. Volkow. In March, the Drug Enforcement Agency announced it had detected a drug called Xylazine in nearly a quarter of all confiscated fentanyl in 48 States.

The combination of these drugs have proven to be very deadly, but the tools that we have to combat fentanyl overdoses, like the test strips we were talking about and Naloxone, may not help us in this situation.

So I wonder if you could talk about the impact that Xylazine has on the medicines that we use for overdose reversal and how NIH research is adapting to new and deadly ingredients that are being added to opioids.

It seems like, you know, every other day we hear about a new challenge with regard to other additives or things that are harmful in different ways.

Can you talk a little bit about Xylazine and how you're adapting your research?

Dr. VOLKOW. It's very important problem that has grown actually very, very fast. I would say in the past 3 or 4 years. So the first thing that we needed to understand is why more and more of the drugs, particularly fentanyl and heroin, were sold mixed with Xylazine, and what appears to be happening is that Xylazine basically expands the duration of the effects of fentanyl or heroin.

So it allows the dealers to actually basically create the product that has the characteristic that may be more reinforcing and therefore greater value.

It's become very challenging because whereas Naloxone serves to reverse an overdose from fentanyl, the response when you combine

these two drugs are not the same. So current research is ongoing to try to determine both in animals and animal models and in humans what should be the optimal target to try to prevent the deaths associated with the combination of fentanyl and Xylazine.

They act by very different mechanisms. Fentanyl inhibits respiration and breathing, so you don't have oxygen in your blood, but Xylazine also by a different mechanism that doesn't engage the same receptors is decreasing oxygenation.

So you have when you combine these two mechanisms that are exacerbating the outcomes which is why in some instances when you use Naloxone, Narcan, to reverse the overdoses, you don't get adequate responses and research is ongoing to develop therapeutics that can actually help in those overdoses.

Senator BALDWIN. Thank you.

NEXT GENERATION RESEARCHERS

Dr. Tabak, I was proud to author the Next Generation Researchers Act with Senator Collins to improve NIH opportunities for new and early stage researchers.

Since this bill was signed into law as part of the 21st Century CURES Act, NIH has increased funding for early stage investigators by 63 percent, and I'm proud of this progress but there's still a long way to go.

The average age of the first-time RO1-funded investigators remains 42 years old. Today, more than twice as many RO1 grants are awarded to investigators over 65 than to those under 36 years old. In the 1990s, those figures were reversed.

So we all know that diversity in the biomedical workforce leads to research innovation, higher quality work, and more participation in clinical trials by people from underrepresented groups. Yet inequities persist, and a study published in February shows that whenever there's an uptick in NIH funding, it creates more inequity.

Women and people of color face increased barriers and an uneven playing field to obtain funding.

So, Dr. Tabak, tell me how NIH is working to support more early stage investigators, including women and those from diverse backgrounds.

Dr. TABAK. Well, thank you for your leadership in this area and certainly we have made some progress, but as you point out, we have a ways to go.

Our target has been a minimum of 1,100 new early stage investigators each year. Last year we were able to fund over 1,600 which is the good news. But you're quite right. Those who already have support have advantage. It's just that simple and so we have set up some additional programs which we hope will level the playing field.

For example, there is the Katz Award where no preliminary data is required for the application. That may seem counterintuitive, but, in fact, what it does is it liberates the applicant from the work of their former mentor, their former Ph.D. advisor or postdoc advisor so that they can come with their best ideas and don't need to have enormous resources to create the preliminary data that's needed to really just support things for a great new idea.

We have the NIH Pathway to Independence Award. It's the Skip the Postdoc Award. You go right from graduate school into a faculty level position. It's not for everybody but there are talented people out there for whom this is just an ideal circumstance.

We are also looking at the NIH Director's New Innovative Award Program where, of course, we are trying to incentivize young people with great ideas to come into our system and this is gradually bringing in people from outside of the traditional biomedical research disciplines.

The good news about this pool of early career investigators is they are enriched for both women and people of color. There are more young people of color. There are more women in this early stage cohort than in the general cohort, and so if we keep pushing to fund more and more of these early career investigators, we are going to see a shift in that right direction that we all hope to achieve.

Senator BALDWIN. Thank you.

Senator Capito.

Senator CAPITO. Thank you.

ARPA–H

I wanted to ask about ARPA–H. In the fiscal year 2023 Omnibus there was $1.5 billion for ARPA–H and moved them under the NIH umbrella and then this new budget is asking for an additional billion dollars.

I'm a supporter of the goals of ARPA–H to be high-risk/high-reward, partnering with the private sector, but I don't really understand why ARPA–H is going up a billion and yet most of the other biomedical research being done at NIH is pretty flat funding.

Dr. Tabak, can you describe how NIH and ARPA–H can complement one another and your perception of this and where is ARPA–H fitting into the overall organization?

Dr. TABAK. So ARPA–H is an independent entity within the NIH superstructure. They have taken advantage of a number of our administrative systems so that they don't have to reduplicate, you know, sort of basic business systems and things of this nature.

The inaugural director, Dr. Wegrzyn, has been putting together her team. They've been onboarding over a hundred folks now. The key to their business model, if you will, is the recruitment of program managers who come with them unique ideas for bold and creative projects that they would like to see supported.

They have been sorting through some 250 candidates thus far. They have hired a few to begin with. They've just recently released a broad agency announcement for research to improve health outcomes across patient populations, communities, diseases, and health conditions.

The ARPA–H leadership has been engaging with the rest of the NIH leadership on a regular basis. We certainly want to avoid duplication——

Senator CAPITO. Right.

Dr. TABAK [continuing]. Or we want to incentivize shared engagement with one entity doing one aspect of a problem and the other entity doing another and so, you know, this is a bold new idea about how to fund biomedical research which we think will

complement what we do at NIH and we're looking forward to continuing to work with Dr. Wegrzyn and her colleagues.

Senator CAPITO. Well, I would hope, you know, the complementary aspect of it certainly and we see all the expertise on the panel and all the folks behind the expertise that we see here seated today certainly makes sense.

So we'll watch that as it fully develops and thank you for that explanation.

Last week the Republicans on Energy and Commerce launched an investigation into the NIH use of public relations communications services worth about a billion dollars since 2018 contracts to 10 public relations companies.

As I was reading this, I was thinking wow, that's a lot of money, a lot of money, and, you know, for 10 companies that's a lot of money, but then when I started thinking about the years and the fact that it had initial funding of $500 million and then was doubled to a billion under COVID, the COVID pandemic, and you and I talked about this on the phone, you know. There's a lot of people who have moved through COVID confused as to the best way to have achieved this, the best way to cope with it, you know. You're seeing all second guesses. Should we have closed the schools, should we not have closed the schools? Is it contagious? Can I get it from touching this? All the different things that we went through during that period.

NIH PUBLIC RELATIONS SPENDING

So I guess I have a two-fold question. First of all, I don't think we got our bang for the buck for NIH spending this much money in public relations because I think the confusion is partially owned by NIH and other health—you know, we could look at who else owns part of this.

We've never really been through this. You know, we don't really know. It was a hundred years ago, the influenza of 1918, you know, might have had some similarities.

But we can't sit here and say this is never going to happen again or could never happen again. So I guess my question is, as you look—first of all, will you keep us here at the Senate, at the subcommittee in the loop as to what that investigation uncovers with the vast amounts of dollars there? So I would like a yes. Thank you.

The other thing I would say is what is NIH doing to do a lookback in this area—I'm not talking about vaccine development or anything like that—of communicating to the American people how you could improve that part of the reaction to COVID and it's going to play into long COVID and everything else as we move forward.

So are you all doing a full analysis of what your reactions were? Are you going to make that public? When can we expect to see that?

Dr. TABAK. So as you well know, our mission is to translate and communicate research findings in a way that's understandable to all of our stakeholders, patients, families, healthcare providers, and again it's all done with the goal of improving health and so we are taking a look back to see how——

Senator CAPITO. In a formal way are you making——

Dr. TABAK. Well, I think it will become more formal, but initially we're sort of doing a landscape because—and again not to make excuses because we have to own, how it came out, okay, and I accept that.

But, of course, we were dealing with something that was ever-evolving and as you know, as you learn more and more, your message can be more and more precise and so we are looking back to try and figure out how things might have been done better with an eye towards what happens the next time because you're right, there will be a next time about something.

Senator CAPITO. There will be, and like if we look at like Dr. Volkow's area of expertise, it was thought initially, oh, well, if people can do telemedicine in this area with their—and then you saw the numbers go up. So maybe that wasn't true, you know. So it had a whole different dynamic.

If you look at mental health, huge issues there, and so I think we've got to do a really deep down analysis, but I think where we really need to—and you all are doctors and thank goodness you are, but sometimes we need to communicate in plain language what is actually going on and what you need to do and you can play a big role here with all the research.

Thank you all very much.

Dr. TABAK. Be happy to do that, yes.

Senator CAPITO. Thank you.

Dr. TABAK. Thank you.

Senator BALDWIN. So this will end our hearing today. I want to thank all of our committee members who attended for their thoughtful questions and thank you to all of you, Dr. Tabak, Dr. Gordon, Dr. Lowy, Dr. Hodes, and Dr. Volkow all for being here and sharing your expertise with us today.

ADDITIONAL COMMITTEE QUESTIONS

For any Senators who wish to ask additional questions, questions for the record will be due on May 12 by 5 p.m., and the hearing record will also remain open until then for members who wish to submit additional materials for the record.

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

QUESTIONS SUBMITTED TO DR. LAWRENCE TABAK

QUESTIONS SUBMITTED BY SENATOR TAMMY BALDWIN

Dr. Lawrence Tabak, Acting Director, National Institutes of Health (NIH)

Question. Swine are an optimal model species for investigation of a large number of human diseases and have made valuable contributions to almost every field of human medicine. Swine share anatomic and physiologic characteristics with humans that make them ideal models for research. In addition the anatomy and physiology make pig organs likely candidates for xenotransplantation. The NIH-funded National Swine Resource and Research Center was established in 2003 to develop the infrastructure to ensure that biomedical investigators across a variety of disciplines have access to critically needed swine models of human health and disease.

Can you provide an explanation of the benefits of designating a second NIH-funded national swine research center? Specifically, please share what the benefits would be of partnering with an academic institution that has existing medical imaging platforms dedicated for swine research use.

Answer. The National Institutes of Health (NIH) has long acknowledged the value of and invested in swine as a model organism for biomedical research. The NIH Office of Research Infrastructure Programs (ORIP) within the Office of the NIH Director (OD), in partnership with the National Institute of Allergy and Infectious Diseases (NIAID) and the National Heart, Lung, and Blood Institute (NHLBI), has supported the National Swine Resource and Research Center (NSRRC) at the University of Missouri since its creation in 2003. The NSRRC serves researchers across the nation by supporting swine-based research across multiple disciplines, providing valuable services to the research community and creating new genetically-engineered swine models in collaboration with investigators. The NSRRC has facilities and laboratories with advanced biosecurity to ensure animals remain pathogen-free from 14 specific pathogens. In addition, the NSRRC serves as a central repository by importing, maintaining, preserving, and distributing swine models and wildtype animals, cells, tissues, and organs to investigators throughout the country while ensuring the highest possible level of animal care and model quality. The NSRRC also serves as a source of information and training related to the use of these animals in biomedical research as models of human health and disease for the broader research community. The NSRRC performs its own cutting-edge research to advance technology in this area. Its inventory of live animals includes more than 20 genetic backgrounds.

The establishment of a second center would require substantial upfront financial and resource investment in equipment, infrastructure, animal care, maintenance, and ongoing research support. The existing NSRRC serves as a valuable resource for researchers, and it is at the forefront of providing swine models to the biomedical research community. The NSRRC's activities have been significantly expanded since its inception, including an $8 million NIH C06 Construction grant in FY 2022 to expand animal housing. This expansion has allowed more efficient use of the existing space and will permit the NSRRC to widen its exploration of applications of new swine models in various research fields and extend its training activity on the use of swine models. The enhanced capacity will also allow the interdisciplinary team of scientists that operate the NSRRC to enhance establishment and characterization, including phenotyping, of existing and newly developed swine models. The NSRRC partnering with an academic institution that possesses the necessary imaging equipment and expertise would be more cost-effective compared to establishing and maintaining imaging capabilities independently. Partnering with an academic institution would also foster interdisciplinary collaboration by bringing together experts from different fields such as imaging, veterinary and comparative medicine, and swine research. We believe that a partnership between an academic institution and the current NSRRC would be of greater benefit with less upfront costs than establishment of a second center.

Question. The Subcommittee's Joint Explanatory Statement (JES) for fiscal year 2023 included explicit recommendations on the implementation of funding for the Clinical and Translational Science Awards (CTSA) program. The JES expressed concerns about disaggregation of the CTSA Hubs and stated the agreement's support for maintaining the size, scope, and historic mission of the CTSA program. The agreement also maintained that no funded CTSA Hub should receive less than 95% of the funding it received in previous awards.

How will the National Center for Advancing Translational Sciences (NCATS) implement the explicit instructions in the FY 2023 JES?

Answer. NCATS leadership reached out in writing to House and Senate Appropriations Staff within 30 days of budget enactment, per the report language. Then on Monday, February 6, 2023, NCATS leadership, along with the NIH Budget Officer, met with House and Senate Appropriations Staff to provide an update on the Clinical and Translational Science Awards (CTSA) program as requested. Based on the discussion and outcome of the briefing, NCATS will continue with its existing funding opportunity announcements and will keep Appropriations Staff apprised of funding plans and any updates to the program, as previously requested. NCATS also encouraged the Appropriations Staff to reach out at any time to discuss the program.

Question. Geroscience offers exciting potential to address a wide range of aging-related diseases and conditions—including Alzheimer's, cancer, cardiovascular diseases, osteoporosis, and many others. Several NIH Institutes and Centers (ICs), as well as the Cellular Senescence Network within the Common Fund, recognize the promise of this approach by supporting research in this field. The comprehensive nature of the research, the number of ICs involved, and the possible applications to many diseases and conditions make it especially critical to track how much funding NIH is allocating for geroscience and for which purposes. This is why Congress asked NIH to submit a report on geroscience to the House and Senate Appropria-

tions Committees within 180 days of enactment of the fiscal year 2023 appropriations bill, which will occur next month. Congress also encouraged NIH to consider launching a trans-NIH initiative that would guide and enhance future research on geroscience.

Please provide an update on the report and plans for such an initiative.

Answer. The required report on geroscience activities across NIH is under review and will be transmitted to Congress in the coming weeks. Geroscience research is a priority across NIH, with more than 20 institutes and centers (ICs) actively involved in this area of research. These ICs participate in an NIH-wide Geroscience Interest Group, which meets monthly to discuss updates from researchers in the field, discuss potential research initiatives, plan future geroscience events, and explore gaps and opportunities in the field.[1] In April 2023, the group hosted the fourth Geroscience Summit, which brought together researchers and clinicians interested in geroscience and aging to explore the state of the science, including identification of research gaps and opportunities.[2]

Question. Urinary incontinence associated with lower urinary tract symptoms affects millions of women. Research to date has shown that the efficacy of treatment for the different types of urinary incontinence associated with lower urinary tract symptoms varies widely depending on individual patient characteristics and symptoms, and that a personalized treatment plan for these conditions has been found to be most effective. There are knowledge gaps around the etiology of these symptoms which are impeding the development of effective treatments and successful utilization of precision medicine for patients with lower urinary tract symptoms.

What needs to be done to advance scientific knowledge of the etiology of lower urinary tract symptoms to enable a personalized precision medicine approach for the treatment of these conditions and how will the NIH and NIDDK accomplish this?

Answer. NIH is dedicated to furthering an understanding of the various causes and manifestations of lower urinary tract symptoms (LUTS) with the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) as the lead institute for research in this area. NIDDK funds the Symptoms of Lower Urinary Tract Dysfunction Research Network (LURN), comprised of an interdisciplinary team of researchers, study coordinators, and medical facilities at six United States clinical sites and a data coordinating center. LURN aims to increase understanding of LUTS to inform strategies to better measure and manage the condition and improve patients' lives. Through development and use of detailed questionnaires, LURN aims to measure patient experiences, assess the wide range of symptoms, and characterize different subtypes of men and women with LUTS as a first step to developing precision medicine approaches. Through the NIH-funded Multidisciplinary Approach to the Study of Chronic Pelvic Pain (MAPP) Research Network, NIDDK hopes to provide a better understanding of the underlying causes and distinct symptom profiles of urological chronic pelvic pain syndrome (UCPPS), which is characterized by chronic pain and diverse LUTS in men and women. Understanding that bladder health is an important aspect in the development of LUTS, NIDDK also supports the Prevention of Lower Urinary Tract Symptoms (PLUS) Research Consortium, to develop tools and strategies to measure and promote bladder health in women. This knowledgebase will inform individualized strategies for the prevention of LUTS in women. Additionally, NIDDK supports basic, translational, and clinical research into LUTS through funding of various other programs, centers, and investigator-initiated research projects. For example, the O'Brien Urology Centers are studying the pathophysiology of urologic diseases and conditions, and the Stimulating Urology Interdisciplinary Team Opportunity Research program supports investigator-initiated projects, some of which are studying how neurologic dysfunctions may impact various types of incontinence.

These activities are ongoing, and NIDDK continues to welcome investigator-initiated research in these areas. The knowledge gained from these studies will provide insight that can lead to more precise diagnoses and more effective, personalized treatment of LUTS.

QUESTIONS SUBMITTED BY SENATOR SHELLEY MOORE CAPITO

Dr. Lawrence Tabak, Acting Director, National Institutes of Health (NIH)

Question. Pulmonary fibrosis, or PF, means scarring in the lungs that, over time, can destroy the normal lung and make it hard for oxygen to get into the blood. There are over 250,000 Americans currently living with the illness. PF affects 1 out

[1] www.nia.nih.gov/gsig.
[2] www.nia.nih.gov/2023-fourth-geroscience-summit.

of 200 adults over the age of 70 in the United States. The prevalence of PF is on the rise with more than 50,000 new cases diagnosed annually and around 40,000 people dying each year from PF. There is currently no cure for PF. The average life expectancy for someone diagnosed with idiopathic pulmonary fibrosis, the most common form of PF, is just three to 5 years.

The National Heart, Lung, and Blood Institute (NHLBI) provides funds that are crucial to advancing pulmonary fibrosis research. In November 2022, the NHLBI brought together stakeholders to identify directions for research in PF. This meeting established the need for funding in several areas: improved research models, tools for earlier diagnosis, streamlined clinical trials, and enhanced focus on the genetics of PF, to name just a few.

A report on the outcomes of the Summit is currently being drafted.

I was pleased to learn that the National Heart, Lung, and Blood Institute (NHLBI) cosponsored a "Pulmonary Fibrosis Stakeholder Summit" last November that brought together leading PF researchers and patients to discuss a research blueprint for this devastating disease for the next 5 years. Can you or Dr. Gary Gibbons, Director of the NHLBI, comment on some of the key outcomes of this meeting and what you see as next steps in implementing strategies and approaches that were discussed?

Answer. On November 8 and 9, 2022, NHLBI, in co-sponsorship with the Three Lakes Foundation and Pulmonary Fibrosis Foundation, hosted a workshop entitled "The Pulmonary Fibrosis Stakeholder Summit." This workshop sought to identify scientific gaps and future basic and clinical research directions related to pulmonary fibrosis (PF) by providing a platform for investigators, sponsors, physicians, and patients to share innovative ideas for synergizing research efforts and ultimately improving patient outcomes for PF. Some key research gaps and opportunities that were identified during this workshop include:

—Development of Novel Models and Research Tools to Better Study PF and Uncover New Therapies
  —Development of models that recapitulate the evolution of PF from injury to fibrogenesis to the point where the disease no longer progresses, and to test drug candidates during the established fibrotic phase of disease in these models.
  —Expanding the practice of collecting fresh tissue and live cells at the time of routine clinical procedures and using standardized collection protocols to establish a central repository for research use of biospecimens across the fibrotic lung disease spectrum.
—Identification of Early Disease Risk Factors and Methods to Improve PF Diagnosis
  —Development of integrated molecular-, imaging-, and AI/ML-based diagnostic tools to predict individual risk factors and mechanistic drivers of disease progression from preclinical to advanced disease and convert those to optimal strategies for screening and surveillance of high-risk populations.
  —Increase diverse race and ethnicity representation in studies of genetic risk for PF onset and progression, and use that information to define guidelines for incorporating genetic testing into clinical practice for individuals with or at risk of PF.
—Advance Innovative Approaches to PF Clinical Trial Design
  —Development and validation of additional patient-centered endpoints for use in PF clinical trials to more comprehensively assess the success or failure of novel interventions to modify disease and/or improve patient quality of life.
  — Leverage more innovative statistical analysis approaches and clinical trial designs, including pragmatic, adaptive, umbrella, basket, and platform designs, to optimize participation in and enhance the output of PF clinical trials.

A workshop report is being prepared by the participants for submission to a scientific journal, with the hopes of disseminating this information to the broader community and stimulating new research in these areas to ultimately improve the diagnosis, care, and quality of life for patients living with PF.

Question. NIH recently has faced criticism surrounding research integrity from OIG reports that NIH had lax controls on its grants with EcoHealth and the subawards to eight subrecipients, including the Wuhan Institute of Virology.

The OIG found several deficiencies in the oversight of the awards. Some of these deficiencies include: EcoHealth's inability to obtain scientific documentation from WIV; and EcoHealth's improper use of grant funds, resulting in $89,171 in unallowable costs.

NIH resumed grant funding for EcoHealth despite OIG reported failures by EcoHealth surrounding previous NIH grant funding. Can you explain the decision process in determining resumed grant funding to EcoHealth?

What corrective actions have EcoHealth and NIH taken to date to address deficiencies identified by the OIG?

Answer. NIH takes its stewardship over the Nation's investment in biomedical research very seriously and routinely considers processes and measures for strengthening its oversight of Federal funds. NIH has implemented additional oversight measures regarding grants awarded to EcoHealth Alliance (EHA) to ensure that EHA's documented efforts to strengthen administrative processes meet NIH's requirements. NIH continues to actively monitor EHA's progress and is taking these further actions to ensure NIH meets its collective goal of supporting rigorous science to improve human health.

As background, awards to EHA aimed to advance our understanding of how pathogens can emerge from wildlife and spillover to cause disease in people. This includes research important for understanding how bat coronaviruses evolve naturally in the environment to become transmissible to the human population. This type of research is critical for the U.S. to prepare for how to respond if these pathogens do enter the human population. All awards were reviewed through NIH's two-stage review process and were determined to be scientifically meritorious during external peer review. Prior to funding, all awards were rigorously assessed by NIH to determine if any additional biosafety or biosecurity measures would be necessary.

After a detailed administrative review of EHA's management of these awards, NIH notified EHA of the need to implement a corrective action plan to ensure robust oversight and accountability to NIH. A summary of these communications and actions are as follows:

—On January 6, 2022, NIH provided Congress with a status update regarding an ongoing NIH Office of Extramural Research (OER) administrative review of EHA. At that time, NIH determined that EHA needed to improve specific areas of its administrative policies and practices representing shortcomings identified by the OER administrative review. Therefore, NIH placed immediate specific award conditions (SACs) on EHA's active awards while the grant recipient worked on developing a requested Corrective Action Plan (CAP) to address the identified issues.

—On August 19, 2022, NIH provided Congress with an update on EHA's implementation of the CAP. At that time, NIH determined that EHA had demonstrated it was working toward correction of the administrative and financial problems with a full implementation plan laid out in the CAP.

—NIH also identified one area of non-compliance under the grant R01AI110964 (R01) that could not be remedied with SACs. NIH had requested EHA provide NIH the laboratory notebooks and original electronic files from the research conducted at WIV. Since EHA failed to provide these records and WIV was unable to fulfill its duties for the subaward, NIH notified EHA on August 19, 2022, that it would be terminating the WIV subaward for failure to meet award terms and conditions.

—To maintain a higher level of oversight, NIH imposed additional SACs for all EHA awards for a minimum of 3 years. These SACs included doubling the frequency of the required scientific progress and financial reports EHA is required to submit to NIH. In addition, EHA is required to conduct onsite inspections of all its subawardees every 6 months to confirm that all terms of subaward agreements are being fully and appropriately executed.

NIH acknowledges prior cooperation and substantial improvement in EHA processes and recognizes EHA is still working on implementing corrective actions. However, given the seriousness of these challenges, NIH will provide additional oversight of EHA's management of its grant awards while EHA addresses the material deficiencies related to financial reporting and subrecipient monitoring. Accordingly, in 2023, NIH imposed four additional SACs on NIH awards to EHA. These include requiring EHA to develop or improve written policies to comply with the NIH Grants Policy Statement (GPS) and requiring EHA to receive prior approval of subaward written agreements from NIH to ensure EHA complies with all requirements in the NIH GPS.

In addition, NIH is removing EHA's eligibility for unrestricted advance drawdowns of funds—which means NIH is converting EHA from an advance payment method to a reimbursement method. This will require EHA to submit monthly reimbursement requests with a detailed list of actual expenses incurred and supporting documentation. The reimbursement method will provide NIH with stronger oversight of EHA's accounting and spending practices. Lastly, NIH is requiring EHA to obtain an independent third-party audit to conduct a comprehensive review of

EHA's accounting practices and financial responsibilities under the terms and conditions of the NIH awards.

NIH believes these additional monitoring mechanisms will allow NIH stronger oversight of EHA to ensure that the grant recipient meets the responsibilities required to receive Federal funding.

EcoHealth Alliance is not suspended or debarred at this time. The HHS Assistant Secretary for Financial Resources' office makes discretionary suspension and debarment decisions, not NIH. Any suspensions or proposed debarments are subject to the Office of Management and Budget guidelines to agencies under the Nonprocurement Common Rule in 2 CFR 180 for nonprocurement transactions (as further implemented by HHS at 2 CFR Part 376) or the Federal Acquisition Regulation 48 CFR Subparts 9.406—9.407 for procurement transactions (as further supplemented by HHS at 48 CFR Subpart 309.4).[3]

Question. Prion disease, which is caused by misfolded proteins in the brain is similar in some respects to Alzheimer's and related dementias. Creutzfeldt-Jakob disease (CJD) is a rare, 100% fatal, degenerative brain disease that causes rapidly progressive dementia.

Is NIH doing any specific research on CJD?

Answer. NIH supports dozens of studies on Creutzfeldt-Jakob disease (CJD) and other prion diseases such as transmissible spongiform encephalopathy, which are fatal brain diseases that occur in sporadic, infectious, and inherited forms, and are caused by misfolded cellular prion protein that propagates rapidly throughout the brain leading to widespread neuronal death. NIH-funded scientists are investigating the normal function of cellular prion protein, what triggers them to misfold and aggregate in neurons, how misfolded prion protein spreads throughout the brain, the mechanisms by which misfolded prion protein contributes to cell death, and how inflammation contributes to the disease process. NIH-funded researchers are also conducting preclinical studies in animal models of prion disease to investigate potential treatment strategies that prevent or attenuate prion misfolding, aggregation, and/or propagation; thereby slowing or stopping disease progression.

Question. Are there areas of research in the ADRD space that can help inform treatments or cures for CJD

Answer. Several neurodegenerative disorders, for example Alzheimer's disease, Alzheimer's disease- related dementias (e.g., Frontotemporal dementia, Lewy body dementias), and Parkinson's disease, share a core disease mechanism with CJD. Although the specific proteins vary between diseases, in all cases, proteins misfold and aggregate and spread throughout the brain, thereby initiating a cascade of cellular events that contribute to wide-spread cell death in the brain.

Ongoing research to understand the mechanisms by which proteins misfold, aggregate, and contribute to cell death as well as research to identify therapeutic agents that could prevent or attenuate prion misfolding, aggregation, and/or propagation could advance research on CJD, as well as other neurodegenerative diseases. Similar to understanding and intervening in prion misfolding, researchers are intently studying misfolding of beta-amyloid and tau (two proteins that are the cellular hallmark of Alzheimer's), as well as misfolding of the protein alpha-synuclein in the context of Lewy body dementia and Parkinson's. It is hoped that advances in any one of these specific areas could help inform treatments for CJD, and vice versa. In fact, research on prion disease has already facilitated major advances in other neurodegenerative diseases. Building upon an assay originally developed by the NIH Rocky Mountain Laboratories for prion disease, scientists have developed a test to detect the abnormal form of alpha-synuclein in the fluid that surrounds the brain of people with Parkinson's. The test requires greater validation, but current data suggests it has good accuracy in diagnosing a particular form of Parkinson's, even years before motor symptoms begin. Currently the test requires a spinal tap, but NINDS-supported scientists are working to modify the test so that it can be used with skin or saliva samples. NIH-funded researchers are developing similar tests for beta-amyloid and tau and are using these same technologies to develop a skin test for prion protein in people with sporadic CJD, which could enable early detection and early intervention.

QUESTIONS SUBMITTED BY SENATOR JERRY MORAN

Dr. Lawrence Tabak, Acting Director, National Institutes of Health (NIH)

Question. Dr. Tabak, at the end of 2020, Congress provided $1.15 billion for research on long COVID. Using this funding, NIH started the RECOVER program,

[3] www.ecfr.gov/current/title-2/subtitle-A/chapter-I/part-180.

which over the life of the program has received a lot of criticism. Concerns have been raised about NIH's lack of urgency and whether it is focused too much on open-ended research questions as opposed to testing treatments and moving therapeutics to clinical trials.

How significantly are you working with private industry to research and test treatments?

Answer. NIH is moving with deliberate speed to understand and clinically define this new post-viral condition, elucidate the underlying biologic mechanisms, and launch clinical trials testing treatment strategies. Recognizing the important role that the private sector plays in development and commercial availability of medical treatments, NIH has met with numerous industry representatives, including industry partners participating in the ACTIV public-private partnership, to review the RECOVER clinical trial program and invite interested groups to discuss potential public-private collaborations.

Question. How many contracts or grants do you have with industry on treatments?

Answer. We have executed confidentiality disclosure agreements with approximately twenty companies/industries to explore possible collaborations. In addition, as of May 4, 2023, there were five agreements under development with industry/private sector to support collaborations and provision of candidate interventions such as antiviral, neuro-stimulatory, and immune modulating interventions.

Question. How much funding has been obligated for public-private collaborations on treatments?

Answer. Four of the five RECOVER clinical trials involve public-private collaborations. As of May 4, 2023, NIH anticipates an approximate investment of $95 million for the conduct of these trials (exclusive of infrastructure costs and subject to adjustment in response to clinical protocol requirements). NIH support of exploratory Phase II studies to provide proof-of-concept and assess safety of candidate interventions across a broad range of interventions (e.g., immune modulators, antivirals, and neurostimulants) and patient populations provides the foundation for larger scale private sector studies.

Question. How many clinical trials are funded by NIH that are testing treatments for long COVID?

Answer. There are five clinical domains that make up the RECOVER clinical trials. These are: a) viral persistence and immune dysregulation; b) neurologic/cognitive dysfunction; c) autonomic dysfunction; d) sleep disorders; e) cardiopulmonary/exercise intolerance/fatigue. These domains were informed by data coming out of RECOVER cohort studies, input from clinicians, and questionnaires that identified some the most burdensome symptoms reported by patients.

Although there are five domains, that does not mean that there will only be five interventions tested. Rather, multiple interventions will be assessed in each clinical domain pending the availability of funds. In addition, trials in the five symptom areas will be run in parallel, which means we will not wait for one set to be complete before starting another one.

RECOVER clinical trials will utilize an adaptive platform trial design. This unique design will allow researchers to easily add different therapies to be tested and to stop interventions if these are proven ineffective. The trials are designed so that they will inform one another. This advanced methodology will enable the best treatments to get to patients on a quicker timeline compared to traditional clinical studies.

Question. How many of these trials are phase I, II, and III?

Answer. Currently the clinical trial portfolio comprises five Phase II trials, including exploratory trials as well as trials designed to pave the way to pivotal Phase III studies.

Question. How much funding has been obligated or committed for clinical trials?

Answer. As of May 4, 2023, NIH RECOVER obligated $171.5 million (inclusive of infrastructure) to launch a suite of clinical trials through the Clinical Trials Data Coordinating Center (DCC) at Duke Clinical Research Institute.

QUESTIONS SUBMITTED BY SENATOR CINDY HYDE-SMITH

Dr. Lawrence Tabak, Acting Director, National Institutes of Health (NIH)

Question. As our understanding of Alzheimer's and related dementias expands, we now have a better understanding that many of these neurological diseases have similar underlying mechanisms. For example, there are many similarities between Alzheimer's Disease (AD)/Alzheimer's Disease Related Dementias (AD/ADRD) and prion disease, which is caused by misfolded proteins in the brain. Alzheimer's Dis-

ease has already benefited from prion disease research, specifically research for Creutzfeldt-Jakob disease (CJD) a rare, 100% fatal, degenerative brain disease that causes rapidly progressive dementia. The specialized protein amplification techniques developed to study CJD are now being applied to Alzheimer's and contributing greatly to our understanding of that disease.

Will NIH consider prion disease, specifically CJD, as a research priority within AD/ADRD? If not, please provide a detailed explanation as to why not.

Will NIH intentionally expand the research the agency funds through the National Institute of Aging (NIA) to include prion disease, specifically CJD?

How does NIH consider updates to what the agency considers to be AD/ADRD to reflect the most current state of scientific understanding of these diseases and their underlying mechanisms?

Answer. The National Plan to Address Alzheimer's Disease and Related Dementias defines the specific diseases and conditions that are considered to be Alzheimer's or a related dementia.[4] Under the implementation approach that NIH uses to identify AD/ADRD research projects, any proposals that explore prion disease that also make a strong and clear scientific connection to AD/ADRD (e.g., disease mechanisms, etiology, health outcomes) are able to be considered for AD/ADRD funding. Currently, NIH uses AD/ADRD funds to support several studies that are exploring direct mechanisms of prion-related neurodegeneration. In FY 2023, NINDS released a funding opportunity announcement (FOA) inviting projects on Cellular and Molecular Mechanisms of Prion-Like Aggregate Seeding, Propagation, and Neurotoxicity in AD/ADRD (PAR–23–023).[5]

The National Plan to Address Alzheimer's Disease and Related Dementias (NAPA) defines the specific diseases and conditions that are considered to be Alzheimer's or a related dementia[6] NIH's AD/ADRD portfolio is wholly inclusive of these National Plan-defined conditions. In addition, other scientifically valid and closely related research conditions may also be eligible for AD/ADRD funding. NIA/NIH considers any meritorious grant application that is relevant to Alzheimer's and related dementias for AD/ADRD funding. NIH already uses AD/ADRD funds to support several studies that explore prion diseases, including CJD, in the context of dementia-related research themes.

The National Plan to Address Alzheimer's Disease and Related Dementias defines the specific diseases and conditions that are considered to be Alzheimer's or a related dementia.[1] As stated in the National Plan, "In addition to AD, this National Plan addresses Alzheimer's disease-related dementias (ADRD) consistent with the approach Congress used in NAPA. These ADRDs include frontotemporal dementia (FTD), Lewy body dementias (LBD—which include dementia with Lewy bodies and Parkinson's disease dementia), vascular contributions to cognitive impairment and dementia (VCID), and mixed dementias—especially AD mixed with cerebrovascular disease or Lewy bodies." While NIH's AD/ADRD portfolio is wholly inclusive of these National Plan-defined conditions, this does not exclude other scientifically valid and closely related research conditions from eligibility for AD/ADRD funding. As mentioned above, any proposals that make a strong and clear scientific connection to AD/ADRD (e.g., disease mechanisms, etiology, health outcomes) are able to be considered for AD/ADRD funding. Therefore, AD/ADRD appropriations are being used to support projects that explore AD/ADRD-related mechanisms or themes in conditions beyond those that are formally defined in the National Plan, for example in prion diseases, ALS, post-traumatic brain injury dementia, and Down syndrome.

QUESTIONS SUBMITTED TO DR. DOUGLAS LOWY

QUESTIONS SUBMITTED BY SENATOR TAMMY BALDWIN

Dr. Douglas Lowy, Principal Deputy Director, National Cancer Institute (NCI)

Question. Clinical trials are essential for determining whether new treatments work against cancer. But often there aren't enough staff who are qualified to support and administer these trials. This is especially true for trials that are testing complicated new technologies. In some cases, the staffing shortage is forcing trial sponsors to delay cancer trials or even abandon them. The FY 2024 President's Budget proposes a $500 million increase for NCI to expand and modernize cancer

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[4] aspe.hhs.gov/collaborations-committees-advisory-groups/napa/napa-documents/napa-national-plan.

[5] grants.nih.gov/grants/guide/pa-files/PAR-23-023.html.

[6] aspe.hhs.gov/collaborations-committees-advisory-groups/napa/napa-documents/napa-national-plan.

clinical trials to more quickly produce prevention, detection, and treatment measures. These investments are expected to double the participation of patients in NCI clinical trials, but we can't expand clinical trials without the staff to run them.

What is NCI doing to address staffing shortages for clinical trials?

Answer. The shortage of clinical research staff (e.g., research nurses, research coordinators, and regulatory staff), as well as healthcare workers, has diminished the capacity of the cancer clinical trials workforce. This is a major concern of the National Cancer Institute (NCI), as this deficit could lead to long-term consequences for the speed of NCI's clinical research programs. In November 2021, NCI directed a survey of NCI-Designated Cancer Centers to assess the ongoing impact of the COVID–19 pandemic on the capacity of Cancer Centers to conduct treatment trials. The results indicated that the pandemic has taken a toll on clinical trial resources and put even greater strain on the workforce who support clinical trials, causing many staff to leave their positions in academic or community research settings for higher pay, career advancement, and/or for the ability to work remotely.

NCI is taking steps to improve cancer clinical trials and to create flexibility for clinical trial sites. NCI has determined that it is possible to develop flexible, faster, simpler, less expensive, and higher impact clinical trials by focusing on four key areas: streamlining processes for trial design and execution, focusing on essential endpoints, setting up trials in a way that broadens rather than limits participant access, and increasing efficiency of data collection, which would help to alleviate demands on the clinical trials workforce.

These recommendations came from a report released by the Strategic Planning Working Group of NCI's Clinical Trials and Translational Research Advisory Committee (CTAC).[7] In alignment with these recommendations, in fall 2023, NCI plans to launch elements of a Virtual Clinical Trials Office (VCTO) supporting NCI trials conducted at NCI-Designated Cancer Centers and NCI Community Oncology Research Program (NCORP) sites to alleviate the strain on the cancer clinical trial workforce. VCTO personnel would work remotely to support local research site health professional staff. Initial services under consideration include eligibility screening, study coordination, and promoting enrollment of patients who are medically underserved. VCTOs may also assist with questions about informed consent and the enrollment process; regulatory support; and adverse event reporting. NCI recently solicited feedback from NCI-Designated Cancer Centers and received universally positive feedback from small and large centers and is collecting additional input regarding specific needs and conditions from individual sites. NCI has already supported the hiring of VCTO personnel and aims to identify up to six Cancer Centers and six NCORP sites to begin the pilot program in fall 2023, based on need, activation time, and accrual of underserved populations.

Question. According to the NCI FY 2024 budget justification, NCI has invested nearly $1.4 billion of the $1.8 billion in available Cures Act Cancer Moonshot funding to support over 240 research projects across more than 70 cancer science initiatives.

Given NCI received the largest proposed boost of all NIH ICs—nearly 7 percent—how is NCI prioritizing the proposed increase and what Cancer Moonshot initiatives will continue or end as a result of the drawdown in Cures Act Cancer Moonshot funds?

Answer. While Cures Act Innovation Funds for the Cancer Moonshot conclude in FY 2023, several Cancer Moonshot projects have timelines that extend beyond FY 2023. Flexibility to carry over funds allows NCI to support each project on the appropriate timeline. At the same time, NCI continues to plan for additional research to pursue new Moonshot goals in FY 2024 and beyond, as described in the FY 2024 Congressional Justification, and pending the availability of new appropriations.

Because Congress provided multi-year budget authority for Innovation Funds under the Cures Act, NCI will be able to continue to support certain Moonshot programs beyond the end of FY 2023. This important flexibility enables NCI to conclude certain Moonshot programs that have met initial goals, avoid any abrupt endings to ongoing projects, and maximize the gains these programs have made—including through the development of new programs to build upon progress made to date.

Approximately 90 percent of the funds appropriated for the Cancer Moonshot from FY 2017 through FY 2023 will be obligated by the end of FY 2023 to support continuing Cancer Moonshot programs including the Cancer Immune Monitoring and

[7] www.cancer.gov/about-nci/organization/ccct/ctac.

Analysis Centers-Cancer Immunologic Data Commons (CIMAC–CIDC) Network[8] and the Human Tumor Atlas Network.[9] NCI plans to deploy an additional $220 million after the close of FY 2023 to minimize any disruptions in the progress of Moonshot projects, including the Participant Engagement and Cancer Genome Sequencing (PE–CGS) Network,[10] projects focused on cancer survivorship transitions of care,[11] and research efforts aimed at developing new approaches to identify and care for individuals with inherited cancer syndromes.[12]

Other programs initially supported through the Cancer Moonshot include the Immuno-Oncology Translational Network (IOTN),[13] established to improve immunotherapy outcomes across the spectrum of adult cancers and to prevent cancers before they occur, and a related follow-on project, the Cancer Immunoprevention Network (CIP-Net),[14] which aims for a deeper understanding of immunoprevention and fostering a community of cancer immunoprevention researchers. Additional examples include the Fusion Oncoprotein Childhood Cancer Consortium (FusOnC2),[15] a collaborative group of transdisciplinary researchers focused on the molecular drivers of childhood cancer, and a subsequently-developed network to support projects to better understand fusion-drive cancers, identifying new drug targets and agents to disrupt fusion oncoprotein drivers for high-risk solid tumors and brain cancers. The projects noted above will be transitioned from Moonshot funding to regular funding mechanisms, pending availability of appropriations.

As described in the FY 2024 Congressional Justification, top priorities for NCI and the Cancer Moonshot in reaching the goal of reducing cancer mortality rates by 50 percent over 25 years include a significant modernization and expansion of NCI-supported clinical trials networks to support doubling patient enrollment and democratizing enrollment in clinical trials. Additionally, modernizing clinical trials infrastructure includes building a National Cancer Research Data Ecosystem to collect, integrate, and share data from clinical trials and a broad range of research studies—while protecting patient privacy.

With the proposed FY 2024 Moonshot funding, NCI would continue successful Moonshot programs that support these FY 2024 priorities to accelerate progress, while also funding new initiatives to leverage progress made so far. Examples of continuing Moonshot programs include the Telehealth Research Centers of Excellence,[16] Acquired Resistance to Therapy Network,[17] and Cancer Moonshot Scholars.[18] These programs will make important contributions to expanding the scope of and access to NCI-supported clinical trials, provide new insights to overcome drug resistance, and fortify the cancer research workforce. The proposed Cancer Moonshot increase will provide critical resources to continue these and other programs and make progress toward a doubling of clinical trials enrollment, and toward the Cancer Moonshot mortality reduction goal.

The proposed Cancer Moonshot increase in FY 2024 aims to both support continuation of successful research initiatives launched with Cures Act funds and to launch the new efforts. These new initiatives and necessary expansions will help more people with cancer and at risk of cancer participate in NCI-supported clinical trials and will ensure data generated through these trials and through other NCI-supported research efforts is available to inform future discoveries.

QUESTIONS SUBMITTED BY SENATOR JOE MANCHIN, III

Dr. Douglas Lowy, Principal Deputy Director, National Cancer Institute (NCI)

Question. We know that the most important way to combat cancer is early detection, however in most rural areas its difficult to access healthcare, let alone cancer

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[8] www.cancer.gov/research/key-initiatives/moonshot-cancer-initiative/implementation/adult-immunotherapy-network#cancer-immune-monitoring-and-analysis-centers-cimacs-and-the-cancer-immunologic-data-commons-cidc.

[9] www.cancer.gov/research/key-initiatives/moonshot-cancer-initiative/implementation/human-tumor-atlas.

[10] epi.grants.cancer.gov/events/pe-cgs/.

[11] grants.nih.gov/grants/guide/rfa-files/RFA-CA-19-035.html.

[12] grants.nih.gov/grants/guide/rfa-files/rfa-ca-19-017.html.

[13] www.cancer.gov/research/key-initiatives/moonshot-cancer-initiative/implementation/adult-immunotherapy-network.

[14] prevention.cancer.gov/major-programs/cancer-immunoprevention-network-cip-net.

[15] www.cancer.gov/research/key-initiatives/moonshot-cancer-initiative/implementation/childhood-cancer-research.

[16] healthcaredelivery.cancer.gov/telehealth/trace.html.

[17] www.cancer.gov/about-nci/organization/dcb/research-programs/artnet.

[18] www.cancer.gov/about-nci/organization/crchd/diversity-training/cancer-moonshot-scholars-diversity-program.

screenings. West Virginia has a high cancer rate than the national average, and in particular has high rates of late stage cancer—such as colon cancer and lung cancer.

Dr. Lowy, what can be done to increase cancer screenings in rural America?

Answer. Increasing uptake of cancer screening is an important priority across the National Cancer Institute (NCI). NCI supports several key programs, partnerships, and individual research grants that aim to increase screening access and uptake. The "Accelerating Colorectal Cancer Screening and Follow-up through Implementation Science (ACCSIS)" Program is a Cancer Moonshot Initiative that supports research to improve colorectal cancer screening, follow-up, and referral for care among populations that have low colorectal cancer screening rates. The ACCSIS program focuses on underserved groups, including underserved racial and ethnic minority populations and people living in rural or difficult-to-reach areas. The program includes research centers in Appalachia (Kentucky and Ohio), Arizona, California (San Diego), Illinois (Chicago), New Mexico, North Carolina, Oklahoma, and Oregon.[19]

NCI is also supporting several research efforts to reduce barriers and increase uptake of cervical cancer screening, including in rural areas. Over half of new cervical cancer cases are diagnosed among women who have never been screened or are infrequently screened, reflecting barriers presented by socioeconomic disparities and geographic inaccessibility, among other factors.

NCI's Cervical Cancer 'Last Mile' Initiative is a public-private partnership that will help inform the accuracy and clinical effectiveness of self-sampling-based human papillomavirus (HPV) testing for primary cervical cancer screening. As part of the 'Last Mile' Initiative, NCI is supporting the "Self-sampling for HPV testing to Improve Cervical Cancer Prevention ('SHIP')" trial, which will include participants representing a wide diversity of socioeconomic and racial/ethnic groups and geographic regions, including both urban and rural populations across the U.S.[20] NCI is also supporting the "Multilevel HPV Self-Testing Intervention for the Increase of Cervical Cancer Screening Among Women in Appalachia" clinical trial, which studies how well an HPV self-testing intervention works for increasing cervical cancer screening among women in four Appalachia states (Ohio, Kentucky, West Virginia, and Virginia).[21] NCI and several Federal agencies have partnered to form the Federal Cervical Cancer Collaborative (FCCC), a Cancer Moonshot Initiative focused on reducing the persistent disparities in cervical cancer through more equitable cervical cancer vaccination, screening, and management among geographically isolated and economically and medically vulnerable populations. The FCCC aims to bring cervical cancer prevention and management guidelines into safety-net settings of care more swiftly.[22]

Activities to increase cancer screening in rural regions are also part of NCI-Designated Cancer Centers' Community Outreach and Engagement efforts.[23] For example, the University of Kentucky Markey Comprehensive Cancer Center, in partnership with community-based hospitals, is engaging in statewide collaborative efforts[24] to increase lung cancer screening and survivorship care, which has helped Kentucky achieve the second highest lung cancer screening rate in the country, leading to a 19 percent reduction in the diagnosis of late-stage lung cancers in the state. The Markey Cancer Center also includes a Patient-Oriented and Population Sciences Shared Resource Facility,[25] which supports an initiative to refine and assist with dissemination of materials designed to increase uptake of cervical cancer prevention among high-risk populations in primary care practices in Ohio, Kentucky, Virginia, and West Virginia.

Another NCI-Designated Cancer Center undertaking efforts to improve screening in rural populations is the University of Virginia Cancer Center (UVACC), which serves 87 contiguous counties across northwestern Virginia and West Virginia, where 30 percent of the population is rural.[26] Among the screening programs developed by UVACC are a Mobile Prevention Coach to provide free/reduced-cost mammograms, Pap tests, and HPV self-sampling tests to low-access communities; a Telehealth Lung Cancer screening program to provide radiology consults to rural hospitals, leading to a sustainable pathway to screening; and a CRC navigator program

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[19] healthcaredelivery.cancer.gov/accsis/.
[20] prevention.cancer.gov/major-programs/nci-cervical-cancer-last-mile-initiative.
[21] www.clinicaltrials.gov/ct2/show/NCT04411849.
[22] dceg.cancer.gov/news-events/news/2022/Federal-cervical-cancer-collaborative.
[23] cancercontrol.cancer.gov/research-emphasis/supplement/coe.
[24] ukhealthcare.uky.edu/markey-cancer-center/community/learning-opportunities/lung-screening.
[25] ukhealthcare.uky.edu/markey-cancer-center/research/srf/popsrf.
[26] med.virginia.edu/community-outreach-engagement/discover-the-community-we-serve/.

to enable a pathway to colonoscopy and increase the utilization of stool-based CRC screening.

NCI is also supporting the discovery, testing, and validation of new tests that may detect cancer more accurately and potentially reduce barriers to screening. The NCI Division of Cancer Prevention is in the process of creating a network to carry out widespread evaluation of cancer detection tests across populations. The Cancer Screening Research Network[27] is on track to begin in 2024, with sites representing different regions and populations across the country.

QUESTIONS SUBMITTED TO DR. JOSHUA GORDON

QUESTIONS SUBMITTED BY SENATOR TAMMY BALDWIN

Dr. Joshua Gordon, Director, National Institute of Mental Health (NIMH)

Question. A recent CDC survey found that teenage girls and LGBTQ youth are grappling with a mental health crisis. Suicide is the second leading cause of death in youth and young adults aged 10–24. Data show that almost 45 percent of LGBTQ youth seriously considered suicide in the past year, and that suicide rates for Black youth are on the rise. The FY 2024 President's Budget proposes at $200 million increase for mental health research. This funding would support a Precision Psychiatry Initiative focused on developing biomarkers for major depression and identifying diagnostics to better predict patient prognosis and optimize treatment.

How would identifying new biomarkers for depression deliver better, faster treatments to patients? And how could these investments help reduce suicide?

Answer. Effective treatments for depression exist; however, identifying the best treatment for a specific person experiencing depression remains a significant challenge. Treatments are often selected by trial and error, with providers and patients sometimes waiting months to see if a treatment is effective. As part of the Precision Psychiatry Initiative, the National Institute of Mental Health (NIMH) aims to support research to uncover why people with depression respond differently to different treatments and identify biomarkers—objective, measurable characteristics that indicate health or disease states—to define depression subtypes, which could greatly improve treatment selection. Using biomarkers, mental healthcare providers may be able to predict a patient's response to different treatment options, which will decrease the time-consuming trial and error process and provide people with a working treatment sooner. Since depression is one of the main risk factors for suicide, advancements in biomarker development to optimize depression treatment may help considerably reduce suicide deaths.

QUESTIONS SUBMITTED BY SENATOR JOHN BOOZMAN

Dr. Joshua Gordon, Director, National Institutes of Mental Health (NIMH)

Question. According to the CDC, rates of suicide among farmers are 1.5 times higher than the national average.

Farming communities are essential in Arkansas with almost 50,000 farms across the state.

I appreciate Congress and the Administration's support for expanding access to mental healthcare. However, I fear that farmers are often left out of the conversation.

How does the NIMH intend to tailor its mental health research to ALL Americans, especially the farmers that are core to our nation's agricultural mission?

Answer. The National Institute of Mental Health (NIMH) recognizes that farmers and others who live or work in underserved rural and frontier areas may experience mental health disparities—that is, increased risk for mental illnesses and suicide, as well as limited access to evidence-based mental health treatments and services. NIMH aims to address this serious and growing concern by supporting research to understand how mental health disparities arise and improve the delivery of mental health services and interventions in rural areas and other under-resourced communities. For example, in September 2023, the NIMH Office for Disparities Research and Workforce Diversity will sponsor a webinar titled "Coming Face to Face with Suicide in American Farming," with the goal of identifying knowledge gaps in this area. Also, NIMH recently published a set of priorities for mental health disparities research, which identified reducing suicide and suicidal behavior among rural populations as a top priority area. The NIMH Office of Rural Mental Health Research

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[27] prevention.cancer.gov/major-programs/cancer-screening-research-network-csrn.

collaborates with others in the Department of Health and Human Services to coordinate and support mental health research activities focusing on the unique strengths, challenges, and needs of individuals who live in rural and other underserved areas. Through these efforts, NIMH remains committed to advancing the goal of mental health equity and ensuring that NIMH-supported research benefits all Americans.

QUESTIONS SUBMITTED TO DR. RICHARD HODES

QUESTIONS SUBMITTED BY SENATOR SHELLEY MOORE CAPITO

Dr. Richard Hodes, Director, National Institute on Aging (NIA)

Question. Precision medicine-based approaches are being used in many fields. Some NIH Institutes, such as the National Cancer Institute, have embraced it significantly.

Can you comment on how precision medicine can be advanced for Alzheimer's Disease and other neurodegenerative diseases?

Answer. NIH is working to advance precision medicine for people living with Alzheimer's and other neurodegenerative diseases, including those living with mixed dementia, a condition in which more than one dementia pathology is observed to occur simultaneously in the brain. Essential to precision medicine is a dedication to ensuring research—from basic science through clinical trials—is inclusive so that findings are applicable to all populations, especially those most at risk for dementia. NIH funds several efforts to meet the need for therapeutics informed by precision medicine. As one example, NIH recently launched the second iteration of the Accelerating Medicines Partnership® Program for Alzheimer's Disease (AMP® AD) program in collaboration with the Foundation for the National Institutes of Health. In its first phase, this partnership involving government, industry, and not-for-profit organizations yielded the identification of more than 600 new potential disease mechanisms and risk factors (e.g., genes and proteins). This helps inform the development of a range of precision medicine treatment approaches by providing additional targets for drug discovery. The second phase builds on this success by collecting and analyzing additional data and samples from populations most at risk for Alzheimer's. Researchers in the program are using cutting-edge approaches to bring new medicines and support to patients by enhancing validation of novel, clinically relevant therapeutic targets and biomarkers.

NIH is also funding several projects at institutions around the country to accelerate the development of precision medicine approaches for Alzheimer's and other neurodegenerative diseases, including a recent funding opportunity to build infrastructure for precision medicine research on minority health and disparities in Alzheimer's and related dementias.[28] This effort is complemented by several workshops and research summits focused on identifying key gaps and opportunities for advancing precision medicine for Alzheimer's and related dementias.[29] These efforts are reflected in the broad range of drug candidates being tested in NIA-funded clinical trials. As a result of the substantial research progress achieved over the last several years in understanding how Alzheimer's and related dementias develop and worsen, the drug development pipeline has never been more diverse. Drug candidates now in NIA-funded clinical studies target multiple aspects of the disease process, from inflammation in the brain to disrupted sleep patterns to changes in hormone levels and more.

Question. How we can tap into dramatic advances in genomics in the past few years towards this?

Answer. Several NIH efforts are aimed at harnessing advances in genomics in broader, more diverse populations to enable a precision medicine approach to preventing and treating these diseases. Ten years ago, we knew of only 10 genes associated with Alzheimer's. Thanks to efforts like the NIH-funded Alzheimer's Disease Sequencing Project,[30] we now know of and are researching more than 70 related genetic variants, which offer a broad range of new targets for intervention, such as those involved in inflammation or metabolism or that are associated with growth factors and hormones. The Alzheimer's Disease Sequencing Project continues to identify new genes and gene variants that contribute to increased risk for or protec-

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[28] grants.nih.gov/grants/guide/rfa-files/RFA-AG-23-020.html.

[29] Examples include: 2021 NIH Alzheimer's Research Summit: Path to Precision Medicine for Treatment and Prevention; NIA-AA Symposium: Enabling Precision Medicine for Alzheimer's Disease Through Open Science; Microphysiological Systems to Advance Precision Medicine for AD/ADRD Treatment Virtual Workshop.

[30] www.nia.nih.gov/research/dn/alzheimers-disease-sequencing-project-consortia.

tion against the disease. This project also includes the Diverse Population Initiative—a targeted effort to sequence the entire genome of individuals from diverse communities to help identify shared and novel genetic riskfactors for Alzheimer's and related dementias across populations. Genomics data from this and other efforts are made available, with appropriate privacy and security safeguards, to the research community via a centralized data repository. These important genomics data can help advance precision medicine for dementia and other neurodegenerative diseases.

Question. The Labor-HHS Committee Report in the last two appropriations cycles contained language expressing concern about a correlation found between medications that are commonly prescribed for overactive bladder and the development of cognitive impairment and Alzheimer's Disease and Related Dementia (ADRD). The report language urged NIA to study these medications and other treatments for overactive bladder to determine their safety and efficacy, as well as their potential risks related to ADRD.

Has NIA initiated research on adverse neurocognitive effects of overactive bladder medications?

If research on these medications has not been initiated, what are the NIA's plans for studying the safety of the medications that are being prescribed to millions of Americans for treatment of overactive bladder?

Answer. NIA has supported and continues to support studies on the safety of drugs used to treat overactive bladder, including research investigating the adverse neurocognitive effects of these medications. As one example, NIA is funding research using a novel model to investigate dementia induced by a specific class of medications meant to treat overactive bladder.[31] NIA is also funding research evaluating the cognitive effects of overactive bladder medications in older women with incontinence.[32] Because these drugs may increase the risk of developing dementia, they may be important targets for deprescribing, a process meant to safely reduce or stop medication to minimize or prevent harmful side effects. Along with other research initiatives,

NIA is funding a clinical trial testing whether discontinuing use of anticholinergics, a class of drugs used to treat overactive bladder, improves cognition and lowers the risk of dementia, as well as other research on the impact of deprescribing on dementia risk.[33] NIA also funds the United States Deprescribing Network, an effort to enhance research on possible ways to deprescribe potentially risky medications and improve medication use among older adults. The Deprescribing Network itself provides funding for several pilot and exploratory studies, grant planning activities, and small collaboration grants.

NIH also funds studies of non-drug therapeutic approaches to treat overactive bladder. One NIA-funded research study is assessing brief mindfulness and non-invasive brain stimulation to reduce symptoms of urgency incontinence in women.[34] NIA also recently supported a study testing a novel, non-invasive nerve stimulation device for in-home treatment of overactive bladder.[35]

In addition, NIA has several broad funding opportunities available to fund meritorious applications proposing additional such research. Some of the current projects on dementia and overactive bladder are funded via these opportunities, which include support for:

—basic and clinical research
—small businesses (such as those developing non-drug therapies for overactive bladder)
—training and career development awards for the next generation of clinicians and researchers working in this area

NIA has funded and continues to fund studies on the safety of drugs used to treat overactive bladder, including those described above.

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[31] reporter.nih.gov/search/0lm26jQsukuQXix5r__QvGw/project-details/10258975.
[32] reporter.nih.gov/search/0lm26jQsukuQXix5r__QvGw/project-details/10343015.
[33] reporter.nih.gov/search/Shaj-qYerkm0U6DRn1S6tg/project-details/10129872.
[34] reporter.nih.gov/search/PWzY007ysEW1d1WslGSukQ/project-details/10259722.
[35] reporter.nih.gov/search/rmFNoL91xkamsqkkLW–QEQ/project-details/10219001.

QUESTIONS SUBMITTED TO DR. NORA VOLKOW

QUESTIONS SUBMITTED BY SENATOR JEANNE SHAHEEN

Dr. Nora Volkow, Director, National Institute on Drug Abuse (NIDA)

Question. Xylazine, a sedative only authorized in the US for veterinary use, has been detected in a growing number of overdose deaths and illicit drug combinations. It is commonly encountered in combination with fentanyl but has also been detected in mixtures containing cocaine, heroin and a variety of other drugs. From 2020 to 2021, the Drug Enforcement Agency found a more than 60% increase in xylazine-positive heroin tested at DEA labs in the Northeast, and xylazine-related overdose deaths also doubled in the Northeast over that same time period. As NIDA is aware, common opioid overdose reversal drugs such as naloxone are ineffective against xylazine, as xylazine is not an opioid.

Could NIDA please detail what research the agency is funding to find overdose reversal drugs, similar to naloxone, for xylazine?

Answer. Given the rapid recent spread of xylazine across the United States, NIDA has been quickly growing its research efforts to understand xylazine toxicity and to develop xylazine overdose reversal agents. Xylazine is a sedating agent that targets alpha-2 adrenergic receptors (A2R) in the brain and is approved by the United States Food and Drug Administration (FDA) for use as an animal tranquilizer. While not approved for human use, it is increasingly mixed with illicit opioids in the United States and has become implicated in a growing number of opioid-related overdose deaths. Case studies show that xylazine alone can cause slowed breathing and heart rate, loss of consciousness, and coma. Given that opioid misuse can cause similar symptoms, there is concern that xylazine and opioids may be an especially dangerous combination. While the opioid reversal agent naloxone should always be administered in cases of overdose involving xylazine laced opioids, effects specific to xylazine do not respond to naloxone.

The mechanisms of xylazine overdose in humans, alone or in combination with opioids, are not fully understood. In veterinary practice, xylazine sedation is reversed using A2R antagonists such as yohimbine. These antagonists may hold promise for reversing overdose in people exposed to xylazine; however, some of them lack specificity for A2R and can trigger adverse reactions, including paradoxically deeper sedation, observed in veterinary settings.[36] There is also concern that rapid, simultaneous reversal of xylazine and opioid overdose could trigger severe withdrawal symptoms. NIDA is supporting preclinical studies to characterize these mechanisms and identify safe, effective reversal agents for xylazine overdose. For example, NIDA intramural investigators are testing the effects of xylazine, with and without opioids, in a rodent model that they originally developed to identify stronger opioid overdose reversal agents.[37] Once these investigators establish the baseline effects of xylazine and xylazine-plus-opioids in this model, they will test the potential therapeutic effects of A2R antagonists, with and without naloxone.

To gain further insight into xylazine overdose and approaches to treatment, NIDA-funded investigators have been gathering data from people who have been exposed to xylazine. In a recent study of patients who presented to the emergency department with opioid overdose or toxicity, those who also tested positive for xylazine had lower rates of cardiac arrest and coma than those positive for opioids alone.[38] In addition, the two groups did not differ significantly in their length of stay in the ED, hospital admission, or mortality. Other studies have found that people heavily sedated or unconscious from xylazine are at high risk of being in environments where they are victims of violent assaults; so, xylazine sedation alone, without effects on heart or lung function, can incur serious health and safety risks.[39] Overall, these studies suggest that overdose and other outcomes associated with xylazine toxicity are more complex than anticipated based on xylazine's known pharmacology, and that it will be important to fully understand the full array of these outcomes as we work toward appropriate therapies, including overdose reversal agents. To that end, NIDA is prioritizing new research on the prevalence and outcomes of xylazine use and treatment of xylazine overdose in combination with other drugs.

Question. Could NIDA please detail the timeline the agency expects for those reversal drugs to be available for commercial use?

Answer. Research on potential xylazine overdose reversal agents has begun but is not yet at a stage in which a timeline to market availability can be predicted.

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[36] pubmed.ncbi.nlm.nih.gov/30372437.
[37] pubmed.ncbi.nlm.nih.gov/36828628.
[38] pubmed.ncbi.nlm.nih.gov/37014353.
[39] pubmed.ncbi.nlm.nih.gov/36846574.

As noted above, preclinical studies are underway to address whether A2R antagonists can also reverse xylazine overdose, alone and in combination with opioids. NIDA intramural investigators estimate that these studies will be complete in 6 months. If these studies show promise, there is potential to further accelerate the development of xylazine overdose reversal agents by repurposing the veterinary medicines already available, as opposed to starting over with new drug discovery and synthesis. We expect that forthcoming research will help further accelerate progress in developing treatments for xylazine use and overdose, including xylazine overdose reversal agents.

QUESTIONS SUBMITTED BY SENATOR JOE MANCHIN, III

Dr. Nora Volkow, Director, National Institute on Drug Abuse (NIDA)

Question. Recent estimates show more than 106,000 Americans, and more than 1,500 West Virginians, died from drug-related overdoses in the last year. West Virginia continues to have the highest rate of overdose deaths in the country with 90 deaths per 100,000 people, which is almost triple the national average of 31.5 deaths per 100,000 people. To combat this ongoing epidemic, the Administration released its National Drug Control Strategy. The Strategy highlights the need to expand the science behind recovery and directs the Office of National Drug Control Policy to partner with the National Institute on Drug Abuse, among others, to develop, prioritize and implement a Federal recovery agenda.

What are other ways that we can better expand access to substance use disorder treatment in rural America, particularly in West Virginia, where the overdose rates are the highest in the nation?

Answer. NIDA acknowledges the vital need to ensure rural access to evidence-based interventions and supports substance use research in rural communities. Through the Rural Opioid Initiative, a collaboration with the Appalachian Regional Commission, the Substance Abuse and Mental Health Services Administration, and the Centers for Disease Control and Prevention, NIDA has funded several projects aimed at assisting rural communities with comprehensive approaches to addressing drug use. Ongoing studies address opioid, stimulant, and tobacco use, spanning diverse approaches such as novel peer-delivered and technology-supported interventions, harm reduction approaches, and strategies that address social determinants of health and reduce stigma. The Kentucky Viral Hepatitis Treatment (KeY Treat) Study underway at the University of Kentucky, for example, is working toward reducing the health burden of hepatitis C infection associated with drug use in rural Kentucky.[40]

With funding from the NIH Helping to End Addiction Long-term Initiative® (HEAL), NIDA supports large research programs with rural components, conducted in real-world settings and in collaboration with a diverse range of stakeholders to ensure that the strategies being studied are sustainable and scalable. NIDA's Clinical Trials Network expanded its multi-site network for developing and testing treatment effectiveness with new nodes and protocols to expand the use of medications for opioid use disorder (MOUD) in rural settings and emergency departments, implement evidence-based models to optimize the delivery of MOUD, and prevent opioid use disorder (OUD) or progression to more severe OUD. Specifically, the CTN added the Appalachian Node,[41] representing a collaboration among the University of Pittsburgh, West Virginia University, and Pennsylvania State University. NIDA's HEALing Communities Study® is testing evidence-based strategies to reduce opioid-related overdose deaths, increase MOUD treatment, and reduce risky opioid prescribing in 67 communities within 4 states, including in rural areas highly affected by the overdose crisis. The recently launched Harm Reduction Research Network also aims to test and improve the effectiveness, implementation, and impact of harm reduction strategies in rural areas and other communities. Finally, through the Integrative Management of chronic Pain and OUD for Whole Recovery program (IMPOWR), a NIDA-led study aims to develop effective, equitable, and sustainable interventions for chronic pain and OUD to meet the needs of people in rural and Black communities. Findings from these studies will provide valuable insights into how specific rural communities can increase access to interventions for OUD through tailored approaches that meet individual and community needs.

Question. Far too many West Virginians are familiar with substance use and the impact it can have on loved ones, families and communities. However, the driving force behind the record numbers of overdose deaths we are seeing is illicit fentanyl.

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[40] www.ncbi.nlm.nih.gov/pmc/articles/PMC8258565/.
[41] www.ctn.pitt.edu/.

In the last year illicit fentanyl became the number one cause of death among Americans 18 to 45, surpassing deaths from COVID–19, suicide and car accidents.

We must act now to better understand substance use and ensure that we do not lose future generations to overdose. West Virginia may lead the nation in drug overdoses, but there are some very smart people leading innovative research projects to find treatments for substance use disorder.

Dr. Volkow, you have been to West Virginia, visited the West Virginia University's Rockefeller Neuroscience Institute, and have seen first-hand the work being done to study and find treatments for substance use disorder.

Dr. Volkow, how can NIDA continue to support research institutions that are studying the science of substance use disorder and working on treatments for substance use disorder?

Answer. Through a variety of NIH funding mechanisms, NIDA continues to fund meritorious applications submitted by researchers from diverse institutions to maximize its support of research. Notably, there are multiple NIH funding mechanisms geared toward increasing research infrastructure.

For example, the congressionally mandated Institutional Development Award (IDeA) program builds research capacity at institutions in states with historically low levels of NIH funding.[42] Similarly, Institutional Research Training Grants support institution infrastructure to enable the recruitment and training of graduate students and postdoctoral candidates.[43]

NIDA also uses novel approaches to bring a variety of institutions into the research enterprise. For example, with funding from the NIH HEAL Initiative, NIDA expanded its Clinical Trials Network, adding five new research nodes and supporting the development of new protocols to develop and test substance use interventions. In addition, through NIDA's Racial Equity Initiative, the Institute issued two notices of funding opportunity (NOFO) specific to Minority Serving Institutes (MSIs) which are underrepresented in substance use research, with companion notices for other research institutions. One opportunity focused on novel research to understand how structural racism impacts substance use and another aims to support visionary applications to study the intersection of substance use and racial equity. Applications submitted in response to these NOFOs are being reviewed and will be funded in FY 2023. NIDA is also currently participating in two novel NIH funding opportunities to further promote the diversity, breadth, and geographic locations of research programs.[44,45] Together, these efforts aim to encourage diversity and, in doing so, increase the scientific value and impact of research.

QUESTIONS SUBMITTED BY SENATOR SHELLEY MOORE CAPITO

Dr. Nora Volkow, Director, National Institute on Drug Abuse (NIDA)

Question. Last year, you [Dr. Volkow] wrote about the financial sense in investing in prevention. You said that "You can't put a dollar value on the losses American families have suffered due to the addiction and overdose crisis," but that certain prevention and treatment strategies can save costs for the healthcare system in the long run.

Can you tell us about the cost savings associated with drugs use prevention and addiction treatment?

Answer. Research has demonstrated that substance use prevention and treatment strategies are a good investment and reduce burden across many sectors of society, including healthcare, public safety and the criminal legal system, behavioral health, and education. These strategies are relatively inexpensive compared to the high costs incurred if substance use disorders develop and are left untreated.

NIDA-funded researchers have found that higher-risk adolescent behaviors, including substance use, accounted for more than 10 percent of all hospital charges to healthcare payors in North Carolina, suggesting there is significant potential for cost savings if barriers to preventative and treatment services are addressed.[46] Another analysis from researchers funded by NIDA showed that implementation of a structured prevention approach called Communities That Care had a sustained impact on reducing risky health behaviors and a continued positive cost benefit, with an approximately $602 investment in each child yielding an estimated $7,754 in savings by the time participants were age 23—a $12.88 return for each dollar in-

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[42] www.nigms.nih.gov/Research/DRCB/IDeA/Pages/default.aspx.
[43] researchtraining.nih.gov/programs/training-grants/T32-a.
[44] grants.nih.gov/grants/guide/pa-files/PAR-23-122.html.
[45] grants.nih.gov/grants/guide/pa-files/PAR-23-144.html.
[46] Ridenour et al., 2022 www.ncbi.nlm.nih.gov/pmc/articles/PMC8554188/.

vested. The return was over twice as great when the downstream economic benefits of completing college was included.[47] Other research studies have shown that addiction treatment is associated with a net positive cost savings, with one study showing greater than 7:1 ratio of benefits to costs, estimating substance use treatment costs at $1,583 while being associated with a monetary benefit to society of $11,487.[48] The primary drivers of these benefits are reduced costs associated with the criminal legal system and increased employment earnings.[49]

It should also be noted that NIH, with leadership from NIDA, is supporting two national studies—Healthy Brain and Child Development (HBCD) study and Adolescent Brain Cognitive Development SM Study (ABCD Study®)—that aim to provide research which can inform prevention service delivery. Specifically, HBCD identifies human brain, cognitive, behavioral, social, and emotional development beginning prenatally through childhood (e.g., age 9–10). The study will help predict and prevent some of the known impacts of pre/postnatal exposure to drugs or adverse environments, including risk for future substance misuse, mental disorders, and other behavioral and developmental problems.[50] The ABCD Study will determine how childhood experiences (such as sports, videogames, social media, unhealthy sleep patterns, and smoking) interact with each other to affect brain development, academic, health, and other outcomes. The results of the ABCD Study will provide a broad array of stakeholders including, families, schools, health professionals; and policymakers with information to promote the health, well-being, and success of children, which can lead to cost savings.[51]

Question. From February 2020 to June 2021, substance use caused a 9–26% decline in prime-age labor force participation. This is an issue that affects not only the workforce in my state of West Virginia, but working adults across the country.

Can you tell us about the potential effects that addiction treatment can have on employment and workforce readiness?

Answer. While NIH is not the United States government lead on labor force participation, we work closely with other Departments and Agencies to address health issues affecting the Nation. Work from other government entities has been summarize below.

According to the United States Bureau of Labor Statistics, the labor force participation rates (LFPR) of workers aged 25–54 declined substantially (around 3 percentage points) during the COVID pandemic. Recovery has been slow: As of January 2022, the rate was still about 1 percentage point below pre-pandemic levels, however, according to data for April 2023[52] the LFPR has fully recovered. A May 2022 study from the Federal Reserve Bank of Atlanta[53] had suggested that up to about one quarter of the post pandemic drop could be accounted for by increased problematic substance use in the workforce, highlighting the importance of maximizing access to substance use treatment in the workplace.

The implementation of effective and comprehensive addiction treatments could have transformational effects on workforce readiness, as employment is one of the most widely acknowledged social determinants of health and well-being among the general population. At the same time, it must be acknowledged that the relationship between problematic substance use and employment is complex. For example, that relationship is bidirectional: substance use can impact labor market outcomes and the experience of work can similarly influence substance use patterns.[54] Another important aspect in need of further research is the effects of remote working on mental health symptoms and substance use patterns in members of the workforce with psychiatric vulnerabilities.[55] Finally, research has shown that the type and rate of substance use varies quite dramatically by occupation and industry.[56]

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[47] Kuklinski et al., 2021 pubmed.ncbi.nlm.nih.gov/33837890/.

[48] Ettner et al., 2006 pubmed.ncbi.nlm.nih.gov/16430607/.

[49] Koenig et al., 2005 pubmed.ncbi.nlm.nih.gov/15797638/.

[50] heal.nih.gov/news/stories/healthy-brain-child-development-hbcd-study.

[51] nida.nih.gov/research-topics/adolescent-brain/longitudinal-study-adolescent-brain-cognitive-development-abcd-study.

[52] fred.stlouisfed.org/series/LNS11300060.

[53] www.atlantafed.org/-/media/documents/research/publications/policy-hub/2022/05/09/05—did-substance-abuse-during-pandemic-reduce-labor-force-participation.pdf.

[54] Addiction, employment, and the return to work. pen.library.ubc.ca/media/stream/pdf/52383/1.0347521/5.

[55] Cohen and Bloomberg. Fortune Magazine May 2023 fortune.com/2023/05/13/remote-workers-substance-use-disorders-return-to-office-mandates/.

[56] SAMHSA 2015. www.samhsa.gov/data/sites/default/files/report__1959/ShortReport-1959.html.

QUESTIONS SUBMITTED BY SENATOR JERRY MORAN

Dr. Nora Volkow, Director, National Institute on Drug Abuse (NIDA)

Question. Insomnia impacts approximately 25 million Americans, with one-third to one-half of servicemembers and veterans impacted. Insomnia is a significant societal problem with a considerable disease burden—including comorbidities of PTSD, anxiety, depression, and drug abuse. Currently, one of the most common insomnia prescriptions is benzodiazepines and z drugs (zopiclone/zolpidem)—that are recommended for short-term use, but are commonly used long-term, resulting in daytime impairments and lead to abuse. Treatment options exist that address chronic insomnia without dependence issues and decrease the likelihood of drug abuse—DORA class. Dual Orexin Receptor Antagonists (DORAs) work by blocking signals in the brain that stimulate wakefulness. DORAs have an excellent safety profile that does not suggest habit-forming behavior. Various research agencies are currently studying DORAs to help with insomnia-associated conditions (DoD for PTSD, NIH/NIDA for Sleep).

Currently, DORAs are schedule IV on the DEA Controlled Substance Schedule. Idorsia filed a Citizens Petition asking the DEA Administrator to initiate a rulemaking process to remove the DORA class medications from scheduling under the Controlled Substances Act (CSA) based on 8 years of real-world evidence that shows the class has an insignificant abuse profile and potential for abuse. The first step in the process for DEA to consider de-scheduling DORAs is for FDA to review the Citizen Petition and, if they concur with the scientific evidence, to then recommend to DEA that it begin the rule making process to propose de-scheduling the DORA class of treatments (which currently includes three products from three separate manufacturers).

The DORA class of drugs are also already available on the market in Europe without any of the restrictions or potential stigma that exist in the U.S. market.

Dr. Volkow, I know that NIDA has focused on finding non-addictive treatments for insomnia. This is particularly an issue for our servicemembers and veterans, who are significantly impacted by insomnia and may be prescribed drugs that can become addictive. Can you discuss the research NIDA has either already done or has planned in this space, particularly with the DORA class of drugs? Has NIDA identified priorities around finding the best treatments, at the lowest risk, for insomnia?

I also understand that NIDA is interested in research into the DORA class of drugs as a potential treatment for opioid use disorder. What relevant research do you have underway or planned on this topic?

Answer. Dual orexin receptor antagonist (DORA) medications block the activity of both versions of the brain's receptors for the signaling peptide orexin, which helps regulate sleep stages and wakefulness. NIDA research on DORA medications is not specific to veteran populations, though NIDA research does address this priority more broadly in the context of addiction, a field where the identification of pharmacotherapies (e.g., for pain and sleep disorders) with less potential for misuse constitutes a strategic research area. DORAs are a good example in this context as the orexin system plays a prominent role in health (e.g., sleep and appetitive behaviors) and disease (e.g., Parkinson's, depression/anxiety, and addiction). NIDA's significant investments in investigating potential applications for DORAs (in the broad context of addiction) illustrates this interest. Relevant projects in this space include studies to:

—Identify potential mechanisms of sleep disruption induced by methamphetamine use via investigations of the orexin system and the therapeutic potential of DORAs. The results of this project may lead to new and more broadly effective medications that will target both methamphetamine abuse and related insomnia;[57]

—Investigate the clinical potential of a potent and selective orexin 1 receptor (OX1R) antagonist (a medication that blocks the activity of only the orexin 1 receptor) (AZD4041/BPN–19302), which studies in rodents and non-human primates have shown can reduce the addiction-like behaviors that are relevant to those commonly found in opioid use disorder patients;[58]

—Evaluate the potential of the FDA approved orexin antagonist suvorexant to alleviate the adverse effects of opioid and methamphetamine co-use, including the sleep disturbances characteristic of this condition;[59]

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[57] reporter.nih.gov/search/A6Z2dnBww0SwLArh0G3z8A/project-details/10631661.
[58] reporter.nih.gov/search/TqdUrvtOv0GD2jHNie__YgQ/project-details/10469590.
[59] reporter.nih.gov/search/A6Z2dnBww0SwLArh0G3z8A/project-details/10577909.

—Identify new compounds to alleviate opioid withdrawal dependent sleep disruption in an animal model of oxycodone dependence;[60]
—Develop novel OX1R antagonists for the treatment of cocaine use disorder without the sleep-inducing liabilities seen with existing DORAs;[61] and
—Translate positive preclinical findings showing orexin antagonism has substantial promise for treating addiction into the clinical domain by administering suvorexant to people who smoke cigarettes with a tobacco use disorder as a means to facilitate smoking cessation.[62]

In addition, the NIH's National Center on Sleep Disorders Research (NCSDR), located within the National Heart, Lung, and Blood Institute (NHLBI), is currently supporting several clinical studies and clinical trials for the treatment of insomnia. As insomnia is commonly associated with, and exacerbates, other medical and psychiatric disorders, it is of critical importance to find effective therapies for this disorder. Currently, cognitive-behavioral therapy for insomnia (CBT-I) is the recommended first-line treatment for this disorder; however, research supported by NIH has shown that there are different "types" of insomnia. Depending on the type an individual may have, treatment can be personalized.

In summer 2023, NHLBI will launch its largest randomized clinical trial, with sites in the United States and Canada, to test both medication and behavioral interventions in individuals that have the different types of insomnia. NHLBI is also supporting a new hybrid effectiveness-implementation trial to use brief behavioral treatment of insomnia in socioeconomically disadvantaged adults in primary care.[63]

SUBCOMMITTEE RECESS

Senator BALDWIN. The committee will next meet in this room, Dirksen 192, on Thursday, May 11, at 10 a.m., for a hearing on the Biden Administration's Budget Request for the Department of Education.

Until then, this committee stands adjourned.

[Whereupon, at 11:40 a.m., Thursday, May 4, the subcommittee was recessed, to reconvene at 10 a.m., Thursday, May 11.]

[60] reporter.nih.gov/search/TqdUrvtOv0GD2jHNie__YgQ/project-details/10516885.
[61] reporter.nih.gov/search/A6Z2dnBww0SwLArh0G3z8A/project-details/10400321.
[62] reporter.nih.gov/search/A6Z2dnBww0SwLArh0G3z8A/project-details/9979831.
[63] reporter.nih.gov/search/zBDt0NIqqESUbopRoK8FzQ/project-details/10507411.

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

THURSDAY, MAY 11, 2023

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

The subcommittee met at 10:01 a.m. in room SD–192, Dirksen Senate Office Building, Hon. Tammy Baldwin (chairwoman) presiding.

Present: Senators Baldwin, Murray, Reed, Shaheen, Schatz, Capito, Hyde-Smith, Boozman, and Britt.

DEPARTMENT OF EDUCATION

OFFICE OF THE SECRETARY

STATEMENT OF HON. MIGUEL CARDONA, SECRETARY

OPENING STATEMENT OF SENATOR TAMMY BALDWIN

Senator BALDWIN. The Senate Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies, will please come to order.

Good morning. Today we are having a hearing on the Biden administration's fiscal year 2024 budget request for the Department of Education. And I am very happy to welcome Secretary Cardona to the subcommittee.

This hearing is an important opportunity for us to hear about how our non-defense discretionary investments support the learning and development of our Nation's students, and help build a stronger and fairer economy for all.

I am looking forward to working with Ranking Member Capito, in allocating and overseeing these investments in order to make sure they are improving the lives of the constituents we serve.

We won't agree on everything, but I am committed to working together to find common ground, and make progress for Wisconsinites, West Virginians, and communities all across the United States.

BUDGET CUTS

Unfortunately, a measure that was passed by House Republicans 2 weeks ago, would actually slash and cap funding for vital pro-

grams that educate our youth, in exchange for raising the debt limit. This bill passed 2 weeks ago utterly fails. The House Republican Bill would force deep cuts to education and training programs, on average, of at least 22 percent, or $17.5 billion, from the Department of Education.

This would be absolutely devastating for students, educators, and families. You know, this is Teacher Appreciation Week, and what we saw from the House Republicans 2 weeks ago, they proposed funding that would—cuts in funding that would, otherwise, support key education, formula grants like IDEA (Individuals with Disabilities Education Act), and that would mean funding also for an estimated 100,000 fewer teachers and educators. That is no way to show appreciation for their important work. That spending plan would cut funding for TRIO and Pell Grants, and ultimately programs that help students graduate with less debt.

It would mean cuts to Impact Aid for schools serving students from military families, and other federally connected school districts, and programs that support HBCUs (Historically Black Colleges and Universities), and other minority-serving institutions. And the list goes on.

THE PRESIDENT'S BUDGET REQUEST

But I am happy to see that the budget before us today rejects that approach. President Biden's proposal for the Department of Education wisely invests in our future, by increasing support for students from preschool to post-secondary education.

I look forward to the hard work of finding compromise with my colleagues, to mark up our fiscal year 2024 Labor, HHS (Health and Human Services) bill that does the same.

Mr. Secretary, as you know, addressing our Nation's education and workforce needs is critical to maintaining our competitiveness globally. We have near record low unemployment, but also near record job openings, including 174,000 unfilled openings in Wisconsin, which I hear echoed in my conversations with employers in my State.

I am happy to see a $226 million increase in this budget for career and technical education, which helps students obtain the skills needed for in-demand careers. Perkins funding is helping Wisconsin to expand regional career pathways, and improve work-based learning programs.

Mr. Secretary, I look forward to working with you to ensure investments in CTE (Career and Technical Education) support and address the needs of States and local communities. I am also pleased to see that the budget proposes increased investments in key Federal elementary and secondary education programs. This includes an increase of $2.2 billion for the Title IA Grant Program, and $2.1 billion in increases for the IDEA state grants.

These programs help ensure all students, including students from low-income families, and students with disabilities; have access to high quality educational opportunities. These proposed increases would build on increases provided in the bipartisan appropriations bills we passed in fiscal years 2022 and 2023.

MENTAL HEALTH CHALLENGES

As we mark National Adolescent Health Month, we have to acknowledge the significant mental health challenges facing many of our youth. In my home State of Wisconsin, the latest survey data released late last year revealed that more than one-third of high school students experienced symptoms of depression. The highest rate since the survey was first administered nearly 30 years ago. An alarming 18 percent of students surveyed seriously considered attempting suicide in the past 12 months, the highest rate in nearly 20 years, and nearly half of all LGBTQ students surveyed reported they seriously considered or attempted suicide.

We must do more to support all of our students, which I am happy to see this budget does with increased investments in key formula and competitive grants that could increase access to mental health services in schools.

SUPPORT FOR ALL STUDENTS

Finally, if we really want to help all of our students, we also need to start accepting them for who they are, and welcoming and supporting them in our schools. I am greatly concerned by the increasing divide and rhetoric in our schools and communities, from laws targeting transgender students, to taking books off school shelves.

Mr. Secretary, I hope you can help, by effectively supporting States and school districts, in providing all students with the high-quality education and support they need to reach their full potential.

In a moment I will turn it over to Ranking Member Capito for her opening remarks. Following Senator Capito's opening statement, we will hear from you Secretary Cardona; and after that Senators will each have 5 minutes for a round of questions.

And we do expect that people will be in and out this morning. There are multiple competing hearings and markups.

So, Senator Capito.

STATEMENT OF SENATOR SHELLEY MOORE CAPITO

Senator CAPITO. Good morning. And thank you, Senator—Chair Baldwin.

Thank you, Secretary Cardona, for the phone call earlier in the week, but also for appearing before the subcommittee today to discuss your funding priorities for the Department of Education, for the fiscal year 2024.

EDUCATION INVESTMENTS OVER TIME

As we know, education is the key to success, and a vital part of maintaining strong communities, which is why I have long been committed to making sure that all Americans have the opportunity to receive high quality education, preschool through college.

In fact, my professional career began as a college counselor and advisor in West Virginia, where I had the opportunity to work closely with first-generation college students, and see first-hand how education provided them with life-changing opportunities. So, I am excited to take on the new role as the Ranking Member, along

with my friend, Chair Baldwin, in charge of funding, and the oversight of the Department of Education.

PANDEMIC RELATED CHALLENGES

It is not lost on me that the last 3 years have been exceptionally challenging for our Nation's education system. Pandemic-related school closures have disrupted the lives of students and families across America, and set our country back 2 decades both in reading and math achievement, according to the most recent National Assessment of Educational Progress Scores. Just last week the NAEP (National Assessment of Educational Progress) reported that knowledge of civics among the Nation's eighth graders fell for the first time since the Federal Government began testing children under the current framework in 1998, along with a five-point decline in average test scores, in history; is troubling.

And these devastating declines in achievement were in spite of the $190 billion in COVID Relief Funding provided for elementary and secondary education. We can and should do better.

THE PRESIDENT'S BUDGET REQUEST

Unfortunately, this budget is almost a carbon copy of the fiscal year 2023 budget, which was recently rejected, recycling partisan proposals, and unrealistic spending levels. The 2024 budget request for the Department of Education is $90 billion, an increase of more than 13 percent over fiscal year 2023.Expensive new Federal programs like free community college, and universal preschool, both of which my home State of West Virginia are already doing without unwanted Federal intervention, are ill-advised and unlikely to be considered. Meanwhile, commonsense bipartisan programs, like the Rural Education Program, were level-funded in this budget. The state of the Federal Student Loan Program is also a problem, and I am very concerned.

STUDENT LOANS

Your budget request increases, $620 million, for the administration of Student Loan—Student Aid, and the majority of that increase would go towards servicing student loans. Yet, the administration has consistently refused to restart collection of student loan payments, delaying return to repayment six times since President Biden took office.

Furthermore, the administration has undertaken an effort to provide widespread student loan forgiveness with no legal basis for that forgiveness. While I share the administration's desire to modernize and improve student loan servicing, as well successfully move to a new long-term servicing solution, I have no faith in any increase provided for the student-aided administration account would be used solely for that purpose.

PRIORITIZING FORMULA GRANT PROGRAMS

Our Nation is facing fiscal challenges that will not make our jobs easy this year, in order to be successful, we must work together to prioritize funding that best supports opportunity for all students. This means supporting core formula grant programs, like Title I,

as were mentioned by the Chair, and IDEA, that provide the most flexibility to local communities, to best meet the demands or the needs of their students, put education decisions as close to the local schools, teachers, and families as possible. And I am encouraged that the budget prioritizes these crucial programs.

CAREER AND TECHNICAL EDUCATION

This also means ensuring students have access to multiple pathways to a successful career. While traditional higher ED is a goal of many students, many others are interested in alternative pathways, including career and technical education, apprenticeships, and increasingly, short-term certificate and licensing programs.

We should continue to invest in programs like Career and Technical State Grants, and explore how our higher ED programs can better support students seeking meaningful, work-based learning opportunities, including expanding the Pell to short-term programs.

EXAMPLES OF CAREER AND TECHNICAL EDUCATION

In West Virginia, we have seen numerous examples for how we can succeed, and the opportunities it can produce. Marshall University, and Mountwest Community and Technical College, who just had an excellent graduation speaker, that would be me, have joined force to develop workforce training programs to support the State's growing aerospace economy.

Educational programming for aerospace will include both workforce training for maintenance technicians, and a new flight school to help address pilot shortages and introduce that career path to our region. Here, they saw a need, and an opportunity for good careers for their students, and they are making it a reality.

Toyota Motor Manufacturing and Bridge Valley Community College have a similar partnership, where Toyota provides industry expertise on curriculum, and donates equipment to ensure students are learning on the latest cutting-edge technology. Students in the Advanced Manufacturing Technology Program attend school 2 days a week, and work at the plant 3 days a week. Some students have earned more than $40,000 through the program.

I would add that Toyota is also incorporating a program with the high school students as well, and just expanded that into Putnam County.

Mr. Secretary, while there are numerous areas where we would disagree, we also have many shared priorities in the budget request. As we go through the fiscal year 2024 appropriations, I look forward to working with you, to prioritize programs that help provide the opportunity for high quality education for all students; and thank you for being here today.

Secretary CARDONA. Thank you.

Senator BALDWIN. Thank you, Senator Capito.

And our witness today is Dr. Miguel Cardona, the Secretary of the Department of Education. Secretary Cardona, thank you so much for joining us.

You will have 5 minutes for your opening remarks. You may begin.

SUMMARY STATEMENT OF HON. MIGUEL CARDONA

Secretary CARDONA. Thank you very much. Good morning, Chairwoman Baldwin, and Ranking Member Capito, and Distinguished Members of the Committee; and congratulations to both of you on your roles. I am really pleased and happy to be able to be here today to testify on behalf of President Biden's fiscal year 2024 budget request for the Department of Education.

This month and next, students across the country are graduating from college, or from high school, and starting the next phase of their lives.

It is a big moment, a moment that is part of a broader educational journey, from cradle to career, and beyond. At every step of the way the choices we make here in Washington might mean the difference between the status quo, or a brighter future for them, if we act together.

INVESTMENTS OVER TIME

That is why I think of this budget proposal through the lens of a child's journey through education. The scenario, a child starting her educational journey builds a strong foundation for learning right away, because the budget that we are presenting today makes it possible to expand high quality preschool for more 4-year-olds across America.

Now, imagine when this student gets to elementary school, if she is a student with disabilities, she benefits from the additional $2.7 billion in this budget to help include her and support her. She also learns the fundamentals of reading, math, and other rigorous subjects she will need to succeed in life.

Her instruction would be strengthened because of the Title I critical funding that helps enable schools to tailor instruction and use data to provide one-on-one support. Thanks to the additional $2.2 billion, this budget delivers for Title I schools, her school, and the schools in rural, urban, and suburban communities across our country are better prepared to succeed.

Wherever she goes to school, she can always count on having a well-prepared and talented teacher to help her learn and grow, because this budget invests $3 billion to fully prepare develop and retain a strong and diverse educator workforce.

And as you mentioned, it is Teacher Appreciation Week, and in my estimation as an educator—a lifelong educator, this budget reflects an appreciation for the dedicated educators we have in this country.

The student and her family would get wraparound supports because we have more than doubled the funding for full-service community schools. And if she faced some challenges with her mental health, as we know many students do, she can go directly to a mental health professional right at her school because the school benefited from our budget investment of another $0.5 billion to advance the goal of doubling the number of school counselors, school social workers, and mental health providers that are available to our kids, at this time when we are living in a youth mental health crisis.

As the student becomes—gets older, and comes closer to adulthood, she has pathways to careers, and skills to succeed in the world, much like you mentioned, Senator Capito.

We set her up to compete and succeed in a stronger economy, than ever, with well-paying jobs at the ready, because this budget delivers a $200 million investment in redesigning our high schools, to better prepare our young people for careers of today and tomorrow, and $43 million in additional funding, for career and technical education, something that our country needs to do more of.

We set her up to compete in a global economy with Proficiency in multiple languages because we delivered $1.2 billion for Title III, and new investments to expand multilingual teaching, and instruction in world language, investments that are good for all students.

She also has a jump-start on her path toward earning a college degree, or credential, because we work together to make post-secondary education inclusive and affordable. We increased the Pell Grant, we invested in proven strategies that help students like her better afford college, and succeed in earning her degree. We supported our HBCUs, our TCUs (Tribal Colleges and Universities), and MSIs (Minority Serving Institution), and we made universal community college a reality worldwide—nationwide.

This vision of our future isn't reality yet, but these are just a few of the incredible ways, together, we can raise the bar for education, when Congress acts to advance these education priorities in President Biden's fiscal year 2024 budget.

If we can work together, I know we can and we will raise the bar for education in this country. Thank you.

[The statement follows:]

PREPARED STATEMENT OF MIGUEL CARDONA

Chair Baldwin, Ranking Member Capito 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 2 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 2 years of high school and the first 2 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 2 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 2 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.

CUTS FOR EDUCATION PROGRAMS

Senator BALDWIN. Thank you, Secretary Cardona. I have several questions that I want to get to. But first, as I noted in my opening statement, the House Republicans passed a measure 2 weeks ago, that would have devastating impacts on our educational system, from preschool all the way through college.

Secretary CARDONA. Yes.

Senator BALDWIN. Very briefly, is there anything you would like to add about what a $17.5 billion cut might mean for education programs in the schools, and educators, and students, and families that they support, that I didn't mention, or that you want to reemphasize?

Secretary CARDONA. Well, I think it is important to remember, you know, as we recover from the pandemic academically and, you know, we, I think in a very bipartisan fashion, agree that there is a level of urgency that is needed to make sure our students not only recover, but achieve higher levels.

The programs that would be impacted the most are Title I, which is support for our schools where students are struggling in reading, and IDEA, which are for students who need extra support because they are students with disabilities. Two groups that have been most impacted by the pandemic, we are talking thousands of teachers being cut.

The education budgets are human resources, right. When I was a district leader, 80/90 percent of our budget was on educators. So this drastic cut would limit the number of teachers we have available to support students, at a time when our kids need it most, and when we are facing a shortage already.

Senator BALDWIN. Secretary Cardona, you and I visited Northeast Wisconsin Technical College together, a few years ago, and I appreciate your focus on career and technical education in this budget. Studies have shown that students who take CTE courses in high school are more likely to graduate high school, and pursue a post-secondary education, among other benefits of those studies.

At the same time, I want to ensure Perkins funding supports State and local communities, and the innovation that is happening there.

Secretary CARDONA. Right.

REQUEST FOR CAREER CONNECTED HIGH SCHOOLS

Senator BALDWIN. So, can you expand on your request for the Career-Connected High School Program, and how you see that leveraging resources provided through the core Perkins Title I State Grants' Program?

Secretary CARDONA. Sure. I do remember that visit, it was a great visit. One thing that I find as a common theme when I visit, whether it is high schools that have career exploration programs, or universities; the level of student engagement is through the roof. Students want to be there, they are excited. That visit, I remember visiting Florida, maybe a week ago, or 2 weeks ago, in Miami, there was a program where there were like 25 different options for students. And earlier, I don't know if it was this week, or maybe Thursday or Friday of last week, there was a school in Hampton, Virginia, that I visited, where students had pathways to careers.

So, we feel strongly that the additional dollars, $200 million for competitive grants for LEAs (Local Educational Agency), is also intended to, what I call "evolve our high schools". You know, our high schools are designed in many ways, like they were two pandemics ago. We have to do better. I call it evolving them to make sure that they are connected to our 2-year schools, to our pathways into career.

I went to a technical high school, and I studied automotive technology for 4 years, the engagement was really high. And I think we have to really address the stigma in this country that, you know, creating pathways is telling students where they are going to end up. It is providing options.

I had options when I graduated. I went to a 4-year school. So, what we are trying to do is really take what we know is working in our 2-year schools because they are more malleable to the industry needs, and the regional workforce needs, and saying: Why don't we start earlier and start giving our high school students an opportunity to get college credits, so they feel like they belong in college? But also do it in a way that aligns it to some of the regional workforce needs that they might experience in the future.

And I have to say, Senator, I am excited about the potential in this country for the jobs that are going to be coming, the careers that are going to be coming with some of the Invest in America strategies. And it is really important that, it is not only good for students, but it is important for our country that we evolve our high schools.

So, the funding that we are asking for is to really accelerate that, and make sure we are lifting up good models in high schools as well.

Senator BALDWIN. With the Ranking Member's indulgence, I have a follow-on on the same topic. It will be easier——

Senator CAPITO. That is fine. Yes.

Senator BALDWIN. Thank you. States have shown what they can do when they have flexibility with additional resources for career and technical education.

Secretary CARDONA. Yes.

Senator BALDWIN. Including with American Rescue Plan funding, it allows States to expand work-based learning opportunities, including registered apprenticeships.

Secretary CARDONA. Mm-hmm.

Senator BALDWIN. It allows States to expand Regional Career Pathway programs, which is what Wisconsin is doing with its Perkins funding. What are some of the innovative ways that you have seen States, and school districts, and communities, and technical colleges, you know, using their Perkins funding?

Secretary CARDONA. Sure. So what I am seeing happening in our country, and it is a step in the right direction, is we are moving from pockets of excellence that are dependent on people that really get it, or people that maybe had had experience in the industry. And now it is becoming systematized.

So what they are doing, is they are creating industry workforce boards that work with higher education institutions, and K–12 institutions, to come together to say: What does good programming look like? What are the critical skills that we need our students to learn? And there is an engagement at an earlier level, behind the scenes, you know, before the students get to the schools. So I am seeing an investment there.

I am seeing curricular development that is focused on the skills that are needed to have success in the workforce; I visited Columbus State Community College in Ohio, and I was able to have a roundtable, and there was the—I think it was the Vice President

for Intel; the Community College President, the Superintendent of the K–12 System, and they were talking to me about how they meet regularly. How folks from Intel are working with the college and the K–12 system.

So, for me, systematizing the work is the direction that we are going, and I am proud that the dollars would be used for that.

Senator BALDWIN. Thank you. Senator Capito.

Senator CAPITO. Thank you. And thank you, Mr. Secretary.

STUDENT LOAN REPAYMENT PAUSE

Let us let us talk about the student loan pause that we are currently under. It has been more than 3 years since student loan borrowers have been required to repay their loans. At the height of the pandemic, it made sense to give borrowers a limited relief from repaying student loans, and Congress provided that relief through the CARES Act.

However, eight extensions of the payment paused later, and with the official end of the public health emergency today, it is time to transition borrowers back to repayment. Will you commit to restarting repayment no later than September 1st, as you have previously announced that you would, regardless of how the Supreme Court may rule on the loan forgiveness?

Secretary CARDONA. Thank you, Senator. And yes, we are, you know, glad today is the day where it ends, and we recognize that during the pandemic that it was very difficult for borrowers.

Senator CAPITO. Right.

Secretary CARDONA. And we are committed to making sure that once a decision is made, that we are going to resume payments 60 days after, but no later than June 30th we are going to begin that process.

Senator CAPITO. Okay. Are you communicating now, are your services communicating with borrowers about the upcoming return? I mean, this shouldn't be surprising people, because obviously they are going to have to plan.

Secretary CARDONA. Right.

Senator CAPITO. And I don't know what kind—we have heard that servicers are being encouraged to not talk with borrowers. So, what is the status of that?

Secretary CARDONA. Sure. So, we recognize that our borrowers need information, and they need a long on-ramp, because it has been 3 years of resuming payments. We are confident, Senator, that the Supreme Court will rule in favor of the targeted debt relief, providing relief for millions of borrowers, and we want to make sure that the information that borrowers get is accurate.

We do plan on making sure it is a smooth re-entry to repayment, and we are prepared, at FSA (Federal Student Aid), to provide the support that our students need.

Senator CAPITO. So are you communicating with them now, those facts?

Secretary CARDONA. We have communicated with them, and we do have our website. We have sent emails in the past about when the loan pause repayment will start.

Senator CAPITO. So they are aware of the dates and everything.

Secretary CARDONA. They are. Yes.

REQUEST FOR STUDENT AID ADMINISTRATION INCREASE

Senator CAPITO. Okay. Let us talk about the increase in your budget of 31 percent to the Student Aid Administration. I mentioned it in my opening statement, an increase of $620 million. I mentioned in my statement the concerns that I have.

Secretary CARDONA. Okay.

Senator CAPITO. That how this money will be used. I think it was used in the past for some loan forgiveness, but that I don't think is the intent of the Student Aid Administration Funding formula. So, what kind of assurances can you give me that you will stick with the core operations if, in fact, you get a bump in this budget?

Secretary CARDONA. Thank you, Senator. FSA, since day one, has really been focused on making sure we are fixing a broken system. A system that——

Senator CAPITO. Well, let us go back here. The system has been in place for years now, right?

Secretary CARDONA. The higher education access wasn't available for all students. So, what I am suggesting is that the FSA has been working on fixing a system which includes public service loan forgiveness, it includes making sure we are providing Federal loan servicing. So, the work at the budget that we are requesting is critical for those services to be administered.

Senator CAPITO. When you are forgiving a loan, are you using the money out of this account to forgive that loan? I mean, is that how the accounting of that goes?

Secretary CARDONA. No. No, the funding is being used to implement programs, like we are simplifying the FAFSA (Free Application for Federal Student Aid) Program, and we are rolling out FAFSA in a way that is going to get more students——

Senator CAPITO. When is that going to be?

Secretary CARDONA. Excuse me?

Senator CAPITO. When is that going to be?

Secretary CARDONA. Yes, that is going to be this year. And I have to say, Senator, we are expecting upwards of 600,000 more students being able to access higher education. I am really proud of the work that is happening there. FSA has been working really hard on that. We are turning to the payment——

Senator CAPITO. I hope Senator—former Senator Lamar Alexander is listening to this, because he talked about it, as you know, all the time. He is going to be happy to know it is finally going to get rolled out. But go ahead.

Secretary CARDONA. Thank you. When I say we are fixing a broken system, we really want to make sure the higher education is accessible to more students. I was a first-generation college student, and I navigated that process, and it is not the simplest process. I want to make sure students today have the ability to attend college, and that it is, in large, part to the work that FSA is going to be doing.

The funding for FSA is critical, and I worry that if not funded adequately, we are not going to be able to provide the services to our students, which could limit the number of students that access college, and limit the benefits to those who are eligible and deserve benefits, like our veterans.

Senator CAPITO. Okay. Thank you.

Senator BALDWIN. Before I recognize Senator Reed.

I am going to have to run to another committee, and I will return. Ranking Member Capito will continue in my absence.

Senator Reed.

Senator REED. Thank you very much, Madam Chair.

ADDRESSING SCHOOL FACILITY NEEDS

Mr. Secretary, thank you. Good to see you. We have approximately, in the United States, about an 85 billion annual shortfall in school facilities investment that is an estimate of the State of Our Schools Report in 2021. And Congressman Bobby Scott and I have been working, and are prepared to reintroduce legislation that will provide $130 billion in Federal investment in needs.

And one of the things that strikes me is that nowadays to have, first of all, the young people, sort of respect education, and they don't want to be in a, literally a dump, they want to be in something that is Upstate Norton. And also there is a big, big push for technical expertise requiring laboratories, and a whole range of different subjects. And they are not in the 1925 high schools.

Secretary CARDONA. Right.

Senator REED. Which you know about. I know about. So what steps are you taking to assist the steps—the States rather, in addressing these needs, anything?

Secretary CARDONA. Yes. Thank you, Senator. I agree with you. It became most evident the importance that we should be placing on our facilities. During the pandemic I remember visiting some communities that were not able to reopen schools because of the deferred maintenance on their heating, ventilation, and air conditioning systems. Meaning, there was no airflow, and it took the pandemic for them to realize that: we should have kept up. I have walked into buildings where, you know, there is no corporate spaces that would ever function that way, but we can put our students in their classrooms of 90 degrees, or higher, in the summer months.

You know, so there is a lot of work to do there, to modernize some buildings, and make sure that it is conducive to learning. This is about learning, right? We know there is an impact on learning when we think about the environment.

We are working on two grant competitions to address healthier and more equitable schools. And we agree with you that we have to pay close attention to it. I think before the pandemic it was an issue that really never got the attention it needed. Now, folks are looking at it, thanks to the American Rescue Plan, there are dollars that are going to that. But I think we need to continue to make sure our schools are conducive to learning.

ENHANCING LITERACY AND NUMERACY

Senator REED. Thank you very much. Many people suggest that we are in a literacy crisis.

Secretary CARDONA. Mm-hmm.

Senator REED. Not just for young students, but also for adults. And this impacts our productivity, and impacts our—everything we do. As chairman on the Armed Services Committee, we are seeing

more and more young people disqualify from service because they certainly——

Secretary CARDONA. Right.

Senator REED [continuing]. Don't have the skills to pass the basic test. And also, there is just a tax on our libraries. And Congressman Grijalva and I have introduced legislation, the Right to Read Act, which would help provide resources, and training for school libraries. I wonder if you could comment on that.

Secretary CARDONA. Sure. Thank you for that. I agree that despite the importance of ensuring our buildings are reopen, and safe, and conducive to learning, the importance of providing mental health support to our students, we cannot take our eyes off the fact that the United States is ninth in reading amongst other countries; 31st in the world in math.

We have to make sure we are focusing on academics, getting our students to read, perform high levels of math, and increase STEM (Science, Technology, Engineering and Mathematics), especially because of the STEM jobs coming. Clearly, the Civics Data that just came out is appalling, we must do better. And we have a plan for that. We have a plan for that.

Our Raise the Bar Strategy is focusing on literacy, and numeracy, and making sure our students are getting access to quality curriculum. You know, we have a bunch of folks at the Department of Education that have spent their careers as school superintendents, State chiefs, school principals. We have done this work, and we are eager to make sure that we are pushing for higher achievement in reading, in math. And happy to share our plan, it is on our website. We want everyone to take a look at it.

Senator REED. Now, all of these necessary initiatives, rebuilding schools, enhancing literacy, and numeracy, also encouraging more individuals to go into teaching, and then have——

Secretary CARDONA. Right.

EFFECT OF FUNDING CUTS

Senator REED [continuing]. A plan for professional development throughout their careers. How would this all be affected if we imposed, roughly, 20 percent cut on the Department of Education?

Secretary CARDONA. Well, I mentioned earlier that I have serious concerns, as a father, if even the schools in my community, were to receive cuts equivalent to 22 percent of the Federal share, we are talking teachers for students that struggle with reading. We are talking cuts to teachers for students with disabilities, those who I would argue, were most impacted by the pandemic. We are talking about cuts in mental health supports for schools which, as you know, we are in a youth mental health crisis.

So, what I would like to share is, while I am very concerned with those cuts, what I am hearing from parents, what I am hearing from students, and educators, is that the dollars that were provided in the American Rescue Plan were able to help with some of that recovery. Cutting not only— we know that the American Rescue Plan dollars come to an end next year. Cutting funding, ongoing funding for education is taking us backwards. And I think it would have a devastating effect on students.

Senator REED. Thank you very much.

Thank you, Madam Chairman.

Senator CAPITO [presiding]. Chair Murray. Welcome.

Senator MURRAY. Well, thank you very much. And I want to thank Chair Baldwin, and Ranking Member Capito, because really as we continue to push towards regular order for the first time in years, these hearings are really crucial to keeping us on track, and a smooth appropriations process is critical, if we want to make sure that our Nation remains competitive on the world stage.

Secretary CARDONA. Right.

Senator MURRAY. We have a responsibility here to work on a timely bipartisan way to pass these funding bills and make the investments that our Nation needs to avoid falling behind. And that is especially important when it comes to education. As a former preschool teacher, I can tell you we have to get this right, for our kids, for our families, because actually when it comes to competing to other countries, winning the future isn't just about how much we spend on the military, it is also about how we invest in our kids.

Are we making sure kids get a strong start in life so they can grow up and thrive? High quality public schools, enriching afterschool summer programs, the opportunity to pursue higher education goals? Are we giving teachers and educators the support they need to take on one of our Nation's most important jobs? Are we giving parents the support they need to both be involved in their kids' education, and do their jobs and support their families? Are we supporting our students and closing achievement gaps?

We can't afford to shortchange these issues, especially if we want to stay ahead of our competitors, like the Chinese Government. If we want to keep on the cutting edge of discovery, we have to support the next generation of researchers, we have to light that spark of curiosity, and we have to invest in higher education institutions that help it burn bright.

If we want a strong workforce, we have to make sure everyone can pursue a high-quality education and career training opportunities.

So, the bottom line is, if we want our country to grow and thrive, like it has for past generations, we have to invest in the next generation, and that is why this committee and this appropriations is so critical. So, I am committed to making sure we move forward in a strong way.

So, Secretary Cardona, good to see you again here.

Secretary CARDONA. Thank you.

Senator MURRAY. You know, thanks to the American Rescue Plan and the earlier bipartisan COVID Relief Plans, we actually provided States and school districts significant funding to support students' academic and overall well-being.

The American Rescue Plan, specifically, required States and districts to set aside funding to address learning loss, and across the country they have implemented supports I have heard about, like high intensity——

Secretary CARDONA. Right.

Senator MURRAY [continuing]. Tutoring, summer learning programs, things like that. And I really want to build on those Investments and make sure we use evidence-based programs, address

barriers to implementation, and get States the technical assistance they need.

ACADEMIC RECOVERY

So can you talk with us today about how the Department is going to continue to prioritize how disproportionately harmed students, will be helped through this budget, and else wise?

Secretary CARDONA. Sure. Thank you very much, Chair Murray. Agree wholeheartedly that we have an obligation to make sure we are lifting up those practices that are really targeting those students who were impacted the most. The set aside for learning loss I believe was 20 percent. We have seen upwards of 60 percent, because we know that right now academic recovery, and making sure our students are reading on grade level, is a key priority. We can't talk about pathways; we can't talk about higher education access if our children are not reading. And we are really focusing on that.

I have seen, in my visits, and also in working with my team at the Department, we probably had more students in summer school this past year, engaged in summer school programs paid for by these dollars, than ever in our history. Targeted tutoring programs with, as you mentioned evidence-based, right, it is not enough to say we are going to bring a student, have a volunteer come in and just help the student with their homework.

I am talking about high-dosage tutoring on curricular-connected topics where their child is struggling that is informed by the student performance in the classroom. We have seen an increase of those programs, and we are supporting it through technical assistance, through lifting up which districts are doing it well, creating a repository of ideas, and best practices.

We have had five summits on academic recovery through the pandemic at the Department of Education, where we lifted up practices across the country on what is working for students. We are proud to elevate the work of educators across the country in how they are using the American Rescue Plan dollars.

STUDENTS WHO ARE HOMELESS

Senator MURRAY. I appreciate that. And I want to ask you about homelessness.

Secretary CARDONA. Sure.

Senator MURRAY. Because there is a 15 percent increase from the previous year, of young students who are homeless, and I am just really concerned about that learning loss.

Secretary CARDONA. Yes.

Senator MURRAY. How we deal with that. Talk to us a little bit about how you deal with the homelessness issue with our kids.

Secretary CARDONA. Definitely. You know, housing insecurity and homelessness has increased during the pandemic. Many students had to move from one State to another, because of issues with COVID, or a loss in the family. And it was really difficult for many of our students.

Thanks to the American Rescue Plan dollars, $800 million toward homelessness, we have seen those dollars being used to provide wraparound supports, we have seen liaisons out in the community, working with community partners to make sure that the

students have, if it is food insecurity, that that is addressed. If they need a place to stay, that is addressed; tutoring and transportation. So those dollars have been used to provide some of those basic needs that our children need in order to be ready to learn when they get into the building.

Definitely, have seen those dollars being used well, to make sure that our needier students are getting the supports that they need.

Senator MURRAY. Well, thank you very much.

Secretary CARDONA. Thank you.

Senator MURRAY. And thank.

Senator CAPITO. Senator Hyde-Smith.

Senator HYDE-SMITH. Thank you, Chairwoman Baldwin, and Ranking Member Capito, for convening today. And I certainly appreciate the Secretary being here and taking time to speak with us.

WORKFORCE DEVELOPMENT

Mr. Secretary, with workforce shortages felt in just about every sector, workforce development is obviously more important than ever. I just had a lot of the maritime industries in my office this morning, with shipbuilding, well its barge companies, and towing companies, that it is just very critical right now. And they came to D.C. to ask me for help with this.

But it just emphasizes the need to strengthen and increase the number of career and technical education programs across our country, especially in rural areas where I come from, that lack certain trained professionals.

In what ways can the Department and Congress assist in promoting and broadening the reach of career and technical education programs, in both K–12 schools, and community colleges?

Secretary CARDONA. Thank you for that. And I share the interest that you express around making sure we are leveling up our career and technical education programs, making sure that our schools are attuned to the careers that are available to our students, and making sure that, in this case, maritime industry partners are connected with our universities, but also our K–12 systems. To give our students exposure earlier to the careers that exist for them.

RURAL COMMUNITIES

That is even more important in rural communities where, oftentimes, I have spoken to folks from the rural community, kind of felt like they are not being listened to as much. And we are taking that very seriously, through our rural education program, we are asking for $215 million. In Title I there is a share for rural communities.

At the Department, we are proud we have brought on Julia Cunningham, who is now the new Director of Rural Engagement. And we want to make sure that we are targeting our support, technical assistance, and guidance to rural communities, in addition to what we are doing generally, but we are creating a rural community of practice on career pathways and I would welcome an opportunity, I would really welcome an opportunity for my team to engage with some of the folks that visited you this morning to see how we can—what we can hear from them, how we can make sure our services are providing the support that they are looking for, and that our schools need in our rural communities.

Senator HYDE-SMITH. So what are these programs doing? Give me some examples.

Secretary CARDONA. Sure. So what they are doing. And I visited a rural community in Kentucky recently where, I saw the students in the CTE Program there, engaging in jobs that could be done from Kentucky where they don't have to leave Kentucky. So it could be, for example, cybersecurity pathway, where the students are able to work remotely, but work on issues of cybersecurity, or get careers in cybersecurity.

We saw them working in different programs that connect them to jobs in the region as well. And I think we also have to make sure we are taking into account the specific challenges. In rural communities oftentimes broadband is an issue, oftentimes there are no large plants next to them. So we have to think about—creatively about what we are going to do in rural communities to make sure that those students have the same access.

Senator HYDE-SMITH. And how do we incentivize the industry groups to increase their investment in workforce training initiatives to train students for these high-skilled, in-demand technical jobs; because a lot of these jobs are really good jobs, six digit.

Secretary CARDONA. Exactly.

Senator HYDE-SMITH. So how do we get industry to address this?

Secretary CARDONA. We created recently a Rural Strategy and Action Team, whose job it is to do just that. And I would be happy to have more engagement with that team that we just created, with you and your team, to share specifics. But as I said earlier, we are trying to focus on rural needs, and making sure that those students have the same opportunities as other students in the country.

CHARTER SCHOOL PROGRAM

Senator HYDE-SMITH. Well, thank you for that. And I have got one more. The Charter School Program has not received an increase in funding since fiscal year 2019, despite the increase in demand and growing student waiting lists across the country. In addition, Charter schools lack sufficient resources for their facilities. What will your Department do to support Charter schools that have had level funding for 5 years, but would like to welcome more students, because they do have waiting lists, and access the needed resources so they can keep their doors open.

Secretary CARDONA. Thank you, Senator. We do believe that Charter schools do provide an option for families. Public Charter schools are an option for families. We have not reduced funding, we have kept the same level of funding, and we recognize that Charter schools do provide support. We are available for technical support and guidance as well, and we will continue to do that.

Senator HYDE-SMITH. So, you will continue to keep it level with no increases?

Secretary CARDONA. We will continue to support Charter schools, and the budget this year does not ask for an increase. We are focusing our increases on areas where we are noticing students are underperforming woefully, to help level up in those situations.

Senator HYDE-SMITH. Yes, because with inflation, if you hadn't had an increase in 5 years, there are definitely cuts having to be made. Thank you so much.

Senator BALDWIN [presiding]. Senator Shaheen.

Senator SHAHEEN. Thank you, Madam Chair.

And Secretary Cardona, thank you for being here this morning, and for your good work.

Secretary CARDONA. Thank you.

COMPLETING PROJECTS SUPPORTED BY AMERICAN RESCUE PLAN FUNDS

Senator SHAHEEN. I enjoyed the exchange with Senator Murray about the funds that Congress allocated through the CARES Act, and the American Rescue Plan that have gone to schools.

Secretary CARDONA. Mm-hmm.

Senator SHAHEEN. And I know that while we designated, specifically, some of the uses, some schools have been using those funds for needed renovations to make facility upgrades.

Secretary CARDONA. Right.

Senator SHAHEEN. To improve schools' ventilation, that sort of thing. And I am beginning to hear some concern from districts in New Hampshire, who, because of the challenges they have encountered from contractor——

Secretary CARDONA. Right.

Senator SHAHEEN [continuing]. Capacity issues, from supply chain problems; they are concerned about whether they are going to be able to complete their projects by the deadline for obligation of the American Rescue Plan funds.

So can you talk about what the Department is doing to provide clarity to school districts? And to ensure that we have got enough flexibility so that we can complete projects that have been started.

Secretary CARDONA. Right. Yes, we recognize, and we have been engaging with districts, district leaders, State leaders, around this issue of making sure that they are able to get the projects that they need done. We recognize, you know, for a period of time there was a challenge getting materials.

Senator SHAHEEN. Right.

Secretary CARDONA. Or you know some of the supply chain issues were delaying some of the materials from getting into districts. And I appreciate the conversations that I am having with superintendents and chiefs around: Well, we want to make sure we are able to use ARP (American Rescue Plan) dollars to do this. We are continuing to work with them and monitor them. We want to make sure that the projects are completed. And we remain in communication with them to make sure that they can continue using those dollars to those projects that they know are best for students.

Senator SHAHEEN. Has guidance been issued to States and school districts about what is allowable? And if they are going to States, are we sure that that information is getting passed down to the districts?

Secretary CARDONA. Well, yes, the Office of Elementary and Secondary Education is in communication regularly with State chiefs, superintendents, but what we can do is make sure that information continues to go to the representative groups. So, for example,

AASA (American Association of School Administrators) represents the superintendents. The school chiefs, officers' group, we get information to them. We will make sure that the information continues to go out, and we will be happy to take——

Senator SHAHEEN. Do we not have a list at the Department of Education of all of the school districts in the country?

Secretary CARDONA. We do. And we will continue to communicate with that, but as you know, that there is a lot of transiency in superintendency, so we want to make sure that through the State Superintendent's Group, they are the ones that really are having the regular meetings, and communicating with them, although we will use various formats of communication.

Senator SHAHEEN. Well, again, I think whatever clarity can be provided——

Secretary CARDONA. Yes.

Senator SHAHEEN [continuing]. Is really important, because as I said, we are hearing from districts in New Hampshire who are not clear about what they need to do in order to ensure that they can complete their projects.

Secretary CARDONA. Thank you, Senator. And if it is okay, I would like to have my team reach out to you.

Senator SHAHEEN. That would be great.

Secretary CARDONA. To reach out to those specific districts. Thank you.

Senator SHAHEEN. Thank you. I appreciate that.

Secretary CARDONA. Sure.

MENTAL HEALTH AND SUBSTANCE ABUSE

Senator SHAHEEN. On Monday, I was at a school in—a high school in New Hampshire, and I was there to talk to them about the Mental Health, Substance Use, Suicide Prevention Program, that they have in place. And it is a very impressive program, but one of the issues that came up was fentanyl.

Secretary CARDONA. Mm-hmm.

Senator SHAHEEN. And we had a hearing yesterday with the Administrator of the Drug Enforcement Agency. They have a whole campaign trying to make sure people understand how deadly this fentanyl challenge is, and how potentially, harmful it is for anybody who may get access to fentanyl.

And I raised this concern with the school, and I was told that they hadn't really engaged on that issue. When I asked the Administrator whether she was working with the Department of Education to do any kind of campaign around awareness for schools and students, it sounded to me like that is not happening.

And I appreciate, having been a teacher, I understand that we ask a lot of our educators, and I appreciate all that they do, but I also believe that this is a crisis.

Secretary CARDONA. Right.

Senator SHAHEEN. When we have lost over 70,000 people from fentanyl, in 1 year, it is a threat to our students that is every bit as bad as suicide, or any other threat that they are facing.

So, can you talk to me about what you all are doing? We also provided $2 billion for mental health in the Safer Communities Act to the Department. Can you talk about addressing mental health?

Can you talk about how you are utilizing that, and how you incorporate substance misuse as part of that?

Secretary CARDONA. Sure. So, I agree with you that, these issues that come up in our communities also come up in our schools, and we have to make sure that our schools, just like we talk about CTE being connected with the changing workforce needs, we too, have to be responding to what our students are facing, or what they are seeing in the community.

Senator SHAHEEN. Right.

Secretary CARDONA. Through the BSCA (Bipartisan Safer Communities Act), as you mentioned, there are dollars intended to make sure that school safety plans are up to par, and part of that includes professional development. I think there is $500 million in BSCA for professional development and activities intended to make sure that our schools have the professional learning opportunities for teachers, for administrators, and that includes addressing whether it is mental health needs, substance abuse needs, or other issues that our students are facing.

We do recognize that it is a significant issue, and we stand ready to support districts and States; if they are looking for support on this, or some direction, happy to reach out.

Senator SHAHEEN. Well, I would encourage you to also reach out to the DEA (Drug Enforcement Administration), about what they are doing, because I think there are some opportunities there to coordinate in ways that would be impactful.

Secretary CARDONA. Yes.

Senator SHAHEEN. Thank you, Madam Chair.

Senator BALDWIN. Thank you. Senator Boozman.

Senator BOOZMAN. Why don't you jump over to Brian, and let him go ahead.

Senator BALDWIN. All right, Senator Schatz.

Senator BOOZMAN. It looks like he has got some place to be.

Senator SCHATZ. No, only, only if you insist.

Senator BOOZMAN. No. Go ahead.

NATIVE HAWAIIAN EDUCATION

Senator SCHATZ. Thank you very much. I have never seen anything like this.

Good morning, Mr. Secretary. Thank you for being here. I want to start with Native Hawaiian education.

Secretary CARDONA. Mm-hmm.

Senator SCHATZ. Do I have your commitment to continue to support robust funding for the Native Hawaiian Education Program?

Secretary CARDONA. Yes.

Senator SCHATZ. I have heard from providers in the State of Hawaii that there are officials at the Department that suggest that the Federal Trust Responsibility that the Federal Government has to Native Hawaiian communities, does not extend to their work. Do you believe that the entirety of your Department has an obligation to carry out this trust responsibility?

Secretary CARDONA. Absolutely, Senator.

Senator SCHATZ. Do I have your commitment to make sure that all of the good people in your Department administering programs,

pushing out grants, overseeing this program and others, get the message with precision and clarity from you?

Secretary CARDONA. It will be very clear, and our actions have shown that we must support all Native students, and it is not limited to one office, it is our entire Department of Education. Thank you.

Senator SCHATZ. Yes. I think your actions have shown that, but I am just telling you that at the line level — and I understand this, because as the Chairman of Indian Affairs, a lot of times what we do is extend obligations into other departments and into other programs where people have been running the program in a certain way for a long time.

Secretary CARDONA. Yes.

Senator SCHATZ. So, I do think it is really important that you have your people drill down, and just make sure that all the good people doing all the good work, understand that they have an——

Secretary CARDONA. Thank you.

Senator SCHATZ [continuing]. Obligation, under Federal law. To do it this way.

Secretary CARDONA. Yes, definitely, yes.

Senator SCHATZ. Thank you. My office has heard concerns with the—from current prison education providers about difficulties working with the Department on the implementation of Pell eligibility. Can you just tell me how the Department is working with existing education providers on Pell restoration, to make sure that we ensure a smooth transition?

Secretary CARDONA. Well, look, we were looking forward to continuing the support, with regard to Pell for incarcerated students, and expanding that, providing opportunities. We look at this as an opportunity to help those who are really trying to get back on their feet and gain skills to be successful. We look at that as an opportunity for us. And we have expanded programming. As you know, we had the pilot program, we expanded it, and we are looking forward to continuing it, and we welcome opportunities to engage with folks, to make sure that the program works.It is fairly new for many, so there may be a lot of questions, but we want to make sure that we are supporting it, and our team is available and ready to have conversations, or meet with folks if there is work that needs to be done, to make it smoother.

COST OF ARMED GUARDS IN SCHOOLS

Senator SCHATZ. Thank you. You know, over the last couple of days and weeks, some have suggested that armed guards in schools might be a solution to school shootings. I want to set aside the practical question of whether or not an armed guard, or two, at a school would actually prevent anything, and I think there is some, at least anecdotal evidence, that it wouldn't.

But I want to talk, because this is the Appropriations Committee, about cost. Recent estimates put the cost of placing two armed guards in each school between $21 and $36 billion per year. Assuming flat funding how—in other words, assuming you had to absorb that new cost, because I don't think there is going to be a $36 billion annual additional appropriation for this purpose. Tell

me about what kinds of cuts you would have to sustain within the Department?

Secretary CARDONA. Sure. Well, first of all Senator let me just share how, as a former school principal, the safety of our students was my number one priority; and that there were multiple strategies to ensure the safest learning environment possible.

With regard to the question about the $36 billion, that translates into teachers. There is no other way to answer that than to say that it would take from what we are currently trying to do, which is help our students learn how to read, achieve in math, and have college and career pathways, if you are taken from the same pot it is going to result in education staff being reduced.

BOOK BANS

Senator SCHATZ. Thank you. A final question: I know these are local decisions, but you are the Secretary of the Department, federally. Just tell me your thoughts on book bans?

Secretary CARDONA. Yes. It is a local decision, but as a father and as an educator, I am just—it is alarming the degree to which we have State leaders taking books out of the hands of kids, and decimating libraries, and politicizing what should be something that unifies us, making sure that our students are literate, providing them diverse text so they can learn about different cultures. And even explicit bans on history that teaches the experience of Black Americans. That, to me, is extremely alarming.

Senator SCHATZ. I think, one final thought on that, I think all—everything you said about book bans is correct, I also think that the way that some of these specific statutes work is unusual, in that it empowers an individual crank to basically remove something from a library. This isn't the Board of Education deciding what curriculum, or curricula are allowed, what books are in the library.

This is like, basically, a private right of action to come in and say: I don't like that book. I think it is offensive in the following ways. And it presumptively gets removed from the library. I think it is a very, very dangerous thing to do, in the education context. Thank you.

Senator BALDWIN. Senator Boozman.

Senator BOOZMAN. Thank you Madam Chair, and Ranking Member, for this important hearing.

TEACHER SHORTAGES

Thank you, Mr. Secretary, for being here. One of the things that I am very, very concerned about is the widespread shortage of teachers across the country, certainly, they are the underpinning of the United States in so many different ways. According to a recent GAO (Government Accountability Office) Report public education lost about 7 percent of its total teaching population, 233,000 instructors between 2019 and 2021.

Furthermore, in Arkansas, data from the State's Education Department indicates the worst shortages are in our rural districts.

Secretary CARDONA. Right.

Senator BOOZMAN. To address teacher shortages in Arkansas, the Arkansas Teacher Corps recently shifted from recruiting newer col-

lege grads, to helping teachers already working but who aren't licensed. The fiscal year 2024 budget requests $3 billion for educator development, including funding specifically to bolster the teacher workforce.

How exactly is the administration planning on spending this money to address the teacher shortage? And specifically, how will the administration ensure that rural areas are not left behind when addressing these shortages? I think almost all of the teachers that were hired in Arkansas actually didn't have teacher—in the rural areas didn't have teaching certificates.

Secretary CARDONA. Right.

Senator BOOZMAN. I mean this is just a very, very serious problem.

Secretary CARDONA. Yes, it is. Thank you, Senator. I share that concern with you. That is a major focus for us at the Department of Education, especially in areas like rural communities where it is even more difficult. So I appreciate that sentiment. I share with you that we are on it. We recognize that rural communities have a greater need.

We are asking for dollars to make sure that we are lifting the profession, that we are providing dollars for professional development, pathways for teachers, recruitment programs. Our budget, unlike budgets in the past, is really focusing on trying to have recruitment programs.

I will give you an example of one that I think will benefit communities, rural communities. We have apprenticeship programs that we are trying to expand. As you know, student teachers don't get paid during the 4 months of student teaching. It is hard to welcome someone into a profession and ask them to work for free for 4 months, especially if teachers, on average, are making 20 percent less than people with similar degrees.

So, we have to change how we are thinking about it. We went from two apprenticeships—two States with apprenticeships to 16. It is my goal to get to all 50. So, we are looking at Pathway Programs through these dollars to expand on. In rural communities, the Rural Education Program, we are asking for $215 million to be very specific around rural education.

And then again, Title I, and IDEA, we are looking at additional dollars for rural communities to make sure that they can bring teachers into those communities to support the students. We recognize that as an issue, and we look forward to working with you to support rural education.

MENTAL HEALTH NEEDS OF STUDENT ATHLETES

Senator BOOZMAN. Good. Thank you very much, Mr. Secretary. As a former student athlete, I am particularly concerned about recent data related to the mental health challenges faced by student athletes. Over the last few months I have heard from student athletes across sports and institutions highlighting the pressure they feel to perform both in the classroom and on the field.

According to an NCAA (National Collegiate Athletic Association) Student Athlete Well-Being Study released last year, the number of student athletes reporting mental health concerns is roughly twice, two times higher than before the pandemic.

Can you elaborate on, any ideas, if you all are working to address the unique mental health needs of the student athlete population on college campuses? And does the Department have specialized programs to serve the student-athlete population?

Secretary CARDONA. Thank you for that. You know, one thing we know is high school and college can be pretty stressful.

Senator BOOZMAN. Right.

Secretary CARDONA. Period. You throw a pandemic on it, basic needs being—need to be met, and then the demands of athletics which—you know, I have a godson who is graduating in two days, and he was on the basketball team, and just the demands of travel and——

Senator BOOZMAN. Right.

Secretary CARDONA [continuing]. In addition to the classes, he is studying engineering. So, I recognize, firsthand, what it feels like. We want to make sure that our students are able to take advantage of those co-curricular activities. In our budget we are asking for $150 million to support mental health in our institutions of higher education, which is an area that I felt, sir, over the last 3 years, our institutions are doing a better job recognizing that some of these needs have to be addressed pervasively, that they cannot be left to the—after the trauma.

So, we are investing in mental health supports in higher education, and we do believe that supporting our athletes is a big part of that, because many of those students have a lot on their plate as well.

Senator BOOZMAN. Good. Thank you, Madam Chair.

Senator BALDWIN. Thank you. We are anticipating at least one additional Senator who is, I think, making her way over for questions. So, I am going to start a second round for—as we expect her to come shortly. And I want to continue on this topic of mental health.

Secretary CARDONA. Right.

ACCESS TO SCHOOL-BASED MENTAL HEALTH SERVICES

Senator BALDWIN. I know we are all aware how hard this pandemic has been on students. And I shared some of the alarming statistics from the State of Wisconsin in my opening remarks. I have certainly heard from parents who are frustrated with how difficult it is to find mental health services for their children.

So, I want to hear from you, not only how the Department is using available funds and authorities, but how your Department is coordinating with the Department of Health and Human Services, which also has authorities——

Secretary CARDONA. Right.

Senator BALDWIN [continuing]. And funding to increase student access to school-based mental health services?

Secretary CARDONA. Absolutely. Thank you. I think that is the way we are moving in the future, that it is not limited to the school personnel. When I was a school principal we had a school-based health center from the community that we gave a classroom and an office to. I had students, on a regular basis, visiting the school-based health—we also had a dental health, because the students teeth hurt, they are not learning as well.

And we recognized that that model worked. So, when we talk about mental health, it is really important that I contextualize it, mental health support is also providing proactive positive activities for students, after school programming, connections with the local Boys and Girls Clubs for them to have a safe place to go after school.

But with regard to the more tier two, tier three mental health support, which is engaging with a school social worker, or a community social worker, we have seen an expansion of programs, and we are funding, and supporting, and lifting up programs that are connected to the community.

I visited a—I believe it was in Nevada—a high school that was connected to a 4-year university, and connected to a hospital. It was just the most expansive program that I have seen, parents are able to come in and get support as well.

We really need to lift up those models, the collaboration with HHS is critical. Xavier and I have talked a lot—Secretary Becerra and I have talked a lot about this. And the President charged us with ensuring that Medicaid is able to support some of the mental health and behavioral health needs of our students.

So, we are pleased to be working more closely together in modeling what we expect in our States, between the State Department of Education and Health Services. I do believe that a shared model is critical. I think the Full Service Community School dollars that we are asking for, will promote that as well.

Senator BALDWIN. Okay. Senator Britt, do I need to give you a couple more seconds. Or are you prepared for— okay. Senator Britt, you are recognized.

Senator BRITT. Thank you so much, Madam Chairman, I appreciate it. And thank you for allowing me to have a few minutes to ask some questions.

Mr. Secretary, thank you so much for being here today. Before moving on to a number of topics, and I know several things have already been covered that I had wanted to kind of dig into, I do want to be just honest and direct about my concerns with the Department of Education, and their role in American Education today.

The issue of education policy, I believe, should fall within the domain of the States and localities, rather than the Federal Government. When the Department of Education was established as a Cabinet level department in 1980, it was hoped that, among other things, the Department would supplement and complement the efforts of States and localities to really improve the quality of education across the country.

IMPORTANCE OF EDUCATION

When I look at my great State of Alabama, obviously, there are pockets of underserved areas that I believe need educational opportunities in order to truly move forward. I am of the belief that education is the foundation; it is the pathway to the American dream. And I am frustrated that there are still so many pockets that lack the ability to really give a child an opportunity to move forward. And so, when the Federal Government is involving . . . moved, if you kind of sort of look back, back then the data showed in read-

ing, that the average score among a 17-year-old student wasn't . . . it is not statistically significantly different than it is today.

And so, I look at those metrics that we use to create the Department, and they look just about the same today. And so, I am frustrated with the lack of movement, with your lack of progress that I believe is hindering our children. So, getting that aside, I want to jump into some questions.

STUDENT LOAN REPAYMENT

Mr. Secretary, on Monday when discussed, the current debate surrounding the debt ceiling, the White House Press Secretary said, "If you buy a car you are expected to pay the monthly payments. If you buy a home, you are expected to pay the mortgage every month. That is the expectation", end quote. Do you agree with that statement?

Secretary CARDONA. Thank you, Senator, for first of all, your comments earlier. I share with you that passion and that urgency to make sure that all kids in this country can succeed, and that place or race are not determinants or predictors of outcomes. So, I truly share that belief and that I appreciate your passion on that.

Senator BRITT. Thank you.

Secretary CARDONA. So, with regard to your question?

Senator BRITT. So, when the White House Press Secretary, this week stated, "If you buy a car, you are expected to pay the monthly payment. If you buy a home, you are expected to pay the monthly mortgage every month. That is the expectation", end quote. And I am saying, do you agree with that statement?

Secretary CARDONA. I agree with that, yes.

Senator BRITT. Okay. So I am of the belief, and this is where I have some frustration.

Secretary CARDONA. Mm-hmm.

Senator BRITT. Is I also believe that same logic must apply to student loans.

Secretary CARDONA. Yes.

Senator BRITT. And so, I would like your perspective on that as well?

Secretary CARDONA. Sure. I appreciate that, Senator. And you know, we agree, and we are preparing to restart repayment because the emergency is—period is over, and we are preparing our borrowers to restart. But as you know, the HEROES Act provides me the opportunity to create a waiver for those who were impacted significantly by the pandemic, very similar to small businesses the year before, where Congress provided a little bit of support.

Senator BRITT. So, it has been reported that the Biden administration is considering a number of steps to ensure a more gradual return to repayment once payments are formally scheduled to resume 60 days about—after the pause expires. So, some of the steps apparently include: one, student loan servicers not charging interest on Federal student loans again until September; the second one that is out there, is delaying until October as the first of the month, in which any borrower will be required to make a payment; and the third one that is out there, is the implementation of a certain safety net period in which borrowers aren't penalized for missing payments once repayments begin.

So, Mr. Secretary, can you confirm if the Department is considering these measures, or any similar measures that might be put into place, after that pause expires?

Secretary CARDONA. Yes. Thank you, Senator. We recognize, after 3 years of pause payments through two administrations; that the repayment restart is going to be a very important step. And we want to make sure it is done right.

We are confident that the targeted debt relief will address some of the concerns of some of our borrowers who are struggling right now. But as they re-enter repayment it is really important that we provide support for them. With regard to specific strategies, I would be happy to have my team follow up, to respond to those specific questions, yes.

Senator BRITT. I would greatly appreciate that. My time is expiring. I just want to say, I agree that if you buy a car you are expected to make your monthly payments, if you buy a home you are expected to pay your mortgage, and if you take out a loan you are expected to repay it, and that comes obviously with student loans as well. So, I think we have to teach our children that if you assume a responsibility you have to figure out and have a path forward to fulfill that responsibility.

So, thank you so much. And I look forward to working with you.

Secretary CARDONA. Thank you.

Senator BALDWIN. Thank you, Senator Britt.

Senator Capito.

COMMUNICATING THE STUDENT LOAN REPAYMENT PROCESS

Senator CAPITO. Yes. Thank you, and thank you for being here. And echoing Senator Britt's frustration, I noticed in response to my question, similar type of question as Senator Britt, we are not getting a real specific answer here. And I think one thing that I have known through the pandemic, and I think we have all learned, is clear communication is absolutely critical, whether it is about a loan, or whether it is about to wear a mask, or if your school is going to close.

So, I would hope that the administration would be more specific, and you would be more specific, and in future communications, with the folks that are either going to have to restart, that should be restarting the payment of their loan, because it is coming, and I think the clearer communication would be much appreciated.

IMPROVING NAEP RESULTS

And the second thing I would say, in terms of a comment, is I mentioned about the NAEP scores in my opening statement. It is deeply troubling to me. I mean, I am a mother of three, I have got eight grandchildren I know those doggone tests when they come in, and the kids have to sit there, and the parents get all nervous because you have got to make sure you get them up, and feed them, and they are all ready for their tests, more like it is the biggest day in their life. But it does show trends if nothing else.

Secretary CARDONA. Right.

Senator CAPITO. And the trend is not good.

Secretary CARDONA. Mm-hmm.

Senator CAPITO. So, my concern here is we cannot reset the bar here. In other words, the baseline can't go down to where we are, we have to keep remembering that we are in a trough right now, and still have all these aspirational goals. I am sure you as an educator——

Secretary CARDONA. Right.

Senator CAPITO [continuing]. We are always looking at that. And so, I would encourage you, rather, as an administration, or as a country, as the leader of our education, to say to the parents and the students out there: You know, we have had a rough time, we have got all these support services we are talking about to try to help you, but we are not going to let you stay where you are. That is not satisfactory. You need to move up. And so, my quick question is, on the short-term Pell.

Secretary CARDONA. Sure.

Senator CAPITO. We have heard a lot about workforce, and a lot of what we are doing in our State is short-term training, and there is nothing in this budget, as far as I understand, that would help us with those folks and certificate programs, and short-term programs.

Secretary CARDONA. Right.

Senator CAPITO. What is your reason?

RAISING THE BAR

Secretary CARDONA. Yes, definitely happy to share that. And let me just tell you, Senator, I couldn't agree more. When I became a fourth grade teacher, I wanted to make sure all my kids had access. I wanted to make sure they were reading. And now I have a wider scope, but that passion is still there, and I appreciated, even your hand gestures, because we are raising the bar, that is our strategy, it is called, raising the bar, for literacy, numeracy.

We shouldn't just aim to recover, because the data before, 2019 wasn't great. So, moving to Pell and short-term Pell; you know, in my conversations and my travel with community college presidents, 4-year college presidents, industry partners who are saying: We want to work with our 2-year schools, to make sure that our employees have the skills, but they don't need a 2-year program.

We recognize that we need to be malleable, and we need to be conducive. If I am asking universities and K–12 institutions to think outside the box and evolve, we too, need to do that. So, I am in favor of exploring short-term Pell, with making sure that there is accountability and there is high quality programming.

And I think that is something we both agree on. So, I am excited to see how that develops, but we recognize that if we are really going to meet the demand of the tsunami of jobs that are coming, we need to be flexible as well.

Senator CAPITO. Thank you. Thank you, Madam Chair.Senator Baldwin: Thank you, Senator Capito.

That will end our hearing today. I want to thank my fellow committee members who participated in a thoughtful conversation, a back and forth.

And thank you to you——

Secretary CARDONA. Thank you.

Senator BALDWIN [continuing]. Secretary Cardona.

ADDITIONAL COMMITTEE QUESTIONS

For any Senators who wish to ask additional questions, questions for the record will be due on May 19, at 5 p.m. The hearing record will also remain open for members who wish to submit additional materials for the record.

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

QUESTIONS SUBMITTED TO MIGUEL CARDONA

QUESTIONS SUBMITTED BY SENATOR TAMMY BALDWIN

Question. Congress took decisive action, including through the American Rescue Plan Act that passed without a Republican vote, in providing unprecedented levels of resources to help schools safely provide in-person learning for all students and help students recover from the COVID–19 pandemic. The Department rejected portions of State plans that failed to comply with requirements of the law, including Wisconsin's plan as modified by Wisconsin's legislature. Unfortunately, delayed approval may have complicated the timely and effective use of these funds as intended. All students need support, particularly those disproportionately impacted by the pandemic and a portion of these funds are required to assist these students using evidence-based interventions.

With the final school year ESSER funds are available for new obligations fast approaching, what steps will you take to provide States and school districts with the assistance they need to timely and effectively use these funds to meet student needs as required by law?

Answer. All States received access to two thirds of their ARP ESSER funds on March 24, 2021, within two weeks of the President signing the American Rescue Plan. The Department was in regular communication with States, urging them to make funds available to their school districts in order to address the needs of students resulting from the pandemic and helping them problem solve, as needed.

The Department has consistently worked with States and school districts to provide them with personalized technical assistance so that they are able to address the unique needs of their communities. The Department uses the results from annual performance reporting, monitoring, inquiries from grantees and other stakeholders to inform a broad array of technical assistance (TA) activities that promote the urgent and wise use of ARP and other recovery funds. Given that recovery funds are State-administered formula grants, TA is primarily focused on the 52 State educational agencies (SEAs) that, in turn, support more than 10,000 school districts implementing locally approved spending plans.

TA is structured as follows:

Helping all States understand recovery fund requirements: Since January 2021, the Department has issued more than 30 pieces of formal, written guidance (Dear Colleague Letters, fact sheets, and frequently asked questions) and dozens of webinars and "Office Hours"[1] to support Governors, SEAs, school districts, and other entities in implementing recovery funds. Formal guidance is a priority as it promotes consistent application of the ARP Act and other recovery act requirements across variously situated grantees and subgrantees and provides a clear basis for monitoring by the Department as well as other entities with oversight responsibilities (e.g., State and local inspectors general, State fiscal officers, private auditors). The Department has also responded to hundreds of unique questions from individual grantees by convening five different agency-wide workgroups to ensure fidelity to the statute and regulations. Monthly calls with each State are also an opportunity for grantees to ask questions and clarify any understanding of the requirements. Finally, the Department understands the massive undertaking by States to implement COVID-relief programs; accordingly, we provide ongoing TA to stakeholder groups that also support States including membership associations, State auditors, and the Office of the Inspector General, to ensure broad and consistent understanding of program requirements.

[1] The Department has provided additional support to all States to help them comply with the annual performance reporting requirements. This support has included multiple webinars, frequently asked questions documents, and a dedicated Help Desk.

Example: The Department's ESSER and GEER Use of Funds FAQs (December 2022) outlines how recovery funds can be used to support mental health services for students and educators, expand summer and after school programs, reduce rates of chronic absenteeism, and promote workforce stability—among other priorities. This non-regulatory guidance includes approximately 115 questions and answers drawn from States, school districts, and stakeholders.

Supporting all States in practical application of these requirements: Within the broad allowability of the ARP Act and other recovery funds, the Department has an obligation to support recipients in making the wisest, possible use of funds. Through regular webinars, the five-part Raise the Bar: Literacy and Math Series, and multi-State communities of practice organized by the Department's National Comprehensive Center (NCC) and other TA centers, the Department can rapidly deploy content to address emerging needs, elevate promising practices, and leverage the expertise of practitioners successfully implementing an evidence-based approach at scale. The Department's Office of the Chief Data Officer (OCDO) develops and delivers resources (webinars, guidance documents, tools to support reporting) designed to assist grantees with the reporting requirements. Access to these resources may be found on the Grantee Help page of the ESF Transparency Portal.

Example: Through the Department's Student Engagement and Attendance Center, more than 200 State and local participants from 34 States are working together to explore student attendance trends, analyze State and local data sets, and identify strategies to find and re-engage missing students and improve student attendance.

Developing all States' awareness of the impact of ARP and other recovery funds: Maximizing the impact of ARP and other recovery funds requires data and evidence to assess how recovery initiatives are working, for which students, and under what conditions. Regional Educational Laboratories (RELs), administered by the Department's Institute of Education Sciences, work in partnership with SEA leaders and practitioners to design, develop, and carry out activities and studies to help achieve meaningful improvements in student outcomes. Specific activities include delivering customized training, coaching, and technical support to build capacity for applying evidence to practice; developing toolkits to help educators use recommendations from What Works Clearinghouse Practice Guides in the classroom; and conducting rigorous applied research in response to local priorities. Earlier this year, IES and the Office of Elementary and Secondary Education partnered to issue a Dear Colleague Letter to new State chiefs, urging them to take full advantage of REL services.

Examples:

—Student outcome data, when disaggregated by student group, school characteristics, or other relevant features, can support decision-makers in focusing resources, monitoring improvement, and adjusting implementation efforts. RELs Midwest and Mid-Atlantic recently provided similar services for their State and district-level partners.

—A recent REL Northwest study examined the implementation and impact of full-day kindergarten in Oregon in light of a funding structure shift that incentivized districts to offer the programming.

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Additionally, the Department has provided ongoing support to states through Communities of Practice (CoPs), including the Evidence-Based Interventions: Using ARP Resources to Accelerate Learning CoP and the Strategic Use of Summer and Afterschool Set Asides CoP. Resources from the CoPs can be found here. In FY 2024, the Department is investing in focused technical assistance and capacity-building support to States to spend remaining recovery funds in ways that are most likely to accelerate student learning and achieve equitable outcomes, building capacity to monitor and evaluate the effectiveness and plan for fiscal sustainability of their investments. Through a series of virtual and in-person events, the Department will support states to develop sustainability plans that identify existing or new funding sources to support effective and equitable investments, to integrate the sustainability plans into ongoing and future spending decisions, and to establish processes for ongoing evaluation of effectiveness of programs and continued impact of ARP

funds that lead to equitable opportunities for lasting improvements in all student outcomes.

Question. Last year's joint explanatory statement directed Education to "increase transparency on the amount reserved by each State for the ESEA Title I–A school improvement set aside, method of distribution to eligible LEAs, uses of such funds..."

Please provide available information responsive to the request and describe actions taken in fiscal year 2023 and plans for future years to provide transparency of this information and support for implementation of related requirements.

Answer. While we appreciate the interest in encouraging States to be more transparent with the use of ESEA section 1003 funds, there is no statutory requirement for a State to do this. ESEA section 1003(i) requires each State to make publicly available on its State and local report cards a list of all LEAs and schools that received section 1003 funds, including the amount of funds each school received and the types of strategies implemented in each school with these funds. As part of OESE's consolidated monitoring, we review to see that this information is included on State and local report cards consistent with this requirement. Of the States monitored in the past 3 years, the Department has found that one State did not meet this report card requirement. Specifically, Tennessee provided some information regarding school improvement funds but did not provide a list of LEAs and schools that receive section 1003 school improvement funds.

As part of consolidated monitoring, OESE also reviews how States are implementing the requirements of ESEA section 1003. This includes reviewing each State's 1003 application template, 1003 guidance to LEAs, processes for reviewing, approving, and monitoring implementation of 1003 applications to ensure compliance with statutory requirements. Much of this information is generally available on each State's website.

In addition, this summer, the Department is conducting an in-depth review of all State and local report card requirements for nine States to gather information about commonly missing items, identify exemplar report cards, and to help guide our future oversight and technical assistance activities. This review will include the requirement in ESEA section 1003(i). We expect to complete this work in fall 2023.

Question. Please identify the specific steps and timeline for providing more information to state and local educational agencies about the late liquidation process for American Rescue Plan Act ESSER funds.

How will you ensure LEAs and SEAs have early knowledge that eligible liquidation requests are approvable as early as possible for the contracts they are signing today for authorized activities that cannot be completed without an extension of the liquidation requirement under 2 CFR § 200.344(b)?

Answer. The Department is currently administering liquidation extensions for CARES Act funds that had an obligation deadline of September 2022 and CRRSA Act funds that must be obligated by September 2023. The Department has been clear that States and local educational agencies should be spending ARP funds with great urgency so they can make maximum use for students, educators, and communities—and complete obligations by September 2024. The Department strongly encourages States and districts to obligate and liquidate ARP Act funds for activities that support students' academic recovery, mental health, and physical health and safety.

Question. Over the last 2 years, Congress has increased investments in Statewide Family Engagement Centers and Parent Training and Information Centers, as well as the Title I-A grant program and its 1 percent reservation of funds and requirements related to parent and family engagement activities.

How are those funds being used to support strong and effective parent and community relationships with schools that serve the best interest of students?

Answer. The Statewide Family Engagement Centers (SFEC) currently have twenty centers operating in 21 states. The purpose of the SFEC program is to provide financial support to organizations that provide technical assistance and training to State educational agencies (SEAs) and local educational agencies (LEAs) in the implementation and enhancement of systemic and effective family engagement policies, programs, and activities. This programming is intended to lead to improvements in student development and academic achievement.

The Secretary is authorized to award grants to statewide organizations (or consortia of such organizations) to establish statewide family engagement centers that:

—Carry out parent education and family engagement in education, programs, and

—Provide comprehensive training and technical assistance to SEAs, LEAs, schools identified by SEAs and LEAs, organizations that support family-school partnerships and other such programs.

Connecticut's SFEC implements the CT Welcoming Schools Initiative which was born out of a desire to improve family involvement in schools and after school programs. The key to engaging parents is to make their schools "feel like family. " Schools that extend a genuine welcome and are inviting to families have strong partners in education. The Initiative aims to make parents feel welcomed, to celebrate the diversity of the school community, and set unique goals to improve how inviting the school appears to its community, which ultimately have a positive impact on student achievement.

Hawaii's SFEC provides an online, asynchronous course for school staff to learn strategies for promoting students' learning and development with an emphasis on the role of families in supporting their children's learning at home. Kentucky's SFEC is implementing the Family Friendly Schools Certification Program which includes the Kentucky Family and School Partnership Guide. The program has certified over 35 schools in Kentucky.

Minnesota's SFEC created an educator toolkit for family engagement. The toolkit includes multiple resources and is designed for anyone who engages in educating children or promoting family engagement.

The Ohio SFEC hosts an annual Family Engagement Leadership Summit which is a free day of professional learning and connecting virtually with those dedicated to advancing effective family-school-community partnerships across Ohio and beyond.

Question. What are the Department's plans for supporting further strengthening of parent and family engagement in our schools and sharing and supporting implementation of evidence-based practices in this area?

Answer. The SFEC program plans to fund down the slate in 2023 and award grants to more than ten organizations. In addition, the 2022 grantees will begin implementing interventions in LEAs in the fall of 2023. IES is currently conducting an implementation evaluation of the SFEC program with plans for its release in 2024. ED will continue to fund a technical assistance contract to assist grantees with implementing their grants.

Question. How would decreased funding as proposed in House Republican debt ceiling legislation (H.R. 2811) affect Federal support for such engagement efforts?

Answer. The proposed funding cuts in H.R. 2811 would significantly reduce the number and scope of activities to promote parent engagement in schools conducted by Department grantees, including grantees in approximately 20 States served under the Statewide Family Engagement Centers program.

Question. Please describe your monitoring and technical assistance plans in fiscal year 2024 and future years related to resource equity requirements of the Elementary and Secondary Education Act, including a timeline for the release of a Dear Colleague letter related to effective implementation of these requirements and further support for conducting resource allocation reviews and identifying and addressing resource inequities.

Answer. As of June 2023, the Department is finalizing the Dear Colleague letter related to effective implementation of the resource equity requirements in the ESEA and hopes to release it soon.

Regarding further monitoring and technical assistance plans in fiscal year 2024, all resource equity requirements are included in OESE's consolidated monitoring. Similar to FY2023, OESE intends to monitor four States in FY 2024. The Department will continue to provide technical assistance to all States, including those States that were part of the pilot targeted monitoring in FY2022 and are still working to address the required actions from that effort. OESE has not yet determined the schedule or topic for any targeted monitoring efforts in FY 2024.

In addition, the Department's Comprehensive Centers will continue to provide support and assistance to States on the topics they raise, including resource equity requirements. In the past 2 years, several States have requested assistance with these requirements and are receiving support from regional comprehensive centers. Existing State projects include a collaborative effort between three comprehensive center regions serving nine States and the Bureau of Indian Education to develop the required periodic resource allocation review, a pilot with Utah to conduct and share the results from periodic resource allocation, and an effort to plan for the resource allocation review with Oklahoma. Additionally, the National Comprehensive Center has hosted a multi-year Community of Practice on Driving Equity Through School Improvement Community of Practice (CoP) to support States and districts to identify and address disparities in student outcomes and opportunities to learn. Materials from the CoP can be found here. These efforts will result in technical assistance materials that can be shared with all States. The National Comprehensive Center, in partnership with Edunomics Lab, launched a tool that is available for all States that is useful for the two Title I resource equity provisions: School Spending

& Outcomes Snapshot (SSOS): Supporting Conversations on Equity and School Improvement (https://compcenternetwork.org/ssos). This tool includes data visualizations and questions for States, LEAs, schools, and education stakeholders to explore spending and outcomes data. This information can be used to advance thoughtful conversations among LEA and school communities about the equitable distribution of resources and how spending patterns may be related to student outcomes or school performance.

Question. Subpart 1 of Title I Part D received just more than $49 million in FY2023 for grants to State educational agencies (SEAs), which in turn must make subgrants to State agencies which provide free public education to neglected and delinquent (N and D) children and youth who are in State-run institutions, attending community day programs, and in correctional facilities. Just more than one-third of youth served by the program during the 2019–20 school year were students with disabilities.

Please describe the Department's plans to provide technical assistance to improve services to such students while in such institutions and during transition and reentry to schools and communities.

Answer. The Department engages in a number of technical assistance activities to improve services to students with disabilities who are served by the Title I, Part D program, primarily through technical assistance provided by the Department's contracted technical assistance provider, the Neglected and Delinquent Technical Assistance Center (NDTAC). NDTAC provides assistance to States, schools, communities, and parents seeking information on the education of children and youth who are considered neglected, delinquent, or at-risk (see https://neglected-delinquent.ed.gov/). Improving the education of youth involved in the juvenile justice system, and supporting their re-entry into local schools and communities, is a primary focus of the Center. NDTAC supports for Title I, Part D state coordinators include webinars, quarterly newsletters, local program spotlights, data collection and evaluation tools, as well as monthly office hours and an annual conference. These services include collaboration with stakeholders who support the needs of students with disabilities. For example, the Department's Office of Elementary and Secondary Education recently partnered with the Office of Special Education and the U.S. Department of Justice on a joint presentation entitled "Correctional Education: Collaboration, Equity, Special Education and Technical Assistance Support." At the Title I, Part D Annual State Coordinators Meeting held in May 2023, we held a session on the needs of students with disabilities in the juvenile justice system, focusing on secondary transition (re-entry to home and community environments). Other sessions at this year's meeting also addressed needs of students with disabilities. The Department is also a member of an interagency work group to address the comprehensive health, welfare and educational needs of students in the juvenile justice system. Finally, over the next year, the Department has brought in a fellow who will focus on increasing collaboration and technical assistance activities for neglected and delinquent students, students experiencing homelessness, and students in foster care. This work will include identifying how to improve resource-sharing across programs.

Question. Both the Government Accountability Office (GAO) and Education's Inspector General have raised concerns about the risks to Federal funds posed by certain types of charter schools from virtual schools to those with contracts with forprofit management organizations, and the need for effective oversight of the Charter School Program.

Please provide an update on actions taken and planned to address recommendations made by the GAO in GAO–22–10444 and recommendations 1.2 and 1.3 of IG ED–OIG/A21IL0034. Will Education take all necessary actions to fully and timely implement corrective actions and recommendations?

Answer. The Charter Schools Program (CSP) works with its data collection contractor, WestED, to support EDFacts' staff with data quality reviews (DQRs) of all charter school related data collected via EDFacts, including data on charter management organizations (CMOs) and charter contracts. The most recent DQR was conducted in May 2022. The DQRs reveal issues with the quality and completeness of the charter data submitted by state educational agencies (SEAs). The May 2022 DQR found the following:

—18 states identified as having at least one charter school but did not report a charter school authorizer;

—in some states, the number of schools without authorizer data was small (e.g., 11 states had fewer than 10 charter schools with this missing data), but five states had 100 or more charter schools with missing charter authorizer data;

—13 states did not submit a crosswalk of charter schools to CMOs and five states identified CMOs in their crosswalk, but not all identified CMOs were reported in the charter roster data file; and

—other EDFacts data that appear to be incomplete include the charter contract data. For example, 35 states with charter schools did not report charter contract data in EDFacts for all charter schools.

Factors associated with the under- and misreporting of this data by SEAs appear to be lack of understanding regarding what to report, and limited capacity at the SEA level to gather and report the data. For the Department's CSP grantees, programmatic funds are authorized by statute for the Department to provide targeted technical assistance to CSP grantees to ensure the successful implementation of their grants. In July 2022, the Department issued a final rule to ensure that CSP grantees manage their school operations with accountability and transparency. The Department's rulemaking requires that all CSP-funded charter schools annually: provide detailed information on proposed school governance; report whether they have entered, or plan to enter into, a contract with a for-profit management organization and if so, provide detailed information regarding such contract; report on individuals who have a financial interest in the for- profit management organization, including any affiliations or conflicts of interest involving charter school staff or board members; and, assure that any for-profit management contract is subject to important controls.

Though the utilization of the CSP national activities' funds, the CSP offers contractual support and technical assistance to all CSP grantees to ensure compliance with these requirements. Since CSP national activities' funds can only be utilized to support CSP grantees, SEAs that are not CSP grantees cannot receive data collection support, to include assistance with the charter related EDFacts data. The Department relies on its oversight responsibilities and authority under the Charter Schools discretionary grant program to ensure that this data is properly collected via the program's Annual Performance Report (APR).

We have modified the CSP data collection contract with WestED to ensure the collection of CSP-funded charter school closure data after CSP grant funding ends. We anticipate releasing this data no later than September 2024. We have also drafted new, program specific APRs to collect this and other information concerning grantee relationships with for-profit entities. We anticipate launching the new APRs in the program's new online performance management platform entitled, COMPS (Charter Online Management Performance System) by September 2024. The COMPS platform is designed to ensure the timely submission and review of all CSP APRs.

The GAO study also provided a recommendation that the Department examine the assessment participation rates in virtual charter schools. As State educational agencies (SEAs) are responsible for ensuring their local educational agencies and schools meet their requirements in the ESEA, including to assess all students, in November 2022, the Department sent a letter to each SEA with a list of any virtual charter school in the State with an assessment participation rate below 95 percent in the 2018–2019 school year. (This was the most recent year with complete data, due to the impact of the pandemic in the 2019–2020 and 2020–2021 school years and because States had not yet submitted their data for the 2021–2022 school year.) We reminded States that as they plan for the 2022–2023 school year assessment administrations, they should closely monitor virtual charter schools' participation rates; consider, if you have not already, creating a remote administration opportunity for virtual charter school students; and work with the charter authorizing entity or entities in your State to provide joint information, including forwarding this communication, and support to virtual charter schools with low participation rates. We also included some assistance to the SEA, including a report from the National Center for Educational Outcomes (NCEO), The 95 Percent State Assessment Participation Requirement: Current Landscape, State Challenges, and Recommended Strategies.

Question. How would the appropriations language change proposed in the fiscal year 2024 budget further assist Education in the effective use and oversight of CSP funds?

Answer. The President's FY24 Budget Request includes language prohibiting the Department from making new Charter Schools Program awards that support charter schools that are operated or managed by for-profit entities, including through contractual relationships. The Administration strongly believes that for-profit management organizations pose a significant risk to students and taxpayers and that Charter Schools Program funds should not support schools operated or managed by entities with a profit motive.

Additionally, the President's FY24 Budget Request includes language that would provide the Department greater flexibility by eliminating specific funding levels for State Entity, Developer and CMO grants and instead setting a floor of $330 million in funding for all three programs. The requested flexibility would enable the Department to allocate funds more efficiently in response to varying demand for component program funding and prevent circumstances such as occurred in fiscal year 2019, when limited demand for State Entity and Developer grants (that could not be used for other CSP purposes) resulted in the Department reprogramming funds to other programs in the Innovation and Improvement account.

Question. On April 21, 2020, GAO reported on the underreporting and misreporting of the use of restraint and seclusion in schools and made a recommendation to address the significant quality issues with such reporting. Education has developed a plan for listening sessions with school districts to help determine the causes for such under and misreporting.

Please describe other actions and plans for improving the quality of reporting for each of the current 2020–21 collection, the 2021–22 collection and the 2023–24 collection.

Answer. As background, CRDC data submitters reported data to OCR's Civil Rights Data Collection (CRDC) for the 2020–21 school year from December 2021 through April 2022. During that submission process, data submitters had access to several technical assistance resources to assist them with reporting restraint or seclusion data accurately. These resources include Zeroes, Nulls, and NS, Restraint and Seclusion, and a video demonstrating how to submit a quick plan. OCR is in the process of reviewing and preparing for public release the 2020–21 CRDC data. OCR anticipates releasing the data this year and will have more to report about the restraint and seclusion data at that time.

As to the 2021–22 and 2023–24 CRDCs, on April 18, 2023, the U.S. Office of Management and Budget approved OCR's proposed CRDCs for those school years. To improve the quality of the restraint and seclusion data reported, OCR revised the definitions of restraint and seclusion to clarify the types of actions data submitters must report. The definitions were informed by diverse stakeholders, including school administrators, during listening sessions and the public comment process for the 2021–22/2023–24 CRDCs.

As OCR prepares for the 2021–22 CRDC collection, we will consider lessons learned from the 2020–21 CRDC and make any necessary changes to instructions or technical assistance documents. Furthermore, as in previous collections, data submitters can contact OCR's technical assistance team, the Partner Support Center (PSC), with any questions they may have about specific data modules, including the restraint and seclusion module. The PSC is open year-round to assist data submitters by telephone, email, or by visiting the CRDC Resource Center, at https://crdc.communities.ed.gov/#program.

Finally, OCR addresses CRDC reporting errors in the course of enforcement investigations. For example, in two recently resolved restraint and seclusion compliance reviews—one with Saco Public Schools [1] in Maine (November 2021) and the other with Horry County Schools [2] in South Carolina (May 2022), school districts committed to take steps necessary to ensure that they provide accurate data to the CRDC following concerns OCR identified regarding data errors during the course of the investigations.

Question. How could OCR expedite planned listening sessions, so it can more quickly understand potential causes for under and misreporting and implement solutions as soon as possible?

Answer. OCR has fully implemented five of six GAO recommendations. See https://www.gao.gov/products/gao-20-345. OCR will endeavor to meet the final recommendation [2] by October of this year This will be accomplished by holding listening sessions with data submitters, focused on the underreporting and misreporting of restraint and seclusion data. OCR will use the information from the listening sessions to inform any changes to CRDC's technical assistance resources provided to data submitters for reporting these data.

[1] See https://www2.ed.gov/about/offices/list/ocr/docs/investigations/more/01195001-a.pdf, and https://www2.ed.gov/about/offices/list/ocr/docs/investigations/more/01195001-b.pdf.

[2] See https://www2.ed.gov/about/offices/list/ocr/docs/investigations/more/11195022-a.pdf, and https://www2.ed.gov/about/offices/list/ocr/docs/investigations/more/11195022-b.pdf.

[3] The Assistant Secretary for the Office for Civil Rights should identify the factors that cause underreporting and misreporting of restraint and seclusion and take steps to help school districts overcome these issues. (Recommendation 5).

Question. Research has found consistently that students of color and students growing up in poverty are disproportionately more likely to be taught by teachers who are inexperienced, less effective or teaching out-of-field. Recent research from the Education Trust on access to experienced teachers found Black and Latinx students are more likely to attend schools that have higher percentages of novice teachers. In 2015, Congress reauthorized the Elementary and Secondary Education Act, with a new requirement for States to submit plans to the Federal Government describing how low- income and minority children enrolled in Title I schools are not served at disproportionate rates by ineffective, out-of- field, or inexperienced teachers, and what States will do to report on this data to the public.

Since then, new research from the National Council on Teacher Quality has found that many States are at least partially out of compliance with the letter of the law. Their analysis found that only 18 states report data on all three measures named in the law: experience, out-of-field, effectiveness.

The Department is monitoring a selective sample of States this year on requirements for State report cards in ESEA section 1111(h)(1), a sample of LEA report cards for the requirements in ESEA section 1111(h)(2), and the requirement to publicly report the progress in addressing any disproportionate rates of access to educators in ESEA section 1111(g)(1)(B).

How will the Department use the results of this monitoring to improve States' compliance with each of these requirements? What other actions will the Department take to improve States' compliance with each of these requirements?

Answer. Based on the information we receive from this review, the Department will determine what actions to take. Last year, the results of the targeted monitoring on resource allocation resulted in several presentations at national conferences that highlighted commonly found issues across the nine states as well as highlighting interesting or promising practices. We anticipate similar activities to come from this year's targeted monitoring.

Question. The Support and Academic Enrichment [SSAE] Grants program provides formula grants to States based on each State's share of title I—A grants, which then sub-grant to LEAs, to help support activities that provide students with a well-rounded education, ensure safe and supportive learning environments, and use technology to improve instruction.

Please describe the Department's plans and timeline for reporting on State and local expenditures, outlined by specific authorized activities, and provide detailed information about the most common uses of funds, as well as information about how LEAs plan to evaluate the effectiveness of their activities.

Answer. The Student Support and Academic Enrichment Grants (Title IV–A) program gathers data on the amount of funds spent and the number of LEAs spending funds for a given academic year as part of the Department's Consolidated State Performance Report. The first indicator focuses on the amount of funds spent by LEAs in the three content areas authorized—Well-Rounded Education, Safe and Healthy Students, and Effective Use of Technology. The second indicator seeks data on the number of LEAs who spent funds by the content areas. In 2020, the Department released a report on the early implementation of Title IV–A grants, including an initial overview of how states and school districts prioritized the use of FY 2018 Title IV–A funds during the 2018—19 school year.

The most frequently reported activity under the Well-Rounded content area was science, technology, engineering, and mathematics (STEM) education, including computer science. Under the Safe and Healthy Students content area, a large number of states reported school-based mental health services and partnership programs as their most frequently reported activity. And under the Effective Use of Technology content area, states most reported that professional development and capacity building to improve the use of educational technology, building technological capacity and infrastructure as their most frequent activity.This report is available at https://www2.ed.gov/rschstat/eval/esea/title-iv-first-look-2020.pdf. The Department is also conducting a deeper implementation study to examine the specific services and activities that states and districts are implementing using Title IV–A funds and how these decisions are made. The estimated timeframe for the release of this report is spring 2024.

Question. The Biden administration has proposed investments in a range of programs that are dedicated to developing a highly qualified, diverse teacher workforce, including Supporting Effective Instruction State Grants (Title II–A), Teacher and School Leader Incentive Grants (TSLIP), Supporting Effective Educator Development Grants (SEED), Teacher Quality Partnerships (TQP), School Leader Recruitment and Support Program (SLRSP), and the Augustus Hawkins Centers of Excellence.

Research has shown the importance of powerful leaders in turning around troubled schools, and these programs address inequities in access to effective teachers and school leaders, and allow for evidence-based, innovative strategies designed to improve educator effectiveness and increase educator diversity. We also know that students assigned to strong teachers in primary school are more likely to attend college and earn more money as adults.

Can you elaborate on the importance of these programs in strengthening and diversifying America's educator workforce?

Answer. The Administration is committed to strengthening the educator pipeline and addressing teacher shortages through the expansion of high-quality teacher preparation programs that prepare and support pre-service teachers. Strengthening the pipeline of diverse, highly qualified teachers into high-need schools begins with high-quality teacher preparation programs across the nation. To that end, on July 9, 2021, the Department released a notice of final priorities (NFP) for the Teacher and School Leader Incentive Grants, Supporting Effective Educator Development Grants, and Teacher Quality Partnership programs that would allow the Department to require applicants to these programs to develop projects that are designed to improve the recruitment, outreach, preparation, support, development, and retention of a diverse educator workforce.

In addition, the Administration's FY 2024 Budget requested significant increases for competitive programs that will strengthen and diversify the teacher pipeline by helping states and districts build high-quality pathways into the profession to recruit and prepare educators. The budget includes:

—$2.19 billion for Supporting Effective Instruction State grants to support State and local efforts to improve teacher and school leader effectiveness and help ensure that all students have equitable access to well-prepared, qualified, experienced, and effective teachers and principals.

—Increase of $62 million for Teacher Quality Partnerships, an 88% increase, to prepare educators through effective programs including teacher residencies and grow-your-own programs.

—$10 million for Graduate Fellowships, to support the training of more higher education faculty with the knowledge and skills to train the next generation of teachers.

—$93 million for the Supporting Effective Educator Development to prepare, develop, and retain an effective and diverse teacher and school leader workforce, that can meet the social, emotional, mental health and academic needs of their students.

—$40 million for the School Leader Recruitment and Support Program for competitive grants to improve the recruitment, preparation, placement, support, and retention of effective principals or other school leaders in high-need schools.

—Increase of $15 million for the Hawkins Centers of Excellence program, doubling funding for the program, to support educator preparation programs at HBCUs, TCCUs, and MSIs.

—Increase of $27 million for Teacher and School Leader Incentive grants, to support school-based models of distributed leadership that give teachers the opportunity to lead beyond the classroom, and be compensated for this work, improving teacher retention.

Question. The Statewide Data System program supports competitive grants to State Educational Agencies to enable such agencies to develop, expand or improve Statewide, longitudinal data systems; improve data access and use for research and evidence-based policy- and decisionmaking; and build capacity in States to secure and protect data.

Please describe actions and plans, including in coordination with the Departments of Health and Human Services of Labor, to support integration of data source systems across all levels of education, workforce and related areas, including implementation and enhancements data governance policies and security measures that protect the rights of individuals.

Answer. Both workforce and early childhood data have figured prominently in the Department's Statewide Longitudinal Data Systems (SLDS) program. While the first two cohorts of SLDS grants focused on supporting States' efforts to transform elementary and secondary education administrative records into more useable longitudinal data systems, all subsequent grant rounds (2009, 2010, 2012, 2015, 2019, and 2023) have supported efforts to link and use data beyond grades kindergarten through 12 (K–12), including early childhood, postsecondary education, and workforce data. Of the 114 grants awarded since 2009, 72 (63 percent) have included workforce-related projects. More than 30 states have used SLDS funds to build out early childhood-related data capacity.

The Department recently published a notice inviting applications for fiscal year (FY) 2023 grant awards under the SLDS program. Funds awarded through this competition will provide support for States to integrate data across all levels of education, including linking data from early childhood or workforce data sources to education data. Of the four priorities included under this competition, two could be used to integrate early childhood data and three could be used to answer questions pertaining to students' transitions between education and the workforce. Applicants must "describe how activities supported by a grant funded by this competition will be coordinated with activities supported by an existing grant, including a state [WDQI] or other grant administered by the US Department of Labor, if applicable." Applications for this competition are due on June 29, 2023.

SLDS and Workforce Activities

The Department's SLDS program team meets regularly with staff in the Department of Labor's Employment and Training Administration (ETA) to discuss connected efforts involving the SLDS and WDQI grants. We also meet regularly with the Coleridge Initiative, a nonprofit organization working with government agencies to ensure that data are more effectively used for public decisionmaking, to identify ways to help States use its Administrative Data Research Facility (ADRF) to support their efforts to link workforce data to K–12 and postsecondary data within and across States. Through conversations with the Department of Defense's Defense Manpower Data Center (DMDC), the SLDS program is also helping States explore opportunities to connect data on military enlistment outcomes for career and technical education, postsecondary, and other education and training programs.

SLDS and Early Childhood activities

The SLDS program has been working closely with the early childhood education community since the 2009 and 2010 (ARRA) grants. Much of the early childhood work done within SLDS grants centered on development of an early childhood integrated data system (ECIDS). The broad purpose of an ECIDS is to provide integrated, cross-program data that inform decisions about early childhood policies, services, and education. While supporting state development of an ECIDS has been a focus for both the Department and the Department of Health and Human Services (HHS), we have also collaborated with HHS's Preschool Development Grants Birth through Five (PDG B–5) team to provide technical assistance related to SLDS.

As one example of our efforts to support States, the SLDS State Support Team developed an Early Childhood Integrated Data System Toolkit (https://slds.ed.gov/services/PDCService.svc/GetPDCDocumentFile?fileId=41566) because we recognized that early childhood education programs receive funding from a variety of Federal and State agencies, which has implications for their ECIDS. The toolkit recommends that States first consider what should be centralized for early childhood education providers, users, and evaluators, and then determine which of those data should be available to the State and linked with longitudinal data records for policy and evaluation purposes. The toolkit and our other technical assistance to States is informed by early childhood working groups as well as our annual SLDS Effective Practices Conference (https://nces.ed.gov/programs/slds/edci.asp).

Data Governance and Security Activities to Protect the Rights and Privacy of Individuals

The Department provides technical assistance to States to support their efforts to build, improve, and use SLDS, including both technical work (for example, data standards and structures) and more process-oriented needs (for example, data governance, stakeholder engagement, and sustainability planning). The Department has created a large array of support materials, many of which are available on the SLDS program website (https://nces.ed.gov/Programs/SLDS/) and the website for SLDS technical assistance to States (https://slds.ed.gov/#program) The Department also provides technical assistance on protecting the rights and privacy of individuals, drawing from best practices recommended by the Privacy Technical Assistance Center. We would be happy to provide specific examples of technical assistance activities resources for any of these topics.

Question. The National Center for Education Statistics has taken steps to develop pk-12 educational equity indicators and a data dashboard.

Please describe major actions taken to date and plans for the remainder of fiscal year 2023 and fiscal year 2024.

Answer. A distinguished committee of the National Academies of Sciences, Engineering, and Medicine (NASEM), funded by the National Center for Education Statistics (NCES), developed an equity framework in 2019, identifying key indicators for measuring and monitoring the extent of equity in the nation's K—12 education system (see "Monitoring Educational Equity"). Following this framework, NCES is

building a publicly facing Equity in Education dashboard that will be populated with metrics recommended by NASEM. The dashboard is meant to:

—provide the public accurate information on indicators of equity in the nation's education system,

—provide the Department and other stakeholders a "single source of truth" accompanied by statistically appropriate, plain language interpretations, and

—assist the Department and other stakeholders in identifying gaps in our collective capacity to understand equity in education.

NCES is developing the initial version of the dashboard, which curates relevant, national-level data, and expects to complete it in fiscal year 2024. The initial dashboard will contain indicators from seven domains—kindergarten readiness, K–12 learning and engagement, educational attainment, access to high-quality early learning programs, access to supportive school and classroom environments, access to high-quality curricula, and the extent of racial, ethnic, and economic segregation. Within each of the seven domains are indicators that highlight disparities in access to opportunities and resources and student outcomes among equity dimensions such as race/ethnicity, sex, English learner status, disability status, rural/urban status (i.e., locale), and various socioeconomic status metrics such as parental education and school poverty level.

Contingent on the availability of funding, NCES could develop subsequent versions of the dashboard in FY 2024. Subsequent versions of the dashboard could incorporate graphical renderings of key data elements, include data on additional indicators and equity dimensions, and present data at lower geographic level, including State and local levels, pending resource availability.

Question. An estimate of chronic absenteeism indicates that the number of students missing 10 percent or more of the school year doubled from 8 million students before the pandemic to an estimated 16 million students in 2021–2022.

How would the budget help States and school districts reverse this dramatic and unfortunate expansion?

Answer. The President's FY 2024 Budget Request recognizes that chronic absenteeism remains a persistent educational challenge and includes a variety of resources to combat its effects, including Title IV–A Student Support and Academic Enrichment Grants, which States and school districts can use flexibly for activities to promote student attendance and engagement. In addition, the Department may use funds from the request for Title IV–A Student Support and Academic Enrichment Grants to continue to support the Student Engagement and Attendance Center, a national center that identifies and disseminates evidence-based practices and provides technical assistance in understanding and addressing the causes of chronic absenteeism.

Question. What steps have been taken to understand the extent to which chronic absence data reported through EDFacts is aligned to state and local definitions and whether a common definition would assist an understanding of the extent of and solutions to chronic absences?

Answer. According to data reported to the Department by State educational agencies (SEAs) via EDFacts file FS195, 8.3 million students were reported as chronically absent in school year 2018–2019, prior to the pandemic. As of school year 2021–2022, 14.8 million students were reported as chronically absent.

The Department requires SEAs to report in accordance with the reporting instructions within EDFacts file specification 195. States are instructed to report students at each school in which they enroll for at least 10 days and are absent 10% of the school year. As a result, when aggregated to the district, state, and national levels the student counts are duplicative. Additionally, a student absence is defined as a student who is not physically on school grounds and not participating in instruction or instruction-related activities at an approved off-grounds location for at least half the school day. While the Department expects SEAs to align their data collections to the reporting requirements in FS195, it is important to note that chronic absenteeism is not defined in statute or regulations. Thus, the Department has limited authority to enforce the common definition set within FS195. During the pandemic, States were given flexibility to report chronic absenteeism data using different definitions than in prior years due to the impact of remote learning on taking attendance. Therefore, data during the years impacted by the pandemic are not comparable across years and are not expected to fully align with the reporting requirements in FS195. For more information on how states were advised to report Chronic Absenteeism and other data, please review the Department's fact sheet on reporting data (https://oese.ed.gov/files/2020/12/SY-19-20-COVID-Fact-Sheet-Final-11.19.20.doc). While more comparable to pre-pandemic school years than SY2019–2020 and SY2020–2021, the Department believes the SY2021–2022 are still impacted by the pandemic.

During the Department's routine data verification process, States continued to cite COVID–19 as part of the reason for the increase in students reported as chronically absent. For example, one State indicated that LEAs continued to provide remote instruction throughout SY2021–2022 and another State indicated that there were periods of remote instruction resulting from peaks in COVID–19 infection rates. During these periods of remote instruction, an absence was reported differently than it was for in-person instruction resulting in variability within the data.

Question. Education's Office for Civil Rights is charged with ensuring education programs that receive Federal assistance comply with Federal civil rights laws that prohibit discrimination on the basis of race color, national origin, sex (including gender identity and sexual orientation), age and disability. Recent appropriations bills have provided significantly less than the President's request.

Please describe the impact of those unfortunate decisions on timely and thorough resolution of complaints filed with OCR and its ability to vigorously enforce civil rights laws under its jurisdiction.

Answer. Reducing the resources available to OCR would mean a significant reduction in OCR's capacity to promptly resolve complaints regarding alleged discrimination that may be denying students access to federally funded education programs and activities. OCR received 18,804 complaints in FY2022, the highest number in OCR's history, with 24 fewer full time equivalent staff than OCR had in FY2013 when OCR received 9,950 complaints (and also needed more staff at that time to efficiently and effectively process those complaints). OCR processes these new incoming cases against an enormous backlog of cases already on our docket: on the first day of this Administration, OCR had 1,058 cases pending that were more than 4 years old. Reducing resources would impede the resolution of many complaints based on disability, race, and sex that are brought to OCR by students and by parents on their children's behalf. Investigating discrimination allegations often involves detailed witness interviews, document review, and onsite visits. In one recently resolved case, OCR interviewed 136 school district employees, students, parents, and others and conducted a week-long site visit at six schools, in addition to reviewing documents and information provided by the school district. To be able to fulfill OCR's charge to assess whether the law is violated with the volume of complaints OCR is receiving and to provide families and school communities timely and effective responses to their concerns, OCR needs additional staffing. For more detailed information about OCR's enforcement of Title VI of the Civil Rights Act of 1964 (Title VI), Title IX of the Education Amendments of 1972 (Title IX), Section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, Title II of the Americans with Disabilities Act of 1990 (Title II), and the Boy Scouts of America Equal Access Act of 2001, please see OCR's most recent annual report to Congress for FY2022.

Question. Please describe current activities and enhancements enabled by the fiscal year 2024 budget to ensure the right of every child to attend school free from discrimination including based on their sexual orientation, gender identity, or gender expression.

Answer. To date in FY2023, OCR has brought on approximately 50 new investigators in OCR regional enforcement offices based on OCR's FY 2023 budget, which in turn has strengthened OCR's capacity to vigorously enforce Congress's commitments to federally funded educational opportunities free from unlawful discrimination. The new staff are responsible for investigating all forms of discrimination under the Federal civil rights laws enforced by OCR. OCR resolved the second highest number of complaints in OCR history during FY 2023, which was nearly double the number of complaints resolved in FY 2019. These resolutions include, for example, ensuring that K–12 schools provide equal access to athletic opportunity for girls, that limited English proficient parents received information about their children's education in the languages they understand, that schools are physically accessible to students with disabilities and that students with disabilities receive the supports to which they are entitled for equal access to education, and that antisemitic harassment in K–12 schools and colleges and universities is effectively addressed and ended.

In addition, OCR has issued new policy resources to assist students, parents and educators better understand how we enforce the laws under our jurisdiction. Recent materials include fact sheets and other resources on Title VI Diversity & Inclusion Activities, Protecting Students from Discrimination Based on Shared Ancestry or Ethnic Characteristics, a joint Dear Colleague Letter on Postsecondary Online Accessibility with the Department of Justice, a Title VI Dear Colleague Letter on Addressing Discrimination Against Jewish Students, a Title VI Resource on Confronting Racial Discrimination in Student Discipline, and three resources on Title IX & Athletic Opportunities.

Question. The Nita M. Lowey 21st Century Community Learning Centers program provides critical support to communities for the establishment or expansion of before- and after-school programs and summer school programs that enable students to access additional learning and engagement opportunities. States are required to subgrant at least 93 percent of their share of funds for such centers, including by prioritizing certain types of proposals.

Please provide the number and descriptions of subgrant priorities established by States for each of the past 5 years.

Answer. The Department does not currently collect data on the number or descriptions of subgrantee priorities established by State educational agencies (SEAs). This information is typically located on the SEA's request for application (RFA). The Department does periodically request State RFAs, which include this information through monitoring and other communications with the State. In our monitoring protocol, for example, we request a copy of the most recent State RFA; however, monitoring reviews for 21st CCLC are conducted for only four to 10 States annually. In addition, note that a State is not required to conduct a competition annually. An SEA's competition in which they publish their RFA may be in three to five-year cycles. Additionally, recently the Department released draft non-regulatory guidance for the 21st Century Community Learning Centers, which encourages certain best practices for districts' and states' consideration based on decades of program implementation.

Question. In A Pragmatic Future for NAEP: Containing Costs and Updating Technologies released last year, the National Academies of Sciences, Engineering and Medicine made recommendations related to innovations for meeting the cost- effectiveness of the National Assessment of Educational Progress while maintaining or improving its technical quality and the information it provides. The IES fiscal year 2023 operating plan identified actions planned to address recommendations of the report.

Please provide a copy of the independent expert study of NAEP cost structures and contracting which NCES commissioned.

Answer. The contract for the independent expert study of NAEP cost structures and contracting was awarded in March and the work is progressing well. More information on the scope of the contract is available in the Request for Quote that the Department released on January 6, 2023 (https://sam.gov/opp/da139fc59d1c4957adbdf21a5fa03d28/view#:~:text=has%20issued%20a-,Request%20for%20Quote,-for%20The%20Review). The contractor's final report is scheduled for completion by the end of calendar year 2023. NCES is looking forward to sharing the study when it is complete.

Question. Please provide a copy of the independent audit of NAGB financials for fiscal years 2017 through 2021.

Answer. In September 2022, the Governing Board commissioned an independent audit of its financials for the period of FY2017 through FY2021. Auditors completed the first stage of the audit (review of contracts and expenditures) in January 2023. Attached is the final report from this first stage, which found NAGB to be "a prudent steward of public financial resources over the budget execution process".

Because the Board relies upon ED for administrative support and entity level controls for contracting, purchasing, financial management system, and key business processes, the auditors did not have access to sufficient information to conduct the second stage of the audit (review of NAGB's internal controls and compliance). Therefore, NAGB requested to be included in OFO's annual auditing conducted for each office within ED. For each area of financial auditing, we have provided OFO with documentation to review for compliance.

Initial communications from OFO indicate that the Governing Board is fully compliant with each risk assessment area for internal controls.

1. Control Environment
2. Risk Assessment
3. Control Activities
4. Information and Communications
5. Monitoring

OFO plans to issue a report for all ED offices, including the Governing Board, in July 2023. A link to the IBS audit report is available here. Follow up actions on the recommendations are underway.



11611 Greenlane Drive
Potomac, MD 20854

Contract # Number 91995922P0009

Financial Auditing Services for the National Assessment Governing Board

Independent Auditors' Financial Report: FY2017-FY 2021

January 3, 2023

Background

IBS Government Services (IBS) is an 8(a) Small Disadvantaged Business and Financial and Accounting Firm located in Potomac, MD. IBS provides recognized experts and thought leaders to provide, improve, and deliver intelligent business solutions (IBS) supporting Financial Management, Audit Remediation, Agency Compliance, Enterprise Risk Management, and Information System efforts. The National Assessment Governing Board (NAGB) has contracted IBS to perform an independent financial audit to review costs pertaining to all aspects of the Governing Board's financial operations over a 5-year period (FY17-FY21).

We have performed an assessment of the NAGB's Budget Execution process (to include Contract spending, Purchase Cards, Travel, and Other Expenses), which comprises five years' worth of consolidated financial information from Fiscal Year 2017 to Fiscal Year 2021. Our consideration for the assessment is based on a limited in scope substantive sample testing described in the assessment paragraph below.

Methodology

Substantive testing is an audit procedure in which we gathered samples to identify any material misstatements records or other information pertaining to NAGB's key business process. The evidence gathered is required to support an assessment of the financial records are complete, relevant, and accurate. Our audit testing procedures were limited in scope in that we focused our audit procedures on these Key Business Processes. The audit procedures focused on NAGB's Budget Execution over Contract Spending, Purchase Cards, Travel, and other Expenses processes. Our audit test procedures were conducted in accordance with the Financial Audit Manual (FAM), OMB Circular A-123 (A-123), and Government Auditing Standards (GAS).



Audit test work consisted of looking at 80% of sample transactions for key business process over a five-year period (FY17-FY21), as shown in the table below:

Total Coverage			
FY	Total Amount	Total Amount Selected	% Covered
FY17-FY21	$ 24,311,889.12	$19,206,483.56	80%

Total contract values sampled are highlighted in the table below:

Contracts			
FY	Total Amount	Amount Selected	% Covered
2017	$ 7,743,000.00	$ 5,993,556.00	77%
2018	$ 7,521,358.32	$ 5,990,292.37	80%
2019	$ 861,982.13	$ 712,208.01	83%
2020	$ 6,885,555.66	$ 5,302,851.30	77%
2021	$ 1,152,461.14	$ 1,090,336.14	95%
	Total Contract Amount	Total Amount Selected	Total Covered
	$ 24,164,357.25	$ 19,089,243.82	79%

Purchase Cards			
FY	Total Amount	Amount Selected	% Covered
2017	$1,585	$1,475	93%
2018	$18,367	$13,162	72%
2019	$5,525	$4,576	83%
2020	$1,102	$1,059	96%
2021	$2,215	$1,810	82%
	Total Contract Amount	Total Amount Selected	Total Covered
	$ 28,794.00	$ 22,081.72	77%

Travel			
FY	Total Amount	Amount Selected	% Covered
2017	$ 7,601.17	$ 6,597.72	87%
2018	$ 48,195.55	$ 37,716.39	78%
2019	$ 40,433.04	$ 32,025.12	79%
2020	$ 17,668.06	$ 15,152.92	86%
2021	$ 4,840.05	$ 3,665.87	76%
	Total Contract Amount	Total Amount Selected	Total Covered
	$ 118,737.87	$ 95,158.02	80%

Assessment

In our assessment, the financial information related to the substantive testing referred to is presented fairly, in all material respects. NAGB showed to be a prudent steward of public financial resources over the budget execution process.

Management's Responsibility for the Financial Statements

NAGB Management is responsible for the preparation and fair presentation of the financial information in accordance with U.S. generally accepted accounting principles. This includes the design, implementation, and maintenance of internal controls relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement.

Auditor's Responsibility

Our responsibility is to perform an assessment on the budget execution process based on that financial information provided. We have conducted our assessment in accordance with auditing standards generally accepted in the United States of America, in accordance with the standards applicable to financial audits contained in Government Auditing Standards issued by the Comptroller General of the United States, and in accordance with Office of Management and Budget (OMB) Bulletin No. 21-04, Audit Requirements for Federal Financial Statements.

Internal Controls and Compliance

In performing our assessment, we considered NAGB's internal controls over financial reporting as a basis for designing our audit test procedures. We understand that NAGB relies on administrative support and entity level controls from the Department of Education headquarter offices for its contracting, purchasing, financial management system (i.e., Oracle Federal Financials) and key business processes. The documentation related to these systems is provided for reference purposes only to provide background information on internal controls and compliance that NAGB follows based on ED guidance However, sufficient evidential matter and documentation could not be obtained to make a specific assessment on NAGB's own internal controls environment. Therefore, we express no opinion on the assessment of NAGB's internal controls environment.



Government Services

Washington, D.C. January 6, 2023

Recommendations

Basis for Recommendations

The objective of the Federal Managers' Financial Integrity Act of 1982 (FMFIA) is to provide reasonable assurance for the following:

- Obligations and costs are compliant with applicable laws and regulations
- Funds, property, and other assets are safeguarded against waste, loss, unauthorized use, or misappropriation
- Revenues and expenditures applicable to agency operations are properly recorded and accounted

A-123, requires the documentation of the key business processes and the internal controls over those key business processes should be prepared by staff knowledgeable in the respective areas. In addition to documenting the key processes and related controls, the agency needs to document its assessment methodology and how key decisions were made during the planning step of the assessment process. Management is responsible for developing and maintaining internal control activities that encompass the following five categories:

1. Control Environment
2. Risk Assessment
3. Control Activities
4. Information and Communications
5. Monitoring

In addition, A-123 requires that management perform monitoring activities that include direct testing of the controls as part of the assessment process, and a separate assurance statement from management on the effectiveness of internal control over financial reporting. This assurance statement should be incorporated into management's overall assurance statement provided under the requirements of the FMFIA, The Department of Education FMFIA Manual, and Departmental Directive ACSD-OFO-002, and NAGB's Internal Controls Guide Document 2022. These documents are appended to this report as provided by NAGB, without any IBS comment or review.



Government Services

Recommendations Summary

We have identified five recommendations related to A-123 compliance that may help to improve efficiency and effectiveness of management resources related to NAGB's key business processes in supporting the FY2025 NAGB's Strategic Vision of (1) Serving as a catalyst for action to improve student achievement, (2) Inspiring improvement in the quality of assessments and standards, and (3) Telling the stories of American achievement for all, over time and in context.

Recommendation #1

We recommend that NAGB establish a standing work group to assure compliance with A-123 requirements, and perform all relevant activities described in the above paragraphs (relating to the basis for recommendations). The group would be responsible for performing all compliance activities related to A-123 in the five categories referenced above (Control Environment, Risk Assessment, Control Activities, Information and Communication, and Monitoring).

Recommendation # 2

We recommend that NAGB document on an annual basis, update and maintain all end-to-end relevant key business processes. It is necessary to distinguish business processes established and managed by the Department's Office of Chief Financial Officer, and internal processes that are established and followed by NAGB. Appendix XX provided by NAGB to IBS describes the ED specific guidance for individual offices to assure that NAGB processes follow ED's protocol for financial controls, monitoring and reporting.

The level of detail in the documentation should help ensure management understands the entire NAGB financial reporting process and can identify how processes relate to financial reporting assertions, potential errors or misstatements, and control objectives. Other financial reporting process documentation considerations could include:

- A walkthrough of all key business processes including examples of the processing documents
- Process relationship to financial statement line items, significant accounts, group of accounts, and major classes of transactions
- Inputs, activities, and outputs in place to accomplish the processes control objectives
- Identification of key financial reporting controls and systems used to support the process
- Performance measures used by management to ensure operational controls are in place
- Monitoring activities in place to ensure controls are functioning properly
- Relationships to other financial reporting processes

The identified key business processes that we deem relevant are as follows (of note some of these processes may be done at the Department of Education level – as noted by an asterisk):

- Budget Planning, Spending and Reporting
  - Budget Formulation
  - Budget Execution
  - Budget Reporting
- Hire to Retire
  - Accession/Rescission*
  - Payroll*
  - Benefits*
- Procure to Pay
  - Contracts
  - Purchase Cards (Individual Accounts) *
  - Travel Cards*
  - Centrally Billed Account for Group Travel) *
  - Other Expenses

Recommendation #3

We recommend that NAGB develop Standard Operating Procedures (SOP) for all relevant key processes for each major key business process area. Development of SOP will help ensure that job functions are fully described with staff roles and responsibilities for each business area to assure protocols are followed for regular operations relevant to the quality consistent with NAGB's missions and objectives. The purpose of a SOP is to carry out the operations in compliance with Federal accounting standards and guidelines and consistently to assure adherence to documented procedures.

Recommendation #4

We recommend that NAGB identify, document, maintain, and test all internal controls for each key business process area annually (to include performing a risk assessment for each internal control). Performing annual internal control review and testing of the NAGB business processes will help meet the following NAGB financial and operational objectives:

- Safeguard NAGB organization assets
- Help prevent fraud, waste, and abuse
- Help promote efficiency and effectiveness to help achieve NAGB goals and objectives
- Minimize and help ensure accuracy of NAGB records
- Compliance to Laws and regulations (such as OMB Circular A-123 and FMFIA)

Question. Please identify the stakeholder groups engaged and summary feedback in developing a better understanding of risks and benefits of reduced contact administration of NAEP.

Answer. NCES has met with a range of key stakeholder groups, including the Council of Chief State School Officers, the Council of the Great City Schools, State and district leadership, the NCES Principals Panel, as well as the NAEP field staff who administered a field test of the first phase of NAEP's reduced contact administration plan. Please see the table below for a list of meetings.

Feedback so far has been similar across stakeholder groups. Stakeholders have provided feedback on both NAEP's plans for device-agnostic administration, which includes using schools' Internet access and eventually their computers and a reduced reliance on NAEP-provided devices, as well as NAEP's plans for reduced contact administration, which involves sending fewer NAEP field staff to schools and asking school staff to help more with the administration of NAEP.

Stakeholders recognize the cost benefits for the NAEP program in reducing the number of testing devices the program will need to obtain and maintain, as well as in reducing the number of NAEP field staff hours needed to administer NAEP. Moreover, they recognized the potential improvement for the student experience and validity of the assessment by allowing students to use school equipment, which will be more familiar to them than NAEP-provided equipment.

However, stakeholders have expressed concerns regarding the difficulty for schools and districts to implement a reduced contact NAEP when fewer NAEP field staff are sent to schools. NAEP's relative convenience to administer is a selling point for district and school buy-in, which some of the planned changes would reduce by shifting some labor burden onto schools. They are concerned that schools and districts are facing staffing shortages that will make it challenging to provide more staff support for administration of NAEP. They are also concerned about potential conflicts between the needs of State assessments and NAEP, both for staff time and device configuration.

NCES will continue to reach out to stakeholders affected by the planned changes and adjust our plans to obtain cost reductions without risking the administration of NAEP or our relationships with our key partners in States, districts, and schools. We would be pleased to continue to discuss our plans with you as we move forward. The next major step in these efforts is the 2024 operational administration of NAEP. The 2024 administration will include the following features related to device-agnostic and reduced contact administration:

—Administration on a combination of NAEP-provided Surface Pros and NAEP-provided Chromebooks (no school-based testing devices in 2024)

—Use of schools' Internet access where possible

—A first phase of reduced contact administration that relies mainly on improved software and processes to reduce the number of field staff required, but also includes the use of school staff, where available, to support proctoring of some sessions for students requiring administration separate from the main school group administration

Plans for the 2024 administration will incorporate lessons learned from the 2023 field test as well as our outreach to stakeholders.

Table. Meetings with Stakeholder Groups on NAEP Reduced Contact Administration:

Spring 2023

Stakeholder Group	Group Purpose	Date of Interaction	Type of Interaction
The Council of Chief State School Officers (State Task Force)	In conjunction with the National Assessment Governing Board (NAGB), the State task force meets to provide support to NAGB and NCES.	03/07/2023	Presentation
NCES Principals Panel	The principals panel is a collection of public and private school principals that gathers to provide support and recommendations to NCES.	03/10/23	Presentation
The Council of the Great City Schools (TUDA Task Force)	In conjunction with the National Assessment Governing Board (NAGB), the TUDA task force meets to provide support to NAGB and NCES.	03/17/23	Presentation
Chief State School Officers	NCES communicates directly to Chiefs each year about upcoming assessment activities.	04/10/23	Letter
NAEP State and TUDA Coordinators	State and TUDA coordinators serve as liaison between the NAEP program and State and TUDA districts.	4/18/23	Webex
NAEP Field Staff Virtual Debriefing	NAEP field staff work with schools to coordinate and administer the NAEP assessments.	04/19/23	Webex
State Assessment Directors	State Assessment Directors serve as a stakeholder group for NCES who provide technical and outreach expertise.	05/04/23	Presentation

Question. The calculation of current expenditures used under the ESEA excludes ESEA Title I–A funding. The amount of funding provided for COVID education relief, particularly through the Elementary and Secondary School Emergency Relief Fund (ESSER), is significantly more funding than is provided annually through Title I–A.

Has the Department analyzed current expenditure data submitted by States to assess how state shares of formula grants shift from previous years as a result of the inclusion of COVID relief funds? What are the findings of such assessment?

Answer. The Department has not conducted an analysis on how state shares of formula grants have shifted from previous years as result of the inclusion of COVID–19 relief funds.

By the end of September 2023, the Department expects to have received from States preliminary current expenditure data for fiscal year 2022 that will include COVID–19 education relief expenditures as part of the current expenditures reported and the COVID–19 education relief expenditures also reported separately by seven specific sources of funds including ESSER I, ESSER II, ARP ESSER, GEER I, GEER II, CRF, and ARP Act SLFRF.

The majority of states will be able to report on the new variables. However, some states are only able to collect data from LEAs on grants that are allocated and

awarded through the state department of education. These states may not be able to report on grants that flow through to LEAs from other agencies, such as the State and Local Fiscal Recovery Funds. In these cases, states may report on only that data which is available and should provide appropriate explanations in their state notes. Some states also expressed concerns about the additional burden of the new survey codes. In some cases, states lack the resources required to make programming changes to their collection and reporting systems.

Once the Department has received these data, we will be in a position to immediately deduct data for COVID–19 relief funds from Current Expenditures, to reach Net Current Expenditures. This will allow for an analysis of the impacts of these funds on allocations.

Question. Average daily attendance (ADA) is a factor that is included in several Federal elementary and secondary education program formulas. Education extended flexibility to states with respect to reporting ADA during the pandemic.

Did this flexibility result in reliable ADA counts or could an entity be advantaged or disadvantaged in the determination of formula grants based on the counting method that it used?

What did the Department's analysis of the impact of COVID–19 on ADA reporting and grant allocations reveal?

Answer. The Department uses average daily attendance (ADA) counts reported by States to calculate State Per Pupil Expenditures (SPPE) by dividing net current expenditures for each State by its ADA. The Department then uses SPPE data to allocate funds appropriated for several formula grant programs. In addition to using the SPPE data as general information on the financing of elementary and secondary education, the Secretary uses these data directly in calculating allocations for certain formula grant programs, including, but not limited to, title I, part A, of the ESEA, Impact Aid, and Indian Education. Other programs, such as the Education for Homeless Children and Youth program under title VII of the McKinney-Vento Homeless Assistance Act, and the Student Support and Academic Enrichment Grants under title IV, part A of the ESEA, make use of SPPE data indirectly because their formulas are based, in whole or in part, on State title I, part A, allocations.

Under the Elementary and Secondary Education Act, as amended, States are permitted to report ADA using either their State's definition or the Federal statutory definition used by NCES:

> (i) the aggregate number of days of attendance of all students during a school year; divided by
> (ii) the number of days school is in session during that year. [20 U.S.C.§ 7801(1)].

As a result of the COVID–19 pandemic, virtually all LEAs closed schools for some period to ensure the safety of students and teachers, which complicated the collection and reporting of ADA data. On January 27, 2021, the NCES Commissioner and the Deputy Assistant Secretary for Elementary and Secondary Education sent a letter to Chief State School Officers that addressed the Department's plans to collect ADA data from States for the 2019–2020 and 2020–2021 school years (https://oese.ed.gov/files/2021/05/20-0127-ADA-Letter.pdf) For fiscal year 2020, States were given two possible options for reporting ADA:

—Option 1 allowed States to report attendance for all students until the date that school facilities closed for in-person learning due to COVID–19, which effectively meant that they ended the school year early for reporting purposes. Anything after the closure of in-person learning was excluded from both the numerator and the denominator.

—Option 2 allowed States to report attendance for all days that school was in session and for which attendance was collected, including remote learning days which occurred due to COVID–19. States could report under this option even if they were unable to report for all schools or local educational agencies (LEAs) or if some schools or LEAs had a temporary inability to report attendance.

NCES and the Census Bureau examined the impact of COVID–19 on ADA and SPPE and presented their findings at the American Education Finance and Policy Association conference in March of 2022. They addressed the following research questions:

1. Did the method for reporting ADA have an impact on the rate of change in ADA?
2. Do states that included attendance for remote learning days which occurred due to COVID–19 have a higher increase in ADA than states that did not?

In FY 2020, almost half of all States, DC and Puerto Rico collected and reported ADA for the entire school year, which included attendance for remote learning days

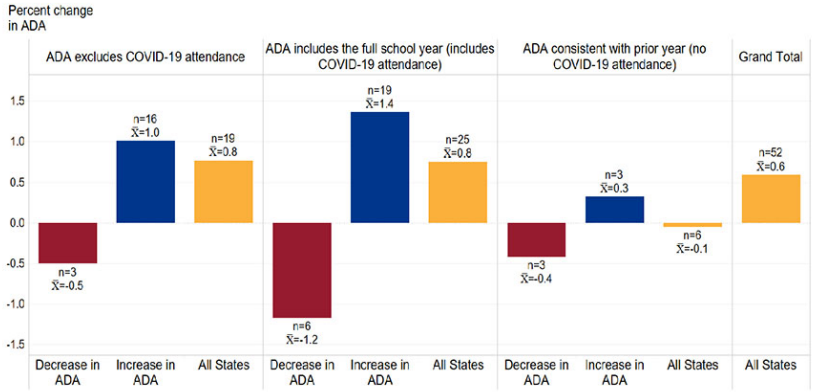
which occurred as a result of COVID–19. Just over one third of States ended the school year early for reporting purposes and excluded attendance for COVID–19. NCES/Census found that:

—In States that excluded COVID–19 attendance, 3 States had a decrease in ADA (averaging 0.5 percent) and 16 States had an increase (averaging 1 percent). In States that included COVID–19 attendance and reported for the full school year, 6 States had a decrease (averaging 1.2 percent) and 19 States had an increase (averaging 1.4 percent).

—In States that reported ADA consistently with the previous year, three States had a decrease (averaging 0.4 percent) and three States had an increase (averaging 0.3 percent).

—In conclusion, even though States that included COVID–19 attendance have larger increases and decreases than those that excluded COVID–19 attendance, the average change in ADA is about the same (0.8 percent).

Average percentage change in ADA by reporting method and direction of change: FY 19 to FY 20



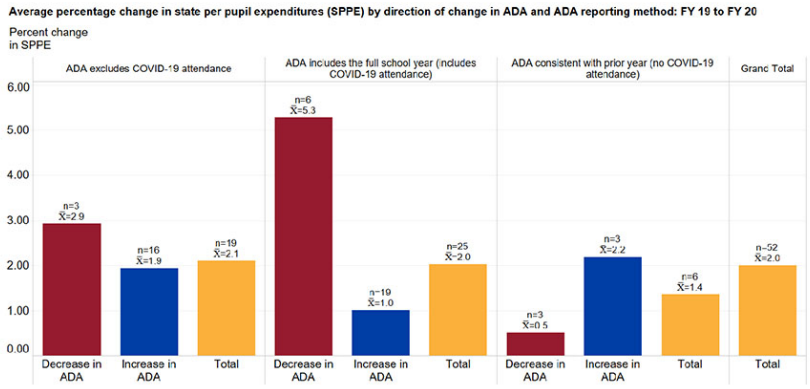
NCES/Census also examined the percentage change in State Per Pupil Expenditure (SPPE) by direction of change in ADA and the ADA reporting method and found that:

—Among States that did not include COVID–19 attendance, the 3 States with decreases in ADA had an average increase in SPPE of 2.9 percent. The 16 States with increases in ADA had an average increase in SPPE of 1.9 percent.

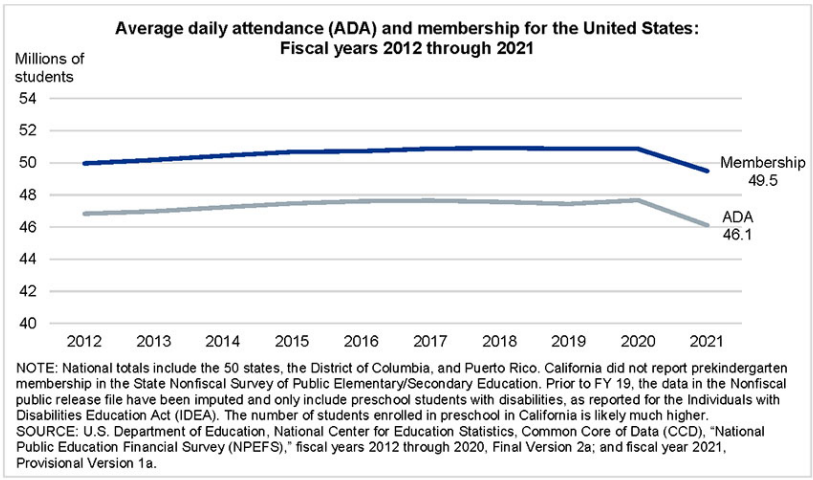
—Among States that included attendance for the full school year, the six States with decreases in ADA had an average increase in SPPE of 5.3 percent. The 19 States with increases in ADA had an average increase in SPPE of 1 percent.

—Among States that reported ADA consistent with the previous year, the three States with decreases in ADA had an average increase in SPPE of 0.5 percent and the three States with increases in ADA had an average increase in SPPE of 2.2 percent.

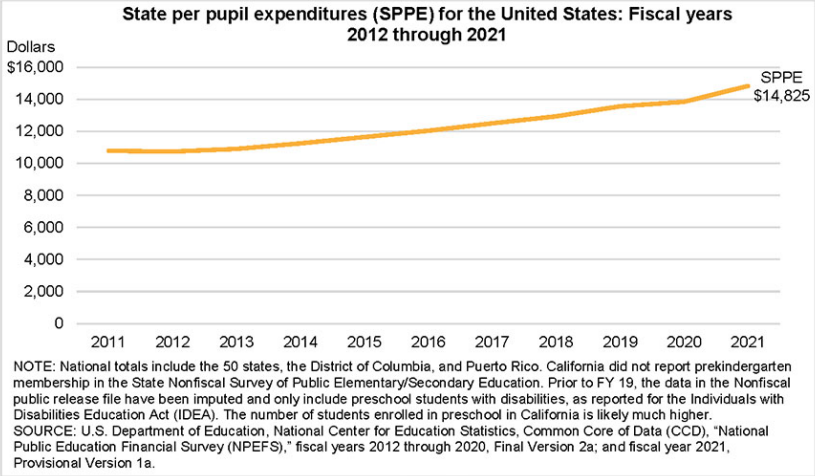
In conclusion, if ADA decreases (as shown in red bars below), then increases to SPPE are mostly larger than increases to SPPE when ADA is increasing (as shown in blue bars below). However, these differences tend to average out across each reporting method (as shown in yellow bars below), so there does not appear to be a difference in the rate of change in SPPE according to how ADA is reported. Instead, the change in SPPE is more closely dependent upon the change in net current expenditures.



Based on these findings, we have determined that the ADA reporting method appears to have no impact on changes to FY 2020 ADA. SEAs were not advantaged nor disadvantaged in the determination of formula grants based on the counting method that they utilized. There is no evidence that the increase in FY 2020 ADA is related to whether ADA includes attendance for remote learning during the COVID–19 pandemic. ADA reports could have been affected by the way in which remote learning attendance is counted, as well as transmission rates of COVID–19 in school districts, and the ability of students to access remote learning, which may explain why large increases and decreases in ADA were reported by some States. ADA has a minimal impact on SPPE in FY 2020, resulting in a smaller average increase in SPPE than previous years, but the rate of change in SPPE is more closely dependent upon the change in net current expenditures.



ADA increased from FY 2012 to FY 2017; slightly declined in FY 2018 and FY 2019; and slightly increased in FY 2020. ADA dropped by 3.28 percent in FY 2021 (from 47.7 million students in FY 20 to 46.1 million students in FY 21). This drop in ADA is matched by a 2.71 percent drop in membership (from 50.9 million students in FY 20 to 49.5 million students in FY 21).



SPPE has been increasing every year since FY 2012, but in FY 2020, the rate of increase is slightly smaller than it was in previous years. In FY 2021, SPPE increased by 7.2 percent.

Question. Alarming rates of mental health issues in our youth indicated more must be done by our schools and communities to help address the significant mental and emotional toll the pandemic has had on our nation's students. Programs designed to address a student's social, emotional, and academic development can have a transformational impact in helping to address these challenges facing students. Furthermore, these programs can help to equip educators with the skills and resources necessary to better address the complex and evolving needs of their students. That is why Congress continued to robustly support social emotional learning initiatives and other whole child approaches in recent appropriations bills, including the Education Innovation and Research program, Supporting Effective Educator Development program, Full-Service Community Schools, and more.

Please describe how increased investments in social emotional learning initiatives and other related efforts can help to better equip educators with the skills and resources necessary to address student needs, and how might the Department help support these programs and other efforts to create a positive and healthy school climate and culture for all students?

Answer. Within the Education Innovation and Research (EIR) grant portfolio, 43 grantees currently focus on social emotional learning with many educator development project activities. Rock Island School District's "How Are the Children" project provides monthly professional development to principals as well as training for teachers on the SEL curriculum. Center for Supportive Schools provided training (11 in-person sessions) as well as coaching to faculty advisors who support student peer leaders in a project that helps sixth grade students successfully transition to middle school. The New Teacher Center is focused on regionally scaling their project ("Advancing Social and Emotional Learning Integrated with Rigorous Content through a Whole-School Professional Learning Model") and includes efforts to prepare coaches to provide SEL-anchored support. There are numerous examples of other innovation projects that equip educators to create positive school climate; for example, San Diego Unified School District's Coding Our Future project includes training for computer science teachers to serve as lead learners who model growth mindsets and foster student relationship building. Additionally, technical assistance from the EIR program office includes an ongoing SEL community of practice for grantees (for example, discussions about SEL resource mapping as a pre-implementation task so educators can connect and leverage disparate resources), multiple project directors' meeting sessions focused on SEL (as well as a session on Ensuring Effective Implementation of Innovations with tips on how to effectively leverage professional learning and coaching), and various public-facing products; examples include "Covid-19: A Look at How EIR-Funded Projects Are Supporting SEL Needs of Students and Teachers and Mediating Learning Gaps" (recording), Connecting

Theory to SEL Practice (recording), and Designing and Implementing Social Emotional Learning Programs to Promote Equity (paper).

The Full-Service Community Schools (FSCS) program requires grantees to implement the four pillars of community schools (integrated student supports, expanded and enriched learning time and opportunities, active family and community engagement, and collaborative leadership) at each school. The four pillars are supported by the Science of Learning and Development Alliance [3] and are used to address the needs of the whole child, including those children and youth whom school and community partners determine to be the most underserved. Implementation of coordinated activities, programs, and strategies aligned with the four pillars allows applicants to develop projects with greater fidelity to evidence-based practices [4] that have been shown to be associated with improvements in teaching, learning and student outcomes.

Specific to mental and behavioral health, integrated student supports at a community school provide in- and out-of-school support for students, address well-being, and address out-of-school barriers to learning through partnerships with social and health service agencies, including mental and behavioral health agencies and providers, and coordinated by a community school coordinator. Services may include (i) Medical, dental, vision care, and mental and behavioral health services, including mental health literacy for students and staff, trauma-informed services to prevent, intervene, and mitigate adverse childhood experiences; and (ii) Individuals to assist with housing, transportation, nutrition, citizenship preparation, or criminal justice issues and other services.

Addressing student barriers to learning, such as mental and emotional health challenges, makes learning possible. It provides both students and teachers with support, which allows teachers to focus on instruction. Through a competitive preference priority—Meeting Student Social, Emotional, and Academic Needs—the FSCS program also encourages grantees to develop and implement projects that build trusting relationships between students, educators, families, and community partners; provide multi-tiered systems of support; and comprehensive school frameworks that support strong and consistent student and educator relationships.

The Bipartisan Safer Communities Act (BSCA) provides the Department with additional funding to support student social, emotional and mental health needs. A total of $1 billion in formula grant funding was provided under the Stronger Connections Grant Program to help schools establish safe and healthy learning environments for all students. Additionally, the Department received $1 billion over 5 years for competitive grants to expand the number of qualified mental health service providers in schools, and recently awarded $286 million to 264 grantees to increase the training, hiring, and diversification of mental health professionals through two grants—the School-Based Mental Health grant program and the Mental Health Service Professional Demonstration grant program. Consistent with the requirements of the BSCA, the Department is working to support states and districts in directing these resources to the schools and communities with the greatest need and where funds may have the most impact.

Question. Students in foster care face enormous obstacles to accessing and succeeding in school, including frequent home and school changes, missing credits, unreliable access to appropriate support services, confusion over education decision-making authority, and inconsistent access to special education services. These students have higher rates of absenteeism than their peers; lower test scores on standardized tests; and are three times more likely to drop out of school. New requirements included in The Every Student Succeeds Act require state education agencies to ensure students in foster care remain in their school of origin unless it is not in their best interest and to collaborate with child welfare agencies on plans for providing cost-effective transportation for students to remain so enrolled, among other requirements.

What steps is the Department alone and in coordination with the Department of Health and Human Services to strengthen partnerships between State and local education and child welfare agencies necessary to support educational stability and improve education outcomes of children in foster care?

Specifically, how will this coordination support implementation of requirements related to remaining in school of origin; making best interest determinations; and

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[3] Science of Learning and Development Alliance. (2020). Science of Learning and Development: Initial Findings. https://soldalliance.org/wp-content/uploads/2021/12/SoLD-Science-Translation__May-2020__FNL.pdf.

[4] Learning Policy Institute & Turnaround for Children. (2021). Design principles for schools: Putting the science of learning and development into action.

planning for transportation needed to remain in school of origin, among other requirements intended to improve education for children in foster care?

Answer. The Department continues to support the implementation of the ESEA requirements to ensure the educational stability of students in foster care. The U.S. Department of Health and Human Services (HHS) remains a key partner in the implementation of these requirements. Staff from the Department's Office of Elementary and Secondary Education regularly collaborate with staff from HHS' Administration for Children and Families. We have jointly facilitated national webinars and conference sessions, jointly released information about the unique educational needs of students in foster care (including, for example, a write-up posted to each agency's official blog), and shared information from each agency's stakeholders and grantees. Staff from the two agencies are in active discussions about opportunities for collaboration throughout the final quarter of fiscal year 2023 and fiscal year 2024.

In its direct engagements with grantees, the Department continues to emphasize the importance of thoughtful, sustained collaboration between child welfare agencies and educational agencies to effectively support students in foster care. For example, during subrecipient monitoring activities, the Department assesses whether each State educational agency has established routines for collaboration with its partners in child welfare, as required under the ESEA. Where there is no evidence of such collaboration, the Department issues findings and requires grantees take affirmative steps to establish such collaborative routines. Through these subrecipient monitoring activities the Department also assesses the extent to which State educational agencies support the development and maintenance of collaborative relationships between school districts and local child welfare agencies. For example, during monitoring we examine whether there is collaboration and joint decisionmaking in school placement determinations and providing school of origin transportation for students in foster care.

Interagency collaboration also remains a cornerstone of the Department's technical assistance provided to grantees and other stakeholders. For example, the Department continues to support educational agencies in the development, implementation, and enhancement of interagency data-sharing agreements and routines with child welfare. In early 2023, the Department published a suite of documents profiling data-sharing routines from eight States across the country, and the Department will continue to focus on the importance of interagency data-sharing through upcoming technical assistance. Planned technical assistance includes a community of practice involving foster care points of contact from State educational agencies and State child welfare agencies, as well as data stewards from these State agencies. The Department's technical assistance plan for the coming year also includes various activities that will be available to foster care points of contact from both educational agencies and State child welfare agencies, including a webinar series and a national convening; interagency collaboration will be a key focus of each of these activities. To model the importance of interagency collaboration, the Department has committed to involve partners from HHS, as appropriate and feasible, in each of these technical assistance projects. Over the summer, the Department will release a Dear Colleague letter to chief State school officers underscoring the need for a continued focus on interagency collaboration to address the unique needs of students in foster care. The Department will also continue to fund the Foster Care Exchange, a virtual platform launched in 2021 in partnership with the Department's National Comprehensive Center, to allow foster care points of contact to collaborate with one another in between more formal technical assistance touch points with one another.

Question. Please describe the Department's plan for ensuring states and school districts comply with ESSA's policy requiring the reporting of actual personnel and non- personnel expenditures, disaggregated by Federal, state and local source of funds for each school and school district and such information is made available to the public in an accessible and understandable manner.

Answer. The Department is taking several steps to ensure that SEAs and LEAS meet the report card requirements in ESEA section 1111(h), including the requirement to post per pupil expenditures that include actual personnel and non-personnel expenditures, disaggregated by Federal, state, and local source of funds for each school and school district and such information is made available to the public in an accessible and understandable manner. To help facilitate compliance with these requirements, the Department released non-regulatory guidance on State and local report cards in September 2019 (available at: https://oese.ed.gov/files/2020/03/report-card-guidance-final.pdf).

To help ensure SEAs and LEAs comply with applicable requirements, a complete review of State and local report cards is included in the Department's Title I, Part A monitoring protocols, which are found at: https://oese.ed.gov/offices/office-of-

formula- grants/school-support-and-accountability/performance-review/. An important aspect of our consolidated monitoring is a thorough review, for each State monitored in a particular year, of the State's report card to ensure that it includes all required elements.

In addition, for the past 4 years, the Department has conducted a review of each State's website to determine if SEAs and LEAs were in compliance with report card requirements, looking at a subset of the requirements each year. This work begins in January to review the report cards for the prior school year. This year, the Department reviewed State and local report cards for:

—Per-pupil expenditure information (ESEA section 1111(h)(1)©(x) and 1111(h)(2)(C)).

—The State's list of schools identified for comprehensive support and improvement, targeted support and improvement due to consistently underperforming subgroups, and additional targeted support and improvement (CSI, TSI, and ATSI, respectively) (ESEA section 1111(h)(1)(C)(i)(V)).

—Educator data, including information regarding inexperienced teachers, principals, and other school leaders, information about teachers teaching with emergency or provisional credentials, and information about out-of-field teachers (ESEA section 1111(h)(1)(C)(ix).

—Performance on the other academic indicator for public elementary and secondary schools that are not high schools (ESEA section 1111(h)(1)(C)(iii)(I)).

—Performance on the school quality or student success (SQSS) indicator for all students and disaggregated by each student subgroup (ESEA section 1111(h)(1)(C)(v).

We have been following up with each State that is missing any of the information reviewed. Similar to prior years, the Department will send letters to all States that have not posted the items above following our report card review this summer.

The Department also continues to provide on-going technical assistance to States to help them improve the collection, reporting, and use of these data. We have established communities of practice with States, districts, and other stakeholders to discuss these requirements. We ran a competition for interested individuals to partner with States to design interactive report card websites and to report per-pupil expenditure data. Through the Department's National Comprehensive Center, we have funded external experts to provide tools and resources for States and districts to support the reporting and use of expenditure data.

Question. How many competitive grant programs will include an evidence priority in fiscal years 2023 and 2024?

Answer. The Department uses evidence in many of its grant competitions, either as "entry evidence," which involves elements in the application to align projects with a particular threshold, or "exit evidence," which is defined as elements to develop lessons learned from the review of the program interventions.

For FY23, the Department is running 66 discretionary grant competitions. 37 Competitions include entry evidence requirements or priorities, and 7 competitions involve exit evidence. For a more detailed breakdown of these requirements, please see the table, below. We will have data for FY24 during the FY24 fiscal year.

	Entry	Exit
Total	37	7
Demonstrates a Rationale	33	–
Promising Evidence	2	3
Moderate Evidence	1	2

Question. For programs in which the evidence requirement of demonstrates a rationale, how is the Department supporting ongoing efforts of grantees to evaluate the effects of such activities, interventions or strategies? Please also describe the ways in which the Department is supporting or plans to support evidence building and use in ESEA formula grant programs.

Answer. The Department continues to support grantees in building and using evidence in its grant programs, including ESEA formula grant programs, in multiple ways.

One key component of this support is the Comprehensive Centers program, which operates a National Center and 19 Regional Centers. The Comprehensive Centers program offers high-quality universal and targeted capacity-building services, including in the area of implementing and scaling evidence-based practices, to State educational agencies (SEAs), regional educational agencies (REAs), local educational agencies (LEAs), and schools to improve educational outcomes for all students, close achievement gaps, and improve the quality of instruction. The Comprehensive Cen-

ters Network and other technical assistance providers also identify evidence-based interventions that support states and school districts in using evidence in the work supported by their ESEA formula grants. Recently, the Comprehensive Centers have led several communities of practice related to evidence-building and use, including the Evidence-Based Interventions: Using ARP Resources to Accelerate Learning Community of Practice (CoP), to identify and collectively address problems of practice related to ensuring effective and sustainable use of ARP funding to support learning recovery/learning acceleration. Through the use of improvement science and peer exchanges, SEA teams deepen their capacity to support LEAs in identifying and selecting evidence-based interventions to accelerate learning. Participants in the CoP also piloted tools to help SEAs and LEAs consider levels of evidence to support their interventions using logic models, including a tool on using Logic Models to Chart a Path to Success. This tool is designed to help SEAs and LEAs to evaluate the impact of education policies, programs, and practices. It includes examples of high-dosage tutoring and summer learning and enrichment programs to show users how to build and use logic models that can be used to monitor implementation, guide evaluation activities, and inform communications around the results of educational investments.

In addition, the Department builds evidence through its grant competitions. Notably, the Education Innovation and Research (EIR) program generates evidence that the Department can share with grantees who receive formula funds.

The Department also provides support through the Regional Educational Laboratories (RELs) program, which the Institute of Education Sciences (IES) administers. The RELs program supports ten Regional Educational Laboratories (RELs) that collaborate with school districts, state departments of education, and other education stakeholders to help these stakeholders translate and apply evidence, with the goal of improving learner outcomes. RELs can help analyze data to support state and local decisionmakers, identify existing evidence, make plans to build evidence, assist with designing and piloting research-based innovations, and support rigorous evaluations.

The Department provides non-regulatory guidance and tools to assist in building and using evidence. Recently, the Office of Education Technology developed an EdTech Evidence Toolkit to support educational leaders in using evidence to inform decisions about educational technology adoption based on the four tiers of evidence identified in the ESEA. The Department also plans to offer updated guidance as a resource that is applicable across programs for building and using evidence.

Next steps that build on programs using a "demonstrates a rationale" level of evidence are often specific to individual programs and grantees. Grantee reporting on performance measures can be one step in the process of further evidence building. In addition, program teams and IES support grantees in providing information to the Education Resources Information Center (ERIC). In planning new competitions, the Department considers emerging evidence, including from recent cohorts of grantees, in identifying appropriate levels of evidence.

Question. Please describe how proposals to increase the amount available for and expand the scope of the National Clearinghouse for English Language Acquisition would better meet state-identified challenges in meeting the needs of English Learners.

Answer. The Department's intent with the requested increase in funding and expanded scope for the National Clearinghouse for English Language Acquisition is to provide technical assistance to SEA's and LEA's to amplify programs such as dual language and seal of biliteracy. Currently, the Office of English Language Acquisition (OELA) does not provide technical assistance on these areas. The Department aims to support the Secretary's Raise the Bar initiative to promote multilingualism.

Question. The Department recently closed the comment period on a Request for Information (RFI) that seeks examples of successful approaches to the Innovation Assessment Demonstration Authority (IADA), which is granted under Title 1, Part B of The Every Student Succeeds Act (ESEA). The program allows the Secretary to grant State educational agencies the authority to establish innovative state assessment systems that better align with the needs of all students.

What is the Department's plan to implement the feedback given on IADA, and how will the FY24 budget support these activities?

Please provide an update on how the Department is using the funding Congress provided for assessment development in fiscal year 2021, 2022 and 2023 to encourage states to improve their statewide assessments to provide more timely and relevant data to educators and stakeholders.

Answer. The Department received over 8,800 comments in response to the RFI and is currently reviewing and evaluating these comments. No definite actions for the IADA have been planned as of yet.

With respect to the funding provided by Congress, the Department has focused the Competitive Grants for State Assessments (CGSA) program on supporting innovation in assessments. In 2020, the Department established priorities to support States in both planning for and implementing IADA. In the most recent CGSA competition in 2022, the Department focused on applications that (a) propose measuring student achievement using multiple measures and (b) evaluate student achievement through assessments that emphasize the mastery of standards and aligned competencies in a competency-based education model. Across these two competitions (in 2020 and 2022), the Department funded 13 projects focused on new assessment designs and 3 States received funding directly related to IADA planning or implementation. In 2022 alone, the Department awarded approximately $28 million in CGSA grants from FY2021 and FY2022 funding to fund 11 SEA applications. You can see here a description of the grants funded in the past two competitions: https://oese.ed.gov/offices/office-of-formula-grants/school-support-and-accountability/competitive-grants-for-state-assessments/awards/.

With the FY2023 funds ($20 million), the Department anticipates continuing to use CGSA to support State innovation in student assessment. The next CGSA grant competition (using FY23 funds) is planned for the 2023–2024 school year with funds awarded before September 2024.

In addition, States may use their formula grants under Title I, Part B of the ESEA ($369.1 million annually under the ESEA) to support the improvement of State assessments for these purposes.

With respect to the Department's FY2024 budget, we proposed additional funding under CGSA for a new $100 million for a proposed new demonstration program to assist school districts in developing high-quality formative and diagnostic assessments.

QUESTIONS SUBMITTED BY SENATOR PATTY MURRAY

Question. What are the Department's plans for evaluating and strengthening its monitoring and support for the use of funds provided by the Elementary and Secondary School Emergency Relief Fund (ESSER) in the American Rescue Plan Act (ARP) for evidence-based strategies to tackle learning loss and help students get back on track, particularly students disproportionately impacted by the pandemic?

Answer. The Department implements a robust system of monitoring and oversight of the Emergency and Secondary School Emergency Relief (ESSER) Fund consisting of routine monitoring activities, both formal and informal, and annual performance reporting to ensure that pandemic relief funds are used lawfully and appropriately, and in compliance with all applicable requirements. Each type of monitoring corresponds to specific protocols and evaluation goals. Over the course of the last year, the Department conducted an analysis of its monitoring processes and protocols and implemented new routines and protocols for providing oversight and support in fiscal year 2023, outlined below.

The Department's revised approach to oversight begins with all grantees participating in monthly calls that cover timely programmatic and fiscal topics. These engagements are important opportunities to provide timely technical assistance to grantees, as well as identify issues related to program compliance that may result in determining that a grantee requires more formal, intensive monitoring. Additionally, all States undergo monitoring through Biennial Reviews, topic-specific reviews conducted with all 50 States, the District of Columbia, and Puerto Rico. Reviews focus on high-priority aspects of program implementation, such as monitoring LEA uses of funds, stakeholder engagement, and SEA reservations. (The Department, in revising its oversight plan for this fiscal year, identified that monthly touch points coupled with reviews that happen on a biennial, rather than quarterly basis, was a more strategic approach to proactively identifying potential compliance issues and addressing grantee technical support needs.)

To date, the Department has conducted two biannual reviews of all grantees. The first review, conducted in the spring and summer of 2022, focused on American Rescue Plan (ARP) ESSER awards to LEAs and the required 20 percent set-aside to address the academic impact of lost instructional time. The second review, conducted in the winter of 2023, focused on the awarding of funds under the Governor's Emergency Education Relief (GEER) Fund and subrecipient grantee oversight. The next review will occur in the fall of 2023. A focus area has not yet been identified for this review.

Further, the Department conducts Targeted Monitoring occurs when the program office determines there is a risk of noncompliance in a specific area of implementation based on a grantee's course of action during the grant performance period. For

example, Targeted Monitoring was conducted in 2021 for three grantees after each drew down ninety percent of their available Coronavirus Aid, Relief, and Economic Security Act balances from the Department's grants management system. Currently, the Department does not have any Target Monitoring events underway or planned for the rest of the fiscal year.

Last, the Department conducts Comprehensive Monitoring or Consolidated Monitoring for select grantees identified based on a risk assessment or as the result of a known compliance issue. Comprehensive Monitoring consists of a full programmatic and fiscal review focused only on a grantee's pandemic-relief programs. This type of monitoring evaluates the systems and processes a grantee uses to implement its program, in addition to reviewing each grantee's identified pandemic-relief program for compliance. Similarly, Consolidated Monitoring also reviews a grantee's systems and grants management processes to ensure compliance with Federal requirements; however, Consolidated Monitoring is a cross-program review of a grantee's implementation of its full portfolio of K–12 formula grants, for both pandemic-relief funding and Elementary and Secondary Education Act of 1965 (ESEA) formula grant programs administered by OESE.

Thus far, four States have participated in Comprehensive Monitoring—California, Indiana, Maine, and Wisconsin. The Department will conduct a Comprehensive Monitoring of New Jersey's ESSER and Emergency Assistance to Non-Public Schools programs in the fall of 2023. Additional States will be identified for Comprehensive Monitoring in FY 2024 this summer.

Thus far, six pandemic-relief program grantees have participated in Consolidated Monitoring. Four States—Florida, Kentucky, Nebraska, and Tennessee—were required to take corrective actions to address findings of noncompliance with Federal requirements. Two States, Washington and Maine, have monitoring determinations pending that will be finalized soon. Additionally, the Department will conduct Consolidated Monitoring of New Mexico in the fall of 2023. Soon additional States will be identified for Consolidated Monitoring in FY 2024.

Pandemic-relief program monitoring events are led by no less than two program staff and may result in reports that identify a grantee's lack of compliance, and the need for additional program support and technical assistance. Given the limited number of staff managing the pandemic-relief programs, as well as Department budget limitations, the Department must be strategic in selecting grantees that will be monitored in a fiscal year and in determining which grantees will receive on-site monitoring.

The Department's monitoring plan and protocols for K–12 pandemic relief programs, revised annually, reflect the subsequent awarding of the Coronavirus Response and Relief Supplemental Appropriations (CRRSA) Act and ARP Act funds. Updates to the plan and protocols assess new program requirements, including the uses of funds to address lost instructional time and for the purposes of construction and renovation. Additionally, these revised protocols help the Department identify areas of need for technical assistance. The updated ESSER monitoring protocols are available on the Office of Elementary and Secondary Education's (OESE's) website: https://oese.ed.gov/offices/education-stabilization-fund/elementary-secondary-school-emergency-relief-fund/esser-comprehensive-monitoring-protocols/.

In FY 2024, the Department, as planned support for ARP grantees, is investing in focused technical assistance and capacity-building support to States, to spend remaining recovery funds in ways that are most likely to accelerate student learning and achieve equitable outcomes, build capacity to monitor and evaluate the effectiveness of programs and plan for fiscal sustainability of their investments. Through a series of virtual and in-person events, that incorporate what has been learned through monitoring, the Department will support States to develop sustainability plans that identify existing or new funding sources to support effective and equitable investments, to integrate the sustainability plans into ongoing and future spending decisions, and to establish processes for ongoing evaluation of the effectiveness of programs and continued impact of ARP funds that lead to equitable opportunities for lasting improvements in all student outcomes.

Question. How will the Department monitor and support improvements to the targeting and effectiveness of the evidence-based interventions being implemented by State educational agencies and local educational agencies, particularly for students disproportionately impacted by the pandemic?

Answer. The Department's monitoring of States, using its revised protocols starting in spring 2023, ensures that grantees are monitoring local educational agencies (LEAs') implementation of the set-aside, including targeting resources to student groups demonstrating the greatest need. Additionally, the Department's protocols include a heightened focus on States using data to assess the effectiveness of their own and their LEAs' chosen evidence-based interventions. In instances where an

SEA may indicate a need for assistance with improving its systems to ensure adequate support and oversight for LEAs in the use of the learning loss set-aside, the Department will direct the grantee to technical assistance providers with relevant expertise and capacity to support the grantee.

Question. How does the Department plan to support the use of Federal funds, including school improvement funds, to sustain effective and necessary ESSER-supported investments in future years?

Answer. Annually, the Department awards grants to states to support ongoing and sustainable efforts to help students succeed academically. The ESEA authorizes Title I funding to support student success through various including tutoring, pre-K and summer and extended-day programs. Title I serves 25.6 million students across the country. Since the beginning of the administration, the Department has worked to increase Title I funding by almost $2 billion.

In addition, funds under Title II of the ESEA support improvements in the quality and effectiveness of teachers and school leaders in K–12 schools and high-quality teaching to students in need. Title III of the ESEA authorizes funds to support English learners in meeting the state's challenging academic standards through language instructional educational programs. Title III serves 4.9 million students. Title IV of the ESEA authorizes funds to improve students' academic achievement by increasing the capacity of States, local educational agencies, schools, and local communities to (1) provide all students with access to a well-rounded education; (2) improve school conditions for student learning; and (3) improve the use of technology in order to improve the academic achievement and digital literacy of all students. Together, Titles I, II, III, and IV provide nearly $23 billion for the country's most vulnerable students.

The Administration has also worked to ensure compliance with two key fiscal equity provisions that will sustain education funding. Through the statutory Maintenance of Effort provision, the Department requires States to maintain their overall commitment to education spending. Through the ARP Act's Maintenance of Equity provision, the Department requires States to ensure that any reductions that do occur protect high- poverty schools and students from disproportionate impacts.

With respect to the question about how we will support the work in future years, the Department is compiling information and best practices through the Best Practices Clearinghouse and other methods, and we will continue to encourage States and districts to look at the activities that are proving effective and find ways to blend and braid funds from all available sources to continue them. Additionally, the Department will provide focused technical assistance in this area through the Comprehensive Center program in FY2024.

Regarding school improvement, in the "Frequently Asked Questions: Impact of COVID–19 on 2021–2022 Accountability Systems Required under the Elementary and Secondary Act of 1965 (ESEA)," the Department encouraged SEAs to address the impact of the pandemic and lost instructional time as part of the school support and improvement plans, which could include leveraging multiple funding sources and aligning school improvement efforts with evidence-based interventions to address lost instructional time. The Department encouraged States to help LEAs and schools to focus on evidence-based approaches that have been demonstrated to be effective at improving opportunities and outcomes for students (see FAQ D–1).

Question. The fiscal year 2023 explanatory statement directed the Department to provide technical assistance to state and local Title I directors on the requirements and uses of funds under section 1113(c)(3)(A) to assist LEAs in effectively using such funds to support students experiencing homelessness and work with SEAs to increase transparency on amounts reserved by LEAs under section 1113(c)(3)(A). In response, the Department has outlined a number of actions to improve compliance with these requirements, including by working with SEAs to ensure they provide guidance on coordination between the LEA's Title I and McKinney-Vento staff and provide training on methods for determining set-asides.

Please identify the timeline for implementing each of the activities planned to improve compliance with related requirements of ESEA and respond to this directive.

Answer. In April 2023, through our TA contractor for the McKinney-Vento program, the National Center for Homeless Education (NCHE), the Department released a pre-recorded webinar on the "Title I, Part A Reservation of Funds for Students Experiencing Homelessness" at Self-Paced Online Training—National Center for Homeless Education. This will complement existing ED non-regulatory guidance and NCHE technical assistance on this topic available at: https://nche.ed.gov/legislation/title-1-part-a/.

In FY 2022, the Department released an updated monitoring plan for the Education for Homeless Children and Youth (EHCY) and the American Rescue Plan Homeless Children and Youth (ARP–HCY) programs. (See the current version here:

https://oese.ed.gov/files/2022/09/SSA-EHCY-ARP-HCY-Monitoring-Plan-FY-23.pdf.)
This also includes a section on the Title I–A set-aside for homeless children and youth. As is often the case when we introduce a new section of our monitoring, this new monitoring topic has resulted in more "actions required" and "recommendations" than other topics. This will help us think about future technical assistance ideas. For example, we are finding that most Title I–A LEA homeless set-aside amounts vary widely in per-pupil amount across districts within a state (i.e., when they are divided by the count of students experiencing homelessness identified by the LEA). In 2023, our required actions are focusing on ensuring that the SEA is providing guidance on systematic coordination between the district's Title I and McKinney-Vento staff—providing training to LEAs and reviewing these set-asides in the district's Title I or consolidated Federal program applications based on homeless enrollment data and students' educational needs. In the next year, we expect to include this information in our regular meetings with McKinney-Vento State Coordinators and Title I State Directors.

In FY 2024, for the first time, SEAs are submitting to the Department a file on Title I set- asides for SY 2022–23 that will include, by district, the initially reserved amounts of the homeless set-asides. AS is often the case when we introduce new data elements, we expect it will take few years of the collection for data quality to improve. NCHE is already developing a data collection tool to be released in summer 2023 to support SEAs in submitting complete accurate data (it will be posted at Data Collection—National Center for Homeless Education).

Also, in FY 2024, NCHE is planning new data analyses comparing the district's Title I set- aside and homeless enrollment counts. As we have done in the past with prior NCHE data analyses, we will make this available to SEAs by August 2024 and NCHE will provide assistance about how to understand and use the data.

Finally, the NCHE contract allows for States to request targeted or intensive technical assistance. Often States request TA before or after our monitoring events that can address the Title I–A homeless set-aside requirement and ways to analyze them for sufficiency. State Coordinators also often request additional support in understanding their data workbooks.

Question. The Comprehensive Literacy State Development Grants program provides resources to improve literacy instruction in high-need schools and early childhood education programs, including through instruction in evidence-based literacy methods for children from birth through 12th grade. In awarding grants, the Secretary is required to give priority to State educational agencies that will use the grant funds for evidence-based activities.

What steps are planned to support an in increase in the percentage of evidence-based activities implemented by subgrantees that meet the requirements of moderate or strong evidence?

Answer. As a condition of funding, CLSD State Education Agency (SEA) applicants were required to explain the extent to which their proposed project would use Federal funds for evidence-based activities. Consistent with Section 8101(21)(A)(i) of the Elementary and Secondary Education Act of 1965, as amended (ESEA), evidence-based was defined in the notice inviting applications (NIA) as activities, strategies or interventions that demonstrate strong evidence, moderate evidence, or promising evidence. The program office intends to continue to include this as a requirement in future competitions.

In response to GPRA measure #5 (evidence-based activities) which was published in the Federal Register on April 3, 2020, FY 2020 grantees have reported an overall 11.87% increase from FY 2021 to FY 2022 in "the percentage of evidence-based activities implemented by subgrantees that meet the requirements of strong or moderate evidence in the definition of "evidence-based" found in the NIA.

The CLSD program office staff monitors information submitted by CLSD grantees through their annual performance reports and supports the implementation of evidence-based activities through technical assistance from subject-matter experts via a CLSD Technical Assistance Contract.

Most recently, technical assistance on evidence-based activities was provided to CLSD grantees at the on-site CLSD National Convening in March 2023. Grantees participated in a session focused on exploring the evidence-based recommendations from the Institute of Education Sciences' (IES) practice guide titled Providing Reading Interventions to Students in Grades 4–9 (https://ies.ed.gov/ncee/wwc/PracticeGuide/29). A contributor to the guide, Kim St. Martin, Ph.D., who is the director of Michigan's Multi-Tiered Systems of Support (MTSS) Technical Assistance Center; gave the presentation on Providing Reading Interventions for Students in Grades 4–9. The session covered recommendations from the practice guide, as well as gave an overview of an intervention infrastructure. Following this presentation, Dr. St. Martin facilitated an interactive session with CLSD grantees on "How Prac-

tice Guide Recommendations Apply to CLSD Contexts". Over 100 attendees participated in the meeting and feedback was very positive. One grantee noted that "This whole meeting was really useful. I particularly appreciated learning from other grantees and Dr. St. Martin's presentations that did a great job illustrating the how-to of adolescent literacy intervention."

CLSD SEA grantees report providing technical assistance to subgrantees on implementing activities, strategies and interventions that demonstrate strong evidence, moderate evidence or promising evidence, consistent with the definition in the NIA. However, based on feedback from CLSD program staff, according to grantees, their ability to provide technical assistance and monitor the extent to which subgrantees have implemented evidence-based practices has been hindered due to the lack of adequate resources (i.e., CLSD grantees may only use up to 5% for state-level activities, including monitoring and administrative activities).

Question. How was grantee performance in and plans for implementing evidence-based activities considered in making supplemental awards earlier this year?

Answer. The Office of Elementary and Secondary Education invited existing CLSD grantees to submit proposals for supplemental funding that was consistent with the overall scope and objectives of their approved CLSD grant applications. In the supplemental application, emphasis was placed on the use of CLSD funds to advance literacy skills through the use of evidence-based practices, activities and interventions. CLSD grantees were also encouraged to consider targeted subgrants to support evidence-based programs that ensure high-quality comprehensive literacy instruction for students most in need, including children from low-income families; English learners; and children with disabilities.

Some examples of how grantees are implementing evidence-based activities, strategies and interventions are:

—Building educator and leadership capacity related to the science of reading.

—Identifying high quality instructional materials (HQIM) for LEAs and focusing on multi-tiered and research-based curriculum reviews to select a list of HQIM that subgrantees could choose to implement.

—Aligning evidence-based practices to the State's Comprehensive Literacy Plan.

Question. The Bipartisan Safer Communities Act built on prior funding for the Mental Health Services Professional Demonstration Grants and School-Based Mental Health Services Grants to train and recruit mental health professionals to work in schools and expand school-based mental health services.

How does the Department plan to measure and report on the progress these grants are making and how does the FY 24 budget build on these efforts?

Answer. The Department will use a variety of strategies to measure and review progress for the Mental Health Services Professional Demonstration Grants and School-Based Mental Health Services Grants. These strategies include regular grantee monitoring, review of performance reports that provide data on attainment of program performance measures and program implementation, analysis of performance measures data, and an evaluation to be conducted by the Institute of Education Sciences. In addition, the Department will establish a center dedicated to providing technical assistance to grantees under the mental health programs to support program activities. The fiscal year 2024 budget request would support not just new and continuation awards under these mental health programs, but it would also technical assistance efforts. In addition, any the information gleaned from efforts to measure and review progress and provide technical assistance would inform future efforts and competitions.

QUESTIONS SUBMITTED BY SENATOR RICHARD J. DURBIN

Question. Over the last year, the Department has provided widespread relief to defrauded students through group borrower defense discharge. This relief has totaled nearly $12 billion for 891,000 borrowers. I applaud the Department for taking steps to offer group borrower defense discharge to students, including former students of Corinthian Colleges (Corinthian), ITT Technical Institute, Inc. (ITT Tech), Westwood College (Westwood), DeVry University (DeVry), and Marinello Schools of Beauty. These students were misled by unscrupulous for-profit colleges, and they are not the only students who are crippled with student loan debt and a worthless degree. Since the closure of Corinthian, I have urged the Department to ensure that students are not left holding the bag, and I have supported group borrower defense discharge early on for students who have been defrauded by for-profit colleges. Please provide, disaggregated for Charlotte School of Law, Vatterott Colleges (Vatterott), schools owned by the Center for Excellence in Higher Education

(CEHE), schools owned by the Education Corporation of America (ECA), and schools owned by the Dream Center Education Holdings (Dream Center), respectively:

The number of borrower defense applications that have been received, approved, denied, ineligible, and closed;

Answer. The requested data is provided in the below chart.

School/Ownership Group	Approved under BD Regulations	Denied (Ineligible)	Approved Under Sweet Settlement	Closed	Pending	Total Received
Charlotte School of Law	0	0	1,100	<50	900	2,000
ECA	0	0	8,200	200	9,900	18,300
Dream Center	0	0	27,600	600	27,700	56,000
CEHE	0	0	1,300	<50	2,300	3,600
Vatterott	0	0	1,600	<50	1,700	3,300
Grand Total	0	0	39,800	900	42,500	83,200

Data as of early June 2023; due to rounding, sums may not equal totals.

School ownership group is based on a list of OPE IDs. Please note that the Dream Center numbers reflect cases against schools that were operated by Dream Center as well as cases from borrowers who attended the schools when they were operated by EDMC (prior to them being purchased by Dream Center). Please note, discharges under the Sweet settlement are granted as settlement relief, not as approved borrower defense claims.

Question. The total loan amount of borrowers who the Department estimates are eligible for group borrower defense discharge;

Answer. The Department has not made determinations on the number of borrowers eligible for group discharge from these schools.

Question. The number of borrowers and the total loan amount that has been discharged through a borrower submitting a borrower defense application; and

Answer. None of the borrowers that attended the listed institutions have received borrower defense discharges due to submitting individual applications, however, many of them, as indicated in the chart above, will or have had their loans discharged because they received settlement discharges under the Sweet settlement.

Question. The number of borrowers and the total loan amount that has been discharged through group borrower defense discharge.

Answer. Zero; the Department has not made group discharge findings relating to any of these schools.

Question. Since June 2018, the Department has released borrower defense data on a quarterly basis:

Please provide a breakdown of "total denied" borrower defense claims to date by institution.

Answer. As of June 2023, fewer than ten cases have been denied and not rescinded. Prior denials issued by the Department and provided in earlier reports were rescinded pursuant to the Sweet settlement. The remaining denials had allegations made in the applications that did not meet the regulatory requirements laid out in 34 C.F.R. § 685.206(c)(1). Due to privacy considerations, we are unable to provide a breakdown of the denied cases.

Question. Please provide a breakdown of "total ineligible" borrower defense claims to date by institution.

Answer. Beginning in May 2021, the term "total ineligible" was no longer used in the borrower defense reports. This term was replaced by "total denied." See response to 2b.

Question. Please provide a breakdown of "total closed" borrower defense claims to date by institution.

Answer. An Excel file providing the requested data as of late July 2023 is enclosed.

Closed Borrower Defense Claims by School Name (as of late July 2023)

School Name	Case Count*
No School Name Listed	3600
Heald College	1660
ITT Technical Institute	1550
Everest College	1460
Altierus Career College	1420
Everest Institute	680
WyoTech	600
University of Phoenix	590
DeVry University	510
Everest University	220
Sanford-Brown College	180
Altierus Career Education	160
Purdue University Global	140
Argosy University	130
Marinello School of Beauty	110
Bryman College	100
American InterContinental University	90
Le Cordon Bleu College of Culinary Arts	90
University of Arizona Global Campus (The)	90
Brooks Institute	80
South University	80
Virginia College	80
Westwood College - Denver North	80
Westwood College - Los Angeles	80
Art Institute of Las Vegas (The)	70
Brightwood College	70
Everest College Phoenix	70
Colorado Technical University	60
Everest University - Pompano Beach	60
Illinois Institute of Art (The)	60
Keller Graduate School of Management	60
Anthem College	50
Art Institute of Pittsburgh (The)	50
Capella University	50
Florida Coastal School of Law	50
Grand Canyon University	50
Ross University, School of Medicine	50
Strayer University	50
Daniel Webster College	40
Las Vegas College	40
New England Institute of Art (The)	40
Walden University	40
American Career Institute	30
Art Institute of Atlanta (The)	30

Bryman School of Arizona (The)	30
Career Point College	30
Charlotte School of Law	30
DeVry Institute of Technology	30
Empire Beauty School	30
Heritage College	30
Keiser University	30
Lincoln Technical Institute	30
Minnesota School of Business	30
Star Career Academy	30
Vatterott College	30
Westwood College - O'Hare Airport	30
Art Institute of California - Los Angeles (The)	20
Art Institute of California - San Diego	20
Art Institute of Colorado (The)	20
Art Institute of Philadelphia (The)	20
Art Institutes International Minnesota (The)	20
ATI Career Training Center	20
Brightwood Career Institute	20
Carrington College	20
Chamberlain University	20
Concorde Career College	20
Florida Career College	20
Fortis College	20
Full Sail University	20
Globe University	20
Kaplan College	20
Lincoln College of Technology	20
Medtech College	20
Miami International University of Art & Design	20
Regency Beauty Institute	20
Remington College	20
Ross University School of Veterinary Medicine	20
Westwood College - South Bay	20
Wright Career College	20
American College for Medical Careers	10
American National University	10
American Public University System	10
American University of the Caribbean	10
Anthem Institute	10
Art Institute of Fort Lauderdale (The)	10
Art Institute of Portland (The)	10
Art Institute of Seattle (The)	10
Berkeley College	10
Brooks College	10
Brown Mackie College	10
Brown Mackie College-Cincinnati	10

Centura College	10
Chicago School of Professional Psychology	10
Collins College	10
Dade Medical College	10
Daymar College	10
Drake College of Business	10
ECPI University	10
Harrison College	10
ICDC College	10
Independence University	10
Le Cordon Bleu College of Culinary Arts in Chicago	10
Le Cordon Bleu Institute of Culinary Arts	10
Liberty University	10
Southern New Hampshire University	10
Ultimate Medical Academy	10
United Education Institute	10
Universal Technical Institute	10
Westwood College - DuPage	10
Wilfred Academy of Hair & Beauty Culture	10
Art Institute of New York City (The)	<10
A. T. Still University of Health Sciences	<10
Abilene Christian University	<10
Abraham Baldwin Agricultural College	<10
Academy College	<10
Academy for Nursing and Health Occupations	<10
Academy of Art University	<10
Academy of Court Reporting and Technology	<10
Academy of Esthetics and Cosmetology	<10
Academy of Stenographic Arts	<10
ACT College	<10
Adams State University	<10
Adelphi Business College	<10
Adelphi Technical Institute	<10
Adelphi University	<10
Advance Beauty Techs Academy	<10
Advanced Technology Institute	<10
Alabama Agricultural & Mechanical University	<10
Alameda Technical College	<10
Albany College of Pharmacy and Health Sciences	<10
Albert Merrill School	<10
Albizu University	<10
Allegheny College	<10
Allen School	<10
Alliance University	<10
Alliant International University	<10
Allied American University	<10
Allied Medical and Technical Institute	<10

All-State Career	<10
Alvareita's College of Cosmetology	<10
Alverno College	<10
American Academy of Art College	<10
American Academy of Cosmetology	<10
American Academy of Hair Design	<10
American Academy of Personal Training	<10
American Bartenders School	<10
American Beauty Academy	<10
American Beauty College	<10
American Business Institute	<10
American Business Institute (Closed)	<10
American Career Academy	<10
American Career College	<10
American Career Training Travel School	<10
American Center for Technical Arts & Sciences	<10
American College	<10
American College of Barbering	<10
American College of Education	<10
American College of Hairstyling-Des Moines	<10
American College of Medical Technology	<10
American Commercial College	<10
American Health Institute	<10
American Institute	<10
American Institute of Trucking	<10
American International College	<10
American National College	<10
American River College	<10
American School of Cosmetology	<10
American School of Technology	<10
American University (The)	<10
American University of Antigua College of Medicine	<10
American Vocational Center	<10
Amridge University	<10
Ams College Home Study Division	<10
Anamarc College	<10
Anne Arundel Community College	<10
Antelope Valley College	<10
Antonelli College	<10
Antonelli Institute	<10
Appalachian State University	<10
Arizona Academy of Beauty	<10
Arizona Automotive Institute	<10
Arizona Institute of Electrolysis Div Unif School of AM	<10
Arizona State University	<10
Arizona Summit Law School	<10
Arkansas Baptist College	<10

Arkansas Beauty College	<10
Arkansas Tech University	<10
Art Institute of California-Hollywood (The)	<10
Art Institute of Charlotte (The)	<10
Art Institute of Dallas (The)	<10
Art Institute of Houston (The)	<10
Art Institute of Tucson (The)	<10
Art Institute of York (The) - Pennsylvania	<10
Art of Beauty College	<10
Arthur's Beauty College	<10
Artistic Nails & Beauty Academy	<10
ASA College	<10
Ashland University	<10
Aspen University	<10
ASPIRA City College	<10
Associated Business Careers	<10
Associated Technical College	<10
ATA College	<10
ATI- Career Training Center	<10
ATI College of Health	<10
ATI Technical Training Center	<10
Atlanta Medical Institute	<10
Atlanta Metropolitan State College	<10
Atlanta's John Marshall Law School	<10
Auburn University	<10
Augusta Technical College	<10
Aurora University	<10
Austin Business College	<10
Austin College	<10
Austin Community College	<10
Avalon Institute	<10
Ave Maria School of Law	<10
Aveda Arts & Sciences Institute Covington	<10
Aveda Institute Boise	<10
Aviation Institute Of Maintenance	<10
Avtech Institute	<10
Bacone College	<10
Bailie School of Broadcast	<10
Bainbridge State College	<10
Baker College	<10
Baker University	<10
Baldwin Wallace University	<10
Baltimore City Community College	<10
Barber - Scotia College	<10
Barclay Career School	<10
Barclay College	<10
Barry University	<10

Barstow Community College	<10
Barton County Community College	<10
Baton Rouge Community College	<10
Bauder College	<10
Bauder College Specializing in Career Education	<10
Bay Area Medical Academy	<10
Bay State College	<10
Baylor University	<10
Beaufort County Community College	<10
Beauty Institute (The)	<10
Beauty Institute Schwarzkopf Professional (The)	<10
Beauty Schools of America	<10
Becker College	<10
Beckfield College	<10
Bel - Rea Institute of Animal Technology	<10
Bellevue University	<10
Belmont University	<10
Benedict Business Institute	<10
Benjamin Franklin Cummings Institute	<10
Bentley University	<10
Berks Technical Institute	<10
Bethel University	<10
Big Sandy Community and Technical College	<10
BioHealth College	<10
Black Hills State University	<10
Bloomfield College	<10
Blue Cliff Career College	<10
Blue Cliff College	<10
Blue Ridge Community and Technical College	<10
Blue Ridge Community College	<10
Boca Beauty Academy	<10
Bonnie Joseph Academy of Cosmetology & Barbering	<10
Boricua College	<10
Bossier Parish Community College	<10
Boston College	<10
Boston University	<10
Bowie State University	<10
Bradford College	<10
Bradford School	<10
Bradley University	<10
Bramson ORT College	<10
Branell Institute	<10
Branford Hall Career Institute	<10
Braxton School of Business	<10
BRAZOSPORT JUNIOR COLLEGE	<10
Brenau University	<10
Briarcliffe College	<10

Brittany Beauty Academy	<10
Brittany Beauty School	<10
Broadview College	<10
Brookline College	<10
Brookstone College of Business	<10
Broward College	<10
Brown Mackie College (The)	<10
Brown Mackie College-Findlay	<10
Brown Mackie College-Louisville	<10
Brown Mackie College-Merrillville	<10
Brown Mackie College-North Canton	<10
Brown Mackie College-South Bend	<10
Bryan College	<10
Bryan Institute	<10
Bryan University	<10
Bryant & Stratton Business Institute - Rochester	<10
Bryant & Stratton Business Institute-Albany	<10
Bryant & Stratton College	<10
Bryant and Stratton College	<10
Bryman School	<10
Buchanan Beauty College	<10
Buckner Barber School	<10
Bunker Hill Community College	<10
Burlington College	<10
Business Career Training Institute	<10
Business Etcetera Institute of Technology	<10
Business Informatics Center	<10
Butler Business School	<10
Butler County Community College	<10
Cabot College	<10
CALC, Institute of Technology	<10
Caldwell Community College & Technical Institute	<10
Calhoun Community College	<10
Caliber Training Institute	<10
California Aeronautical University	<10
California Baptist University	<10
California College of Vocational Careers	<10
California College San Diego	<10
California Northstate University	<10
California Polytechnic State University	<10
California School of Court Reporting	<10
California State University - Sacramento	<10
California State University Channel Islands	<10
California State University, East Bay	<10
California State University, Fresno	<10
California State University, Long Beach	<10
California State University, Los Angeles	<10

California State University, Northridge	<10
California State University, San Marcos	<10
Cambria-Rowe Business College	<10
Cambridge College of Healthcare & Technology	<10
Cambridge Techl Inst	<10
Cameo College of Essential Beauty	<10
Campbell University	<10
Canada College	<10
Canisius College	<10
Cape Fear Community College	<10
Capitol City Careers	<10
Capitol City Junior College	<10
Capitol City Trade & Technical School	<10
Capri Institute of Hair Design	<10
Cardinal Stritch University	<10
Career Academy of Beauty	<10
Career Care Institute	<10
Career Colleges of America	<10
Career Colleges of Chicago	<10
Career Institute of Health and Technology	<10
Career Point Business School	<10
Career Quest Learning Centers	<10
Career Technical College	<10
Career Training Academy	<10
Careercom College of Business	<10
Carlow University	<10
Carnegie Career College	<10
Carnegie Institute	<10
Carousel Beauty College	<10
Carson City Beauty Academy	<10
Case Western Reserve University	<10
Cashier Training Institute	<10
Casper College	<10
Cayuga Community College	<10
Cazenovia College	<10
CBM Education Center	<10
CCIC Beauty College	<10
CDA Technical Institute	<10
CDE Career Institute	<10
CDI Career Development Institute	<10
Center for Employment Training	<10
Central Alabama Community College	<10
Central Carolina Technical College	<10
Central Community College	<10
Central Florida Institute	<10
Central Georgia Technical College	<10
Central New Mexico Community College	<10

Central Ohio Technical College	<10
Central State University	<10
Central Washington University	<10
Century College	<10
Cerritos Community College	<10
Chancellor University	<10
Chapman University	<10
Charles A. Jones Career and Education Center	<10
Charles Stewart Mott Community College	<10
Charmayne Beauty Academy	<10
Charter College	<10
Chase College	<10
Chattahoochee Technical College	<10
Chattanooga College - Medical, Dental and Technical Careers	<10
Chemeketa Community College	<10
Cheseapeake Business Inst of Virginia	<10
Chester Career College	<10
Chester College of New England	<10
Cheyney University of Pennsylvania	<10
Chicago State University	<10
Chowan University	<10
Chris' Beauty College	<10
Christine Valmy International School forEsthetics, Skin Care & Make-up	<10
Cincinnati Metropolitan College	<10
Cincinnati State Technical & Community College	<10
CIT College of InfoMedical Technology	<10
City College	<10
City College of San Francisco	<10
Clark Atlanta University	<10
Clark College	<10
Clark State College	<10
Clearwater Christian College	<10
Cleveland Chiropractic College	<10
Cleveland Clinic Educational Fndtn Schoolof Radiologic Therapy Techlgy	<10
Cleveland Institute of Technology	<10
Cleveland University-Kansas City	<10
Clover Park Technical College	<10
Coast Career Institute	<10
Coastal Alabama Community College	<10
Coastal Pines Technical College	<10
Cobb Beauty College	<10
Coconino County Community College	<10
Coleman University	<10
College of Court Reporting	<10
College of Eastern Idaho	<10
College of Health Care Professions (The)	<10
College of New Rochelle (The)	<10

College of Office Technology (The)	<10
College of Saint Mary	<10
College of Saint Rose	<10
College of Southern Idaho	<10
College of Southern Nevada	<10
College of Staten Island/CUNY	<10
College of the Mainland	<10
CollegeAmerica - Flagstaff	<10
CollegeAmerica Denver	<10
Collin County Community College District	<10
Colorado Mesa University	<10
Colorado State University	<10
Columbia College	<10
Columbia College Chicago	<10
Columbia Southern University	<10
Columbia State Community College	<10
Columbia University in the City of New York	<10
Columbus College of Art & Design	<10
Columbus State Community College	<10
Commercial College of Shreveport	<10
Commonwealth International University	<10
Commonwealth University of Pennsylvania	<10
Community College of Baltimore County	<10
Community College of Philadelphia	<10
Compass College of Cinematic Arts	<10
Computer Learning Center	<10
Computer Learning Center of Alexandria	<10
Computer Learning Centers Los Angeles	<10
Computer Systems Institute	<10
Concho Career Institute	<10
Concord Law School	<10
Concorde Career Institute	<10
Concordia College Alabama	<10
Concordia University	<10
Concordia University - Saint Paul	<10
Connelley Technical Institute & Adult Education Center	<10
Consolidated School of Business	<10
Consumer Electronics Training Center	<10
Cornell College	<10
Cornerstone University	<10
Cortiva Institute	<10
Cortiva Institute - Seattle	<10
Cosumnes River College	<10
County Schools Home Study	<10
Court Reporting Institute of St Louis	<10
Court Reporting Institute,Inc	<10
Covenant College	<10

Coyne College	<10
Creighton University	<10
Crescent City School of Gaming & Bartending	<10
Crowder College	<10
Crown College	<10
Cuesta College	<10
CUNY Borough of Manhattan Community College	<10
CUNY Bronx Community College	<10
CUNY John Jay College of Criminal Justice	<10
CUNY Lehman College	<10
CUNY Medgar Evers College	<10
Curry College	<10
Cutting Edge Hairstyling Academy	<10
Cuyahoga Community College	<10
Dakota State University	<10
Dalenas College of Beauty	<10
Dallas Baptist University	<10
Dallas College	<10
Dallas Court Reporting College	<10
Dallas Institute of Funeral Service	<10
Dallas Theological Seminary	<10
Darton State College	<10
Davenport University	<10
Day Spa Career College	<10
Dayton Barber College	<10
Daytona College	<10
Daytona State College	<10
De Anza Community College	<10
Debbies School of Beauty Culture	<10
Decker College	<10
Del Mar College	<10
Delaware County Community College	<10
Delaware County Institute of Training	<10
Delta Career Institute	<10
Delta State University	<10
Demarge College	<10
DePaul University	<10
Des Moines Area Community College	<10
DeSales University	<10
Detroit Engineering Institute	<10
Detroit Institute Of Commerce	<10
DeVry College of Technology	<10
Diablo Valley College	<10
Divers Academy of the Eastern Seaboard	<10
Dominican College	<10
Dominion College	<10
Dorsey College	<10

Douglas J Aveda Institute	<10
Dover Business College	<10
Dowling College	<10
Drake School of Westchester	<10
Draughon Business College	<10
Draughons Business College	<10
Draughons College	<10
Dret School	<10
Drexel University	<10
Duke University	<10
Duluth Business University	<10
Durham Beauty Academy	<10
Durham Technical Community College	<10
East Mississippi Community College	<10
East Ohio College	<10
East Tennessee State University	<10
Eastern Florida State College	<10
Eastern Kentucky University	<10
Eastern Mennonite University	<10
Eastern Michigan University	<10
Eastern Technical School	<10
Eastern University	<10
Education America-Topeka Technical College	<10
Edutek Professional College	<10
Edutek Professional Colleges	<10
El Camino College	<10
Eldorado College	<10
Electronic Computer Programming Inst	<10
Elegance International	<10
Elite College of Cosmetology	<10
Elizabethtown Community and Technical College	<10
Elkin's Inst in Dallas	<10
Elmira College	<10
Elon University	<10
Embry-Riddle Aeronautical University	<10
Emerson College	<10
Empire State University	<10
Empire Technical School	<10
Empire Technical School of New Jersey	<10
ESS College Of Business	<10
Essex Community College	<10
Estrella Mountain Community College	<10
ETI Technical College of Niles	<10
Eugenio Maria De Hostos School of Law	<10
Eureka Institute of Health and Beauty	<10
Everglades University	<10
Evergreen State College (The)	<10

Excelsior University	<10
Fairfield University	<10
Fairleigh Dickinson University	<10
Faith International University	<10
Fashion Institute of Design & Merchandising	<10
FastTrain of Fort Lauderdale	<10
FastTrain of Miami	<10
FastTrain of Tampa	<10
Faulkner University	<10
Felician University	<10
Ferris State University	<10
Fielding Graduate University	<10
First School for Careers	<10
Fisher College	<10
Five Towns College	<10
Flagler College	<10
Flamingo Beauty College	<10
Florence - Darlington Technical College	<10
Florida Agricultural & Mechanical University	<10
Florida Atlantic University	<10
Florida College of Careers	<10
Florida International University	<10
Florida SouthWestern State College	<10
Florida State College at Jacksonville	<10
Florida Technical College	<10
Forrest College	<10
Fort Hays State University	<10
Fortis Institute	<10
Fortis Institute - Towson	<10
Fountainhead College of Technology	<10
Four-D College	<10
Framingham State University	<10
Francis Tuttle Technology Center School District No. 21	<10
Franciscan Missionaries of Our Lady University	<10
Franklin College	<10
Franklin University	<10
Fremont University	<10
French Fashion Academy	<10
Fresno City College	<10
Fresno Technical College	<10
Frostburg State University	<10
G Skin & Beauty Institute	<10
Gaither & Company Beauty College	<10
Galen Health Institutes	<10
Gallaudet University	<10
GateWay Community College	<10
Gateway Electronics Inst	<10

Gateway Technical College	<10
Gene Juarez Academy	<10
Genesis Career College	<10
George Mason University	<10
George Washington University	<10
Georgia Beauty Academy	<10
Georgia Gwinnett College	<10
Georgia Perimeter College	<10
Georgia Piedmont Technical College	<10
Georgia School of Bartending	<10
Georgia Southern University	<10
Georgia State University	<10
Gibbs College	<10
Gibson's Barber & Beauty College	<10
Gino Robair Beauty College	<10
Glendale Career College	<10
Glenwood Beauty Academy	<10
Globe Institute of Technology	<10
Golden State School	<10
Goodwin University	<10
Grambling State University	<10
Grand Rapids Community College	<10
Grand Valley State University	<10
Great Lakes Techl Inst	<10
Green River College	<10
Greenville Technical College	<10
Gretna Career College	<10
Griffin Bellevue Business College	<10
Guilford College	<10
Guilford Technical Community College	<10
Gwinnett College	<10
Gwinnett College-Sandy Springs	<10
Gwinnett Technical College	<10
Hair Design Institute at Livingston Street	<10
Hallmark Institute of Photography	<10
Hallmark University	<10
Hamilton College	<10
Hamline University	<10
Hannibal - LaGrange University	<10
Harcum College	<10
Hardin-Simmons University	<10
Harford Community College	<10
Hargest Vocational Technical College	<10
Harrington College of Design	<10
Harris - Stowe State University	<10
Harris School of Business	<10
Harrisburg Area Community College	<10

Harrison Career Institute	<10
Hartford Techl Inst	<10
Hartwick College	<10
Hausman Computer Associates School of Computer Programming	<10
Hawkeye Community College	<10
HCI College	<10
Heald Business College	<10
Heald College, School of Business	<10
Heald Institute of Technology	<10
Healthy Hair Academy	<10
Helene Fuld College of Nursing	<10
Helms Career Institute	<10
Helms College	<10
Henry Ford College	<10
Heritage Institute	<10
Heritage University	<10
Herzing University	<10
Hill College	<10
Hillsborough Community College	<10
Hinds Community College	<10
Hofstra University	<10
Hollywood Beauty College	<10
Hollywood Institute of Beauty Careers	<10
Holyoke Community College	<10
Hondros College of Nursing	<10
Honolulu Community College	<10
Hope International University	<10
Horry - Georgetown Technical College	<10
Houston Christian University	<10
Houston Community College	<10
Houston Training Schools	<10
Howard University	<10
Hunter Business School	<10
Hutchinson Community College	<10
Hypnosis Motivation Institute	<10
IBMC College	<10
Idaho State University	<10
Idea Career Training	<10
Illinois CareerPath Institute	<10
Illinois School of Commerce	<10
Illinois School of Health Careers	<10
Illinois Wesleyan University	<10
Indian Hills Community College	<10
Indian River State College	<10
Indiana Institute of Technology	<10
Indiana University - Bloomington	<10
Indiana University - Kokomo	<10

Indiana University - Northwest	<10
Indiana Wesleyan University	<10
Institute for Business & Technology	<10
Institute for Health Education (The)	<10
Institute For Therapeutic Massage	<10
Institute of Allied Medical Professions	<10
Institute of Business & Technology	<10
Institute of Culinary Education	<10
Institute of Medical Education	<10
Institute of Production and Recording (The)	<10
Institute of Technical Arts	<10
Institute of Technology	<10
IntelliTec College	<10
Inter American University of Puerto Rico - San German Campus	<10
Interactive College of Technology	<10
Interboro Institute	<10
InterCoast Colleges	<10
Interface College	<10
International Academy of Design and Technology	<10
International Aviation & Travel Academy	<10
International Beauty School	<10
International Business College	<10
International Dealers School	<10
International School of Health, Beauty & Technology	<10
International Technical Institute	<10
International Training	<10
International Training Center (Closed)	<10
Interstate Techl Inst	<10
Iowa Central Community College	<10
Iowa State University of Science & Technology	<10
Itawamba Community College	<10
Ithaca College	<10
Iverson Institute	<10
Ivy Tech Community College of Indiana	<10
Ivy Tech Community College of Indiana - Region 5	<10
Ivy Tech Community College of Indiana - Region 7	<10
J Sargeant Reynolds Community College	<10
Jackson State Community College	<10
Jackson State University	<10
Jacksonville Business and Careers Institute	<10
Jacksonville University	<10
James Madison University	<10
Jamestown Community College	<10
Jay Truck Driving Training Center	<10
Jay's Technical Institute	<10
Jefferson Business College (Closed)	<10
Jefferson College	<10

Jefferson Community and Technical College	<10
Jett College of Cosmetology	<10
John Amico School of Hair Design	<10
John Hopkins University	<10
Johns Hopkins University	<10
Johnson C. Smith University	<10
Johnson County Community College	<10
Jolie Health and Beauty Academy	<10
Joliet Junior College	<10
Jon Louis School of Beauty	<10
Jones International University	<10
Kansas City Business College	<10
Kansas City Kansas Community College	<10
Kaplan Career Institute	<10
Kasturba Medical College	<10
Katharine Gibbs School	<10
Katherine Gibbs School	<10
Kean University	<10
Keene Beauty Academy	<10
Kemper Military School and College	<10
Kenneth Shuler School of Cosmetology & Hair Design	<10
Kenny's Academy of Barbering	<10
Kent State University	<10
Keuka College	<10
Keystone Technical Institute	<10
Kilgore College	<10
Kings College	<10
King's College	<10
Kingsborough Community College/CUNY	<10
Knoxville Institute of Hair Design	<10
Krissler Business Institute	<10
L T International Beauty School	<10
LA College International	<10
La' James International College	<10
Lab Paul Mitchell Partner School (The)	<10
LabourÃ© College of Healthcare	<10
L'Academie de Cuisine	<10
Lackawanna College	<10
Lacy Cosmetology School	<10
Lakes Region Community College	<10
Lakeside School of Massage Therapy	<10
Lamar University	<10
Lambuth University	<10
Lamson College	<10
Lane College	<10
Lane Community College	<10
Langston University	<10

Lansing Community College	<10
Laramie County Community College	<10
Latin Beauty Academy	<10
Lawrence Technological University	<10
Lawton School for Medical and Dental Assistants	<10
Lehigh University	<10
Lehigh Valley College	<10
Lenoir-Rhyne University	<10
Lesley University	<10
LeTourneau University	<10
Lighthouse Career Institute	<10
LIM College	<10
Limestone University	<10
Lincoln College of New England	<10
Lincoln Technical Institute - Hartford	<10
Livingstone College	<10
Logan University	<10
Lone Star College System	<10
Long Beach City College	<10
Long Island Beauty School	<10
Long Island University	<10
Long Technical College	<10
Lorain County Community College	<10
Los Angeles Business College	<10
Los Angeles City College	<10
Los Angeles Community College District Office	<10
Los Angeles Film School (The)	<10
Los Angeles Mission College	<10
Los Angeles Pacific College	<10
Los Angeles Pierce College	<10
Los Angeles Trade-Technical College	<10
Los Angeles Valley College	<10
Louisiana Delta Community College	<10
Louisiana State University at Eunice	<10
Louisiana Technical College - Morgan Smith Campus	<10
Lu Ross Academy	<10
Luzerne County Community College	<10
Madison Area Technical College	<10
Madison Media Institute	<10
Madison Schools	<10
Madisonville Community College	<10
Madonna University	<10
Manchester Community College	<10
Mandl School	<10
Manhattan Beauty School	<10
Manhattan School of Music	<10
Manor College	<10

Mansfield Business College	<10
Marian Health Careers Center	<10
Maric College	<10
Marinello Schools of Beauty	<10
MarJon School of Beauty	<10
Marquette University	<10
Mary Holmes College	<10
Marycrest College	<10
Marygrove College	<10
Maryland University of Integrative Health	<10
Marymount Manhattan College	<10
Marywood University	<10
Mason Anthony School of Cosmetology Arts & Sciences	<10
Massasoit Community College	<10
Massey Business College	<10
Masters of Cosmetology College	<10
Mattia College	<10
Maurice Charles Academy of Hair Styling	<10
Mayville State University	<10
McCann School of Business & Technology	<10
MCI Institute of Technology	<10
McIntosh College	<10
McKendree University	<10
McLennan Community College	<10
McNally Smith College of Music	<10
McNeese State University	<10
MCPHS University	<10
Med Help Training School	<10
MediaTech Institute	<10
Medical Career College	<10
Medical Institute of Palm Beach	<10
Medical University of the Americas	<10
Memphis Institute of Barbering	<10
Menlo College	<10
Mercer University	<10
Mercy College	<10
Meridian Institute of Surgical Assisting	<10
Merit College	<10
Merrillville Beauty College	<10
Mesa Community College	<10
Mesabi Range College	<10
Methodist University	<10
Metro Business College	<10
Metropolitan College	<10
Metropolitan College of New York	<10
Metropolitan Community College	<10
Metropolitan Learning Institute	<10

Metropolitan State University of Denver	<10
Miami - Jacobs Career College	<10
Miami Dade College	<10
Miami Media School	<10
Miami Regional University	<10
Miami University	<10
MIAT College of Technology	<10
Michigan Computer Institute	<10
Michigan State University	<10
Micropower Career Institute	<10
MidAmerica Nazarene University	<10
Mid-Continent University	<10
Middle Georgia State University	<10
Middle Tennessee State University	<10
Middlesex College	<10
Middlesex University	<10
Midland Career Institute	<10
Midland College	<10
Midlands Technical College	<10
Midwest Technical Institute	<10
Midwestern State University	<10
Milan Institute	<10
Milan Institute of Cosmetology	<10
Miles College	<10
Miles Community College	<10
Miller - Motte Technical College	<10
Miller-Motte College	<10
Miller-Motte Technical College	<10
Millersville University of Pennsylvania	<10
Milwaukee Area Technical College	<10
Mineral Area College	<10
Minneapolis Business College	<10
Minneapolis Community and Technical College	<10
Minnesota State University Moorhead	<10
Minnesota State University, Mankato	<10
Mississippi Gulf Coast Community College	<10
Mississippi State University	<10
Mississippi Valley State University	<10
Missouri Baptist University	<10
Missouri College	<10
Missouri Valley College	<10
Missouri Vocational Center	<10
Missouri Western State University	<10
Mitchell Technical College	<10
Mohawk Valley Community College - SUNY Office of Community Colleges	<10
Moler Beauty College	<10
Molloy University	<10

Monmouth University	<10
Monroe College	<10
Monroe Community College	<10
Montana State University - Billings	<10
Montclair State University	<10
Montefiore School of Nursing	<10
Montgomery College	<10
Morehouse College	<10
Morgan State University	<10
Morris Brown College	<10
Morris College	<10
Mount Ida College	<10
Mount Washington College	<10
Mountain State University	<10
Mt. Hood Community College	<10
Mt. Sierra College	<10
MTA School, Resident School	<10
MTI Business College	<10
MTI College of Business and Technology	<10
Muir Technical College	<10
Murray State College	<10
Murray State University	<10
MyComputerCareer at Indianapolis	<10
MyComputerCareer at Raleigh	<10
Nairobi College	<10
Nashua Community College	<10
Nashville Auto-Diesel College	<10
Nashville College of Medical Careers	<10
Nassau Technological Center	<10
Nasson Institute	<10
National Academy of Beauty Arts	<10
National American University	<10
National Broadcasting School	<10
National College	<10
National Education Center Bryman Campus	<10
National Education Center National Institute of Tech Campus	<10
National Education Center National Institute of Technology Campus	<10
National Education Center Temple School Campus	<10
National Education Center, Bryman Campus	<10
National Graduate School of Quality Management (The)	<10
National Holistic Institute	<10
National Louis University	<10
National Park College	<10
National School of Health Technology	<10
National Training	<10
National Training Systems - Correspondence School	<10
National University	<10

National University College-IBC Institute	<10
National University of Health Sciences (The)	<10
Naugatuck Valley Community College	<10
Navarro College	<10
Nettleton Career College	<10
Neumont College of Computer Science	<10
New College of California	<10
New England College	<10
New England College of Business and Finance	<10
New England Institute of Technology	<10
New England School of Acupuncture	<10
New Jersey City University	<10
New Life Business Institute	<10
New Mexico State University	<10
New School, The	<10
New York Career Institute	<10
New York College of Health Professions	<10
New York Institute of Massage	<10
New York Institute of Technology	<10
New York Medical Career Training Center	<10
New York School Of Dog Grooming	<10
Newberry Schools of Beauty	<10
Newbridge College	<10
NHTI - Concord's Community College	<10
Nichols College	<10
Norfolk State University	<10
North American Trade Schools	<10
North Carolina Agricultural and Technical State University	<10
North Carolina Central University	<10
North Carolina Wesleyan University	<10
North Central College	<10
North Central Missouri College	<10
North Hennepin Community College	<10
North Iowa Area Community College	<10
North Park University	<10
Northampton County Area Community College	<10
Northcentral University	<10
Northeast Iowa Community College	<10
Northeast Texas Community College	<10
Northeastern Technical College	<10
Northern Illinois University	<10
Northern Oklahoma College	<10
Northern Virginia Community College	<10
Northwest - Shoals Community College	<10
NorthWest Arkansas Community College	<10
Northwest Hair Academy	<10
Northwest Missouri State University	<10

Northwest Schools	<10
Northwestern College	<10
Northwestern Institute of Health and Technology	<10
Northwestern State University	<10
Northwood University	<10
Norwich University	<10
Nova Southeastern University	<10
NUC University	<10
Oakland Community College	<10
Oakwood University	<10
Odessa College	<10
Ohio Christian University	<10
Ohio College of Podiatric Medicine	<10
Ohio Dominican University	<10
Ohio Media School	<10
Ohio State University (The)	<10
Ohio University	<10
Old Dominion University	<10
Olympic College	<10
Omnitech Institute	<10
Onondaga Community College	<10
Onondaga Cortland Madison BOCES	<10
Orange Coast College	<10
Orange County Business College	<10
Orangeburg - Calhoun Technical College	<10
Oregon Polytechnic Institute	<10
Orion College	<10
Orion Technical College	<10
Our Lady of The Lake University	<10
Ozarks Technical Community College	<10
PACE UNIV ALL CAMPUSES	<10
Pace University	<10
Pacific Coast College	<10
Pacific Oaks College	<10
Pacific Travel Trade School	<10
Paine College	<10
Palm Beach State College	<10
Palomar College	<10
Paris Junior College	<10
Park Avenue School of Cosmetology	<10
Park University	<10
Park West Barber School	<10
Pasadena City College	<10
Pasco - Hernando State College	<10
Patsy And Rob's Academy of Beauty	<10
Paul Mitchell the School - Little Rock	<10
Paul Mitchell The School Costa Mesa	<10

Paul Mitchell the School Green Bay	<10
Paul Mitchell the School Roanoke	<10
Paul Mitchell The School Tinley Park	<10
PCCenter	<10
PCI Health Training Center	<10
Pearl River Community College	<10
Pellissippi State Community College	<10
Pennco Tech	<10
Pennsylvania College of Technology	<10
Pennsylvania Highlands Community College	<10
Pennsylvania School Of Business	<10
Pennsylvania State University (The)	<10
Pensacola School of Massage Therapy & Health Careers	<10
Pensacola State College	<10
Pepperdine University	<10
Phillips College of Chicago	<10
Phillips Colleges	<10
Phillips Junior College	<10
Phoenix College	<10
Phoenix Educational Systems of Pensacola	<10
Piedmont Technical College	<10
Piedmont University	<10
Pierce College	<10
Pierpont Community & Technical College	<10
Pikes Peak State College	<10
Pima Medical Institute	<10
Pinellas Technical College - Clearwater Campus	<10
Pinnacle College	<10
Pitt Community College	<10
Pittsburgh Career Institute	<10
Pittsburgh Technical College	<10
Pivot Point Academy	<10
Platt College	<10
Platt College - San Diego	<10
Plaza Beauty School	<10
Plaza College	<10
Plaza Three Academy	<10
Point Park University	<10
Pontiac Business Institute	<10
Porter and Chester Institute	<10
Porterville College	<10
Portland Community College	<10
Post University	<10
Poteau Beauty College	<10
Prairie View Agricultural & Mechanical University	<10
Praxis Institute	<10
Presbyterian College	<10

Prince George's Community College	<10
Prism Career Institute	<10
Pro Career Center	<10
Professional Business School	<10
Professional Career Centers	<10
Professional Career College	<10
Professional Careers Institute	<10
Professional Skills Institute	<10
Prospect Hall School of Business	<10
PSI Institute	<10
PTC Career Institue of Washington	<10
PTC Career Institute	<10
Pulse Beauty Academy	<10
Purdue University	<10
Purdue University Northwest	<10
Quincy College	<10
Quinebaug Valley Community College	<10
Radians College	<10
Rancho Arroyo Vocational Technical Institute	<10
Rasmussen College	<10
Rasmussen University	<10
Real Barbers College (The)	<10
Refrigeration School (The)	<10
Regent University	<10
Regina's College of Beauty	<10
Remington College - Cleveland Campus	<10
Remington College - Lafayette Campus	<10
Remington College - Mobile Campus	<10
Remington College - New Orleans Campus	<10
Remington College - Tampa Campus	<10
RENO JUNIOR COLLEGE OF BUSINESS	<10
Richard Bland College	<10
Richard J Daley College-City Colleges of Chicago	<10
Ridgewater College	<10
Ridley - Lowell Business & Technical Institute	<10
Ridley-Lowell School of Business	<10
Robert Fiance Hair Design Inst	<10
Robert Fiance Institute of Florida	<10
Robert Morris University Illinois	<10
Roberts Walsh Business School	<10
Rochester Community and Technical College	<10
Rocky Mountain College of Art + Design	<10
Roger Williams University	<10
Rollins College	<10
Roosevelt University	<10
Rosedale Technical College	<10
Ross Medical Education Center	<10

Rosston College	<10
Roswell College of Cosmetology	<10
Rowan University	<10
Roxbury Community College	<10
Roy Jorgensen Associates Truck Driving School	<10
Royal Beauty Careers	<10
Royale College of Beauty and Barbering	<10
RTP Hispanic American College	<10
Rutgers, the State University of New Jersey	<10
SABER College	<10
Saddleback College	<10
SAE Expression College	<10
SAE Institute of Technology, Los Angeles	<10
SAE Institute of Technology, New York	<10
Saginaw Valley State University	<10
Saint Ambrose University	<10
Saint Augustine's University	<10
Saint Francis College	<10
Saint Gregory's University	<10
Saint John's University	<10
Saint Joseph's College	<10
Saint Joseph's University	<10
Saint Leo University	<10
Saint Louis Community College	<10
Saint Paul College - A Community & Technical College	<10
Saint Peter's University	<10
Saint Vincent College & Seminary	<10
Saint Xavier University	<10
Salem University	<10
Salon Academy (The)	<10
Salon Professional Academy (The)	<10
Salt Lake Community College	<10
Sam Houston State University	<10
Samford University	<10
San Antonio College	<10
San Bernardino Beauty College	<10
San Bernardino Valley College	<10
San Diego Christian College	<10
San Diego Miramar College	<10
San Diego State University	<10
San Francisco Art Institute	<10
San Francisco State University	<10
San Joaquin Valley College	<10
Sanford-Brown Institute	<10
Santa Ana College	<10
Santa Barbara Business College	<10
Santa Barbara City College	<10

Santa Fe College	<10
Santa Fe University of Art and Design	<10
Sanz Secretarial School	<10
Sarasota School of Massage Therapy	<10
Savannah College of Art and Design	<10
Savannah River College	<10
Savannah State University	<10
Savannah Technical College	<10
Sawyer College at Ponoma	<10
Sawyer School	<10
Sawyer School (The)	<10
Sawyer School of Business	<10
Saybrook University	<10
SBI Campus - an affiliate of Sanford-Brown	<10
Schenectady County Community College	<10
School of Communication Arts of North Carolina	<10
School of Visual Arts	<10
Schreiner University	<10
SCS Business and Technical Institute	<10
Seattle Pacific University	<10
Seminole State College of Florida	<10
Shear Finesse Beauty Academy	<10
Shepherd University	<10
Sierra Valley College of Court Reporting	<10
Simdex Techl Inst	<10
Simmons University	<10
Skagit Valley College	<10
Skelly Beauty Admy	<10
Skyline College	<10
Skyline College - Richmond	<10
Smith Chason College	<10
Sojourner-Douglass College	<10
South Carolina State University	<10
South College	<10
South College-Asheville	<10
South Texas College	<10
Southeast Community College	<10
Southeast Kentucky Community and Technical College	<10
Southeastern Academy	<10
Southeastern Bible College	<10
Southeastern College	<10
Southeastern Louisiana University	<10
Southeastern University	<10
Southern Career Institute	<10
Southern Careers Institute	<10
Southern Illinois University at Carbondale	<10
Southern Illinois University Edwardsville	<10

Southern Institute of Cosmetology	<10
Southern New Jersey Technical School	<10
Southern Technical College	<10
Southern Technical Institute	<10
Southern University and Agricultural & Mechanical Colg at Baton Rouge	<10
Southern University at New Orleans	<10
Southern University at Shreveport - Bossier City	<10
Southwest College	<10
Southwest Institute of Healing Arts	<10
Southwest School of Medical Assistants	<10
Southwest University at El Paso	<10
Southwest University of Visual Arts	<10
Southwestern Community College	<10
Southwestern Community College District	<10
Southwestern Illinois College	<10
Southwestern Law School	<10
Spartan College of Aeronautics and Technology	<10
Spartanburg Methodist College	<10
Specs Howard School of Media Arts	<10
Spencerian College	<10
Spokane Community College	<10
Spokane Falls Community College	<10
Spoon River College	<10
Spring Arbor University	<10
St. Catharine College	<10
St. Joseph's University New York	<10
St. Mary's University	<10
St. Paul's School of Nursing	<10
Stage One The Hair School	<10
Stanbridge University	<10
Stanly Community College	<10
Star Technical Institute	<10
Stark State College	<10
State University of New York at Albany	<10
State University of New York at Buffalo	<10
State University of New York at Farmingdale	<10
State University of New York at New Paltz	<10
State University of New York at Oswego (SUNY Oswego)	<10
State University of New York at Stony Brook	<10
Stautzenberger College	<10
Stenotype Institute of Jacksonville	<10
Stenotype Institute of Springfield	<10
Stephen F Austin State University	<10
Stevens Henager College All Campuses	<10
Stevenson University	<10
Stockton University	<10
Stone Academy	<10

Stratford School	<10
Stratford University	<10
Suburban Technical School	<10
Sullivan College of Technology and Design	<10
SUM Bible College & Theological Seminary	<10
Summit Academy Opportunities Industrialization Center	<10
Summit Beauty School	<10
Summit Institute	<10
SUNY Broome Community College	<10
SUNY College at Geneseo	<10
SUNY College of Agriculture & Technology at Morrisville	<10
Superior Training Services	<10
Swedish Institute	<10
Talladega College	<10
Tallahassee Community College	<10
Tarleton State University	<10
Tarrant County College District	<10
Taylor Business Institute	<10
TDDS Technical Institute	<10
Technical Career Institutes	<10
Temple University	<10
Tenaj Salon Institute	<10
Tennessee Career Institute	<10
Tennessee College of Applied Technology - Murfreesboro	<10
Tennessee Temple University	<10
Tennessee Wesleyan University	<10
Texarkana College	<10
Texas A&M University	<10
Texas Barber College	<10
Texas Chiropractic College	<10
Texas Schools	<10
Texas Southern University	<10
Texas State University	<10
Texas Tech University	<10
Texas Tech University Health Sciences Center	<10
Texas Vocational School	<10
Texas Woman's University	<10
Texcel Career Center	<10
Thiel College	<10
Thomas College	<10
Thomas Edison State University	<10
Tidewater Community College	<10
Tiffin University	<10
Tompkins Cortland Community College	<10
Touro University	<10
Trainco Bus School	<10
Transwestern Inst	<10

Treasure Valley Community College	<10
Trebas Institute of Rec Arts	<10
Trend College	<10
Triangle Tech	<10
Tribeca Flashpoint College	<10
Tri-County Technical College	<10
Trident Technical College	<10
Trident University International	<10
Trinity International University	<10
Tri-State College of Acupuncture	<10
Tri-State Institute of Hair Design	<10
Tri-State Semi Driver Training	<10
Troy University	<10
Truckee Meadows Community College	<10
Truman State University	<10
Tulsa Community College	<10
Tulsa Welding School	<10
Tunxis Community College	<10
Tuskegee University	<10
Twin City Beauty College	<10
UEI (United Education Institute)	<10
UEI College	<10
Ultissma Beauty Institute (CLOSED)	<10
Unified Schools of America-Compton Campus	<10
Union College	<10
Unitech Training Academy	<10
United College	<10
United College of Business	<10
United Schools	<10
Unitek College	<10
Universal Career School	<10
Universidad Ana G. MÃ©ndez - Cupey Campus	<10
Universidad Ana G. MÃ©ndez - Gurabo Campus	<10
Universidad del Sagrado Corazon	<10
University of Advancing Computer Technology	<10
University of Alabama at Birmingham	<10
University of Arizona (The)	<10
University of Arkansas	<10
University of Arkansas - Grantham	<10
University of Arkansas - Pulaski Technical College	<10
University of Arkansas at Fort Smith	<10
University of Arkansas at Monticello	<10
University of Arkansas for Medical Sciences	<10
University of California, Berkeley	<10
University of California, Irvine	<10
University of California, Los Angeles	<10
University of California, Riverside	<10

University of California, San Diego	<10
University of Central Arkansas	<10
University of Central Missouri	<10
University of Central Oklahoma	<10
University of Cincinnati	<10
University of Colorado Colorado Springs	<10
University of Connecticut	<10
University of Dayton	<10
University of Detroit Mercy	<10
University of Glasgow	<10
University of Hawaii at Manoa	<10
University of Health Sciences and Pharmacy in St. Louis	<10
University of Houston - Clear Lake	<10
University of Houston - Downtown	<10
University of Illinois at Chicago	<10
University of Illinois Urbana-Champaign	<10
University of Indianapolis	<10
University of Iowa	<10
University of La Verne	<10
University of Louisiana at Lafayette	<10
University of Louisiana at Monroe	<10
University of Louisville	<10
University of Lynchburg	<10
University of Maine	<10
University of Maine - Farmington	<10
University of Management and Technology (The)	<10
University of Mary Hardin-Baylor	<10
University of Maryland - Baltimore County	<10
University of Maryland - Eastern Shore	<10
University of Maryland Global Campus	<10
University of Maryland, Baltimore	<10
University of Massachusetts - Dartmouth	<10
University of Massachusetts - Lowell	<10
University of Medicine & Dentistry of New Jersey	<10
University of Memphis (The)	<10
University of Miami	<10
University of Michigan	<10
University of Michigan - Dearborn	<10
University of Minnesota - Crookston	<10
University of Minnesota Duluth	<10
University of Minnesota - Twin Cities	<10
University of Mississippi	<10
University of Missouri - Columbia	<10
University of Montevallo	<10
University of Nevada , Reno	<10
University of New Haven	<10
University of North Alabama	<10

University of North Carolina at Pembroke	<10
University of North Florida	<10
University of North Georgia	<10
University of North Texas	<10
University of Northwestern Ohio	<10
University of Oregon	<10
University of Oxford - St Catherine's College	<10
University of Portland	<10
University of Rhode Island	<10
University of Rio Grande	<10
University of Sarasota	<10
University of Scranton	<10
University of Silicon Valley	<10
University of South Alabama	<10
University of South Carolina Upstate	<10
University of South Dakota	<10
University of South Florida	<10
University of Southern California	<10
University of Southern Maine	<10
University of Southern Mississippi	<10
University of Southernmost Florida	<10
University of St. Augustine for Health Sciences	<10
University of Sydney	<10
University of Tampa (The)	<10
University of Tennessee	<10
University of Tennessee - Martin	<10
University of Texas at Arlington	<10
University of Texas at Austin	<10
University of Texas at Tyler	<10
University of Texas Rio Grande Valley	<10
University of the Cumberlands	<10
University of the District of Columbia	<10
University of the Incarnate Word	<10
University of the Pacific	<10
University of the Rockies	<10
University of the Virgin Islands	<10
University of Toledo	<10
University of Utah	<10
University of Virginia	<10
University of Washington - Seattle	<10
University of West Florida (The)	<10
University of West Georgia	<10
University of Wisconsin - Milwaukee	<10
University of Wisconsin - River Falls	<10
University of Wisconsin - Stout	<10
University of Wisconsin - Whitewater	<10
University of Wisconsin Colleges	<10

University of Wyoming	<10
UNKNOWN-SCHOOL-NAME	<10
Urbana University	<10
USA Training Academy Home Study	<10
Utica School of Commerce	<10
Utica University	<10
Valdosta State University	<10
Valencia College	<10
Valley Commercial College	<10
Valor Christian College	<10
Vanderbilt University	<10
Vantage College - San Antonio	<10
VEEB Nassau County School of Practical Nursing	<10
Velvatex College of Beauty Culture	<10
Vernon College	<10
Verve College	<10
Vet Tech Institute of Houston	<10
Victory University	<10
Video Symphony EnterTraining	<10
Video Technical Institute	<10
Villanova University	<10
Vincennes University	<10
Virginia Commonwealth University	<10
Virginia Institute of Technology	<10
Virginia Intermont College	<10
Virginia Polytechnic Institute & State University	<10
Virginia State University	<10
Virginia University of Lynchburg	<10
Vista College	<10
Walsh College of Accountancy & Business Administration	<10
Wards Corner Beauty Academy	<10
Warner Pacific University	<10
Washington School of Secretaries	<10
Washington State University	<10
Washington University in St. Louis	<10
Watterson College Pacific	<10
Wayland Baptist University	<10
Wayne County Community College District	<10
Wayne State University	<10
Webster Career College	<10
Wesleyan College	<10
West Chester University of Pennsylvania	<10
West Coast University	<10
West Virginia Junior College	<10
West Virginia Northern Community College	<10
West Virginia University	<10
Westech College	<10

Western Career College	<10
Western Governors University	<10
Western International University	<10
Western Oregon University	<10
Western Piedmont Community College	<10
Western State University College of Law	<10
Western Suffolk BOCES	<10
Western Technical College	<10
Westfield State University	<10
Wharton County Junior College	<10
Wheeling University	<10
White Mountains Community College	<10
Whittier College	<10
Widener University	<10
Wilberforce University	<10
Wilbur Wright College	<10
Wiley College	<10
Wilfred Academy	<10
Wilfred Academy of Hair Design & Beauty Culture	<10
Willfred's Frederic Hairstyling	<10
William Paterson University of New Jersey	<10
William Penn University	<10
Willsey Institute	<10
Wilmington University	<10
Wilson Community College	<10
Winthrop University	<10
Wolford College	<10
Wood Tobe - Coburn School	<10
Woodbridge Business Institute	<10
Wooster Business College	<10
Wright State University	<10
Wyoming County Career and Technical Center	<10
Wytheville Community College	<10
Xavier University of Louisiana	<10
York Institute	<10
York Technical College	<10
Yorktowne Business Institute	<10
Youngstown State University	<10

*Case counts are rounded to the nearest 10.

Question. Please provide the top five reasons that borrower defense claims are placed in "total denied," "total ineligible," and "total closed." Please also provide the number and corresponding percentage for borrower defense claims placed in each category.

Answer. Per our response above, "total ineligible" is no longer used as a category in borrower defense reporting. Due to privacy considerations, we are unable to provide a breakdown of the denied cases.

As of late-July 2023, the top five reasons applications have been closed were as follows (numbers have been rounded to the nearest (5):

—No Loans Pre-Adjudication (e.g., no Federal loans; no loans at the applicable school) (12,395 applications or 67%);

—No Response from Customer (2135 applications or 12%);

—Borrower Received an Automatic Closed School Discharge (965 applications or 5%);

—Incomplete Application (685 applications or 4%);

—Borrower Requested Case Closure (645 applications or 3%).

Question. According to the most recently published borrower defense report (January 2023), the Department currently has nearly 464,724 pending borrower defense claims. Please provide:

The average length of time the 464,724 claims have been pending.

Answer. The average length of time that all applications have been pending as of mid-June 2023, is 492 days. This is not specific to the 464,724 claims referenced, but rather the total number of pending applications, as of mid-June 2023.

Question. The percentage of pending claims related to for-profit institutions (including institutions that have been for-profit institutions within the past 10 years), public institutions, and private not-for-profit institutions respectively.

Answer. As of mid-June 2023, 74% of total pending applications were related to for-profit institutions; 11% were related to public institutions; 13% were related to private not-for-profit institutions; and 1 percent were related to foreign institutions. Applications without a school listed were excluded from this calculation as well as a small number of schools for which school type was unknown. Schools were assigned a school type based on the most recent eligibility data available in PEPS.

Question. A breakdown of the 464,724 pending claims by institution.

Answer. An Excel file providing the requested data as of mid-June 2023 is enclosed.

Pending Claims by School Name (as of mid-June 2023)

School Name	Case Count*
University of Phoenix	37240
DeVry University	20350
Ashford University	10270
ITT Technical Institute	10120
Walden University	9070
Purdue University Global	8800
Argosy University	7990
Capella University	7880
Grand Canyon University	6830
Sanford-Brown College	5750
HEALD COLLEGE	5450
VIRGINIA COLLEGE	5400
American InterContinental University	4810
South University	4570
Altierus Career College	4210
Colorado Technical University	4200
Keller Graduate School of Management	4170
Strayer University	3840
Keiser University	3810
Chamberlain University	3640
Brightwood College	3360
Art Institute of Las Vegas (The)	3060
Fortis College	3040
Florida Coastal School of Law	3030
Empire Beauty School	2630
Everest College	2400
Le Cordon Bleu College of Culinary Arts	2250
Art Institute of Pittsburgh (The)	2080
Concorde Career College	2070
Lincoln Technical Institute	2040
Ross University School of Veterinary Medicine	1970
Ross University, School of Medicine	1920
Full Sail University	1750
Independence University	1730
Vatterott College	1570
Chicago School of Professional Psychology	1550
Everest Institute	1530
Everest University	1530
Illinois Institute of Art (The)	1520
Lincoln College of Technology	1490
Miller - Motte Technical College	1430
Remington College	1420
Art Institute of Atlanta (The)	1410
WyoTech	1390

Florida Career College	1380
Carrington College	1350
Universal Technical Institute	1200
Bryman School of Arizona (The)	1160
Liberty University	1100
Berkeley College	1070
Brightwood Career Institute	1070
Ultimate Medical Academy	1060
Southern New Hampshire University	1030
Fortis Institute - Towson	1010
Fortis Institute	990
Arizona Summit Law School	980
Academy of Art University	940
American National University	940
Charlotte School of Law	940
Bryant & Stratton College	920
Marinello School of Beauty	910
Rasmussen University	910
Harrison College	880
Blue Cliff College	850
National American University	850
Western Governors University	840
Medtech College	830
ICDC College	820
National University	820
McCann School of Business & Technology	810
Devry Institute of Technology	780
Miami International University of Art & Design	780
American Public University System	770
Anthem College	770
Miller-Motte College	770
Concorde Career Institute	760
No School Name Listed	760
Art Institute of California - Los Angeles (The)	750
Miller-Motte Technical College	740
Art Institute of Philadelphia (The)	730
Heritage College	730
Regency Beauty Institute	730
Altierus Career Education	710
United Education Institute	690
Branford Hall Career Institute	680
Daymar College	680
Brooks Institute	670
ECPI University	670
Brown Mackie College-Cincinnati	660
Baker College	650
Southern Technical College	650

Minnesota School of Business	640
Art Institute of Houston (The)	630
Drake College of Business	610
Kaplan College	600
Remington College - Mobile Campus	590
ATI Career Training Center	580
Herzing University	580
Western International University	580
Art Institute of Fort Lauderdale (The)	530
Harris School of Business	530
Florida Technical College	500
Dorsey College	490
San Joaquin Valley College	490
American Career College	480
Centura College	480
Vista College	480
Briarcliffe College	470
Star Career Academy	470
Dade Medical College	460
Northcentral University	460
Bauder College	440
Globe University	440
Mountain State University	440
New England Institute of Art (The)	440
Art Institute of Colorado (The)	430
Art Institute of California - San Diego	420
Art Institutes International Minnesota (The)	420
Beckfield College	420
Nova Southeastern University	420
Ross Medical Education Center	420
Everest University - Pompano Beach	410
Pima Medical Institute	410
Post University	410
University of Maryland Global Campus	410
American University of the Caribbean	400
Pittsburgh Career Institute	400
Concordia University	390
Technical Career Institutes	390
Career Colleges of America	380
Everest College Phoenix	380
Gwinnett College	380
Ivy Tech Community College of Indiana	380
University of the Rockies	380
Wright Career College	380
Art Institute of Seattle (The)	370
American College for Medical Careers	360
Arizona State University	360

NUC University	360
Art Institute of Charlotte (The)	340
Art Institute of Portland (The)	340
Career Point College	330
Heritage Institute	320
Charter College	310
Jones International University	310
Robert Morris University Illinois	310
Southeastern College	310
Collins College	300
Katharine Gibbs School	300
Le Cordon Bleu Institute of Culinary Arts	300
Westwood College - Denver North	300
All-State Career	290
ASA College	290
Brookline College	290
Brown Mackie College-Findlay	290
Bryman College	290
Business Career Training Institute	290
Dowling College	290
Grantham University	290
Spartan College of Aeronautics and Technology	280
Anthem Institute	270
Brown Mackie College (The)	270
Brown Mackie College-South Bend	270
Columbia Southern University	270
Davenport University	270
Le Cordon Bleu College of Culinary Arts in Chicago	270
Miami - Jacobs Career College	270
Morris Brown College	270
Remington College - Tampa Campus	270
Saint Leo University	270
Western State University College of Law	270
Beauty Schools of America	260
Temple University	260
Antonelli College	250
City College	250
College of New Rochelle (The)	250
Remington College - Cleveland Campus	250
Sullivan University	250
CollegeAmerica Denver	240
UEI College	240
University of Southern California	240
Art Institute of New York City (The)	230
College of Health Care Professions (The)	230
Institute of Technology	230
Milan Institute	230

Mount Washington College	230
UEI (United Education Institute)	230
Cortiva Institute	220
Georgia State University	220
Harrington College of Design	220
Houston Community College	220
Stratford University	220
Webster University	220
Florida International University	210
Johnson & Wales University	210
National College	210
Remington College - Lafayette Campus	210
Westech College	210
Art Institute of California-Hollywood (The)	200
Bryan University	200
Columbia College	200
Four-D College	200
Life University	200
Long Island University	200
Northwestern College	200
Pennsylvania State University (The)	200
Porter and Chester Institute	200
Texas Southern University	200
Troy University	200
Everglades University	190
Florida Agricultural & Mechanical University	190
Harrison Career Institute	190
Illinois School of Health Careers	190
King's College	190
Spencerian College	190
Berks Technical Institute	180
Bethune Cookman University	180
California College San Diego	180
Fashion Institute of Design & Merchandising	180
InterCoast Colleges	180
Platt College	180
Rutgers, the State University of New Jersey	180
Tennessee State University	180
Victory University	180
ATI- Career Training Center	170
Chicago State University	170
Indiana Institute of Technology	170
Indiana Wesleyan University	170
Las Vegas College	170
Sawyer School (The)	170
Southern Careers Institute	170
University of Memphis (The)	170

Westwood College - Los Angeles	170
Academy of Court Reporting and Technology	160
American Commercial College	160
Barry University	160
Brooks College	160
Career Technical College	160
Court Reporting Institute of St Louis	160
Delgado Community College	160
DePaul University	160
Florida Institute of Technology	160
Florida State College at Jacksonville	160
Howard University	160
Lone Star College System	160
Madison Media Institute	160
Mildred Elley	160
Monroe College	160
Prism Career Institute	160
Sanford-Brown Institute	160
University of Central Florida	160
Wayne State University	160
Art Institute of Dallas (The)	150
Clark Atlanta University	150
Computer Systems Institute	150
Helms Career Institute	150
Jackson State University	150
Kent State University	150
Midwest Technical Institute	150
Sojourner-Douglass College	150
Southern University and Agricultural & Mechanical Colg at Baton Rouge	150
St. Petersburg College	150
University of Cincinnati	150
All-State Career School	140
Brown Mackie College	140
Gibbs College	140
International Academy of Design and Technology	140
International Beauty School	140
Jersey College	140
SBI Campus - an affiliate of Sanford-Brown	140
Thomas Jefferson School of Law	140
University of Texas at Arlington	140
Alabama State University	130
Art Institute of York (The) - Pennsylvania	130
Aviation Institute of Maintenance	130
Bellevue University	130
Bethel University	130
Broadview College	130
Center for Employment Training	130

Columbia College Chicago	130
Galen Health Institutes	130
Hondros College of Nursing	130
International Business College	130
Los Angeles Film School (The)	130
Mercy College	130
New York University	130
Northern Illinois University	130
Pioneer Pacific College	130
South College	130
Tiffin University	130
Trident University International	130
University of South Florida	130
Valencia College	130
West Coast University	130
Western Career College	130
Albany State University	120
Allen School	120
American Beauty Academy	120
ATI Technical Training Center	120
Chester Career College	120
CollegeAmerica - Flagstaff	120
Eastern Michigan University	120
Goodwin University	120
HALLMARK INSTITUTE OF PHOTOGRAPHY	120
Hillsborough Community College	120
La' James International College	120
Lehigh Valley College	120
McNally Smith College of Music	120
New England College of Business and Finance	120
Prairie View Agricultural & Mechanical University	120
Southern Illinois University at Carbondale	120
Star Technical Institute	120
Stenotype Institute of Jacksonville	120
University of Southern Mississippi	120
ACT College	110
Alabama Agricultural & Mechanical University	110
Arizona College	110
Benedict College	110
Bradford School	110
Brandman University	110
Broward College	110
Brown Mackie College-Merrillville	110
Bryan College	110
Columbus State Community College	110
Community College of Philadelphia	110
Drexel University	110

Excelsior University	110
Florida Atlantic University	110
Franklin University	110
Grambling State University	110
Hallmark University	110
Indiana University - Purdue University Indianapolis	110
Jones College	110
Kaplan Career Institute	110
Kennesaw State University	110
Lindenwood University	110
National Louis University	110
Newbridge College	110
North Carolina Central University	110
North-West College	110
Pinnacle Career Institute	110
Pittsburgh Technical College	110
Purdue University Northwest	110
Ridley - Lowell Business & Technical Institute	110
Rio Salado Community College	110
Savannah College of Art and Design	110
Stone Academy	110
Touro University	110
Unitech Training Academy	110
University of Akron (The)	110
University of North Texas	110
Wood Tobe - Coburn School	110
Alliant International University	100
Aspen University	100
ATI College of Health	100
Brookstone College of Business	100
Career Institute of Health and Technology	100
Central Michigan University	100
Cincinnati State Technical & Community College	100
Coleman University	100
College of Office Technology (The)	100
Daniel Webster College	100
Florida National University	100
Florida State University	100
Georgia Gwinnett College	100
Georgia Perimeter College	100
Maric College	100
Michigan State University	100
Mt. Sierra College	100
Norfolk State University	100
Sage College	100
Southwest University of Visual Arts	100
Stautzenberger College	100

Trident Technical College	100
University of Toledo	100
Wayne County Community College District	100
American Institute	90
ATA College	90
Business Industrial Resources	90
California State University, Northridge	90
Colorado State University - Global Campus	90
Crown College	90
Dallas Nursing Institute	90
Divers Academy of the Eastern Seaboard	90
Eagle Gate College	90
Florida Memorial University	90
Georgia Southern University	90
Harrisburg Area Community College	90
Henry Ford College	90
Hinds Community College	90
IBMC College	90
Mattia College	90
MDT College of Health Sciences	90
Middle Tennessee State University	90
Milwaukee Area Technical College	90
Missouri College	90
Morgan State University	90
Mount Ida College	90
New York Institute of Technology	90
North Carolina Agricultural and Technical State University	90
Northern Arizona University	90
Ohio State University (The)	90
Pennsylvania Western University	90
Savannah State University	90
South Carolina State University	90
Stark State College	90
Summit College	90
Tarrant County College District	90
Tidewater Community College	90
University of Arizona (The)	90
University of Illinois at Chicago	90
University of Nevada - Las Vegas	90
University of South Alabama	90
Virginia State University	90
Western Michigan University	90
Atlanta Technical College	80
Bossier Parish Community College	80
Cambridge College of Healthcare & Technology	80
Clayton State University	80
Cleveland Institute of Dental - Medical Assistants	80

College of Southern Nevada	80
Computer Learning Center	80
Cuyahoga Community College	80
Decker College	80
DeVry College of Technology	80
East Carolina University	80
Faulkner University	80
Governors State University	80
Greenville Technical College	80
Gwinnett Technical College	80
Hamilton College	80
Hofstra University	80
Hussian College	80
Institute for Business & Technology	80
Kean University	80
Lamar University	80
Laurus Technical Institute	80
Lincoln University	80
Manhattan Beauty School	80
Marygrove College	80
Maryville University of Saint Louis	80
McIntosh College	80
Mercer University	80
Mid-Continent University	80
Montclair State University	80
Old Dominion University	80
Orion College	80
Owens Community College	80
Pace University	80
Pennco Tech	80
PSI Institute	80
Roosevelt University	80
SAE Expression College	80
Saint John's University	80
Santa Fe University of Art and Design	80
Seminole State College of Florida	80
St. Louis College of Health Careers	80
Tallahassee Community College	80
Thomas M. Cooley Law School	80
Tricoci University of Beauty Culture	80
University of Arkansas - Pulaski Technical College	80
University of Florida	80
University of Houston	80
University of Houston - Downtown	80
University of South Carolina - Columbia	80
Valdosta State University	80
Virginia Commonwealth University	80

Westwood College - DuPage	80
Academy of Healing Arts	70
American University of Antigua College of Medicine	70
Anamarc College	70
Arkansas State University	70
Azusa Pacific University	70
Becker College	70
Belhaven University	70
Career Technical Institute	70
CDA Technical Institute	70
Chancellor University	70
Cleveland State University	70
Collin County Community College District	70
Columbus State University	70
Community Care College	70
Daytona State College	70
Delta School of Business and Technology	70
East-West University	70
Elmira Business Institute	70
Embry-Riddle Aeronautical University	70
Fort Valley State University	70
George Washington University	70
Glendale Career College	70
Indiana State University	70
Institute of Audio Research	70
Institute of Technical Arts	70
Iverson Institute	70
Loyola University Chicago	70
Metropolitan State University of Denver	70
Miami Dade College	70
Midlands Technical College	70
National Academy of Beauty Arts	70
New School, The	70
Northeastern University	70
Oakland Community College	70
Ogle School Hair Skin Nails	70
Ohio University	70
Olympian Academy of Cosmetology	70
Portland Community College	70
Purdue University	70
Rasmussen College	70
Regent University	70
Santa Barbara Business College	70
Sinclair Community College	70
Smith Chason College	70
South Texas Vocational Technical Institute	70
Southeastern University	70

Southern University at Shreveport - Bossier City	70
St. George's University, School of Medicine	70
Sullivan and Cogliano Training Centers	70
Texas State University	70
University of Alabama	70
University of Alabama at Birmingham	70
University of Arkansas at Little Rock	70
University of Illinois Urbana-Champaign	70
University of Miami	70
University of North Carolina - Charlotte	70
University of Texas at San Antonio	70
University of Wisconsin - Milwaukee	70
Western Kentucky University	70
Westwood College - O'Hare Airport	70
Westwood College - South Bay	70
Alcorn State University	60
American Musical & Dramatic Academy	60
Apex School Of Theology	60
Austin Peay State University	60
Aveda Arts & Sciences Institute Covington	60
Bastyr University	60
Baton Rouge Community College	60
Beauty Institute (The)	60
Benedictine University	60
Boston University	60
Brenau University	60
Brown Mackie College-Louisville	60
Brown Mackie College-North Canton	60
Caliber Training Institute	60
California State University - Sacramento	60
California State University, Long Beach	60
Cambridge College	60
Colorado Christian University	60
Computer Learning Center of Alexandria	60
Computer Learning Centers Los Angeles	60
Delaware State University	60
Dover Business College	60
DPT Business School	60
ESS College Of Business	60
Fayetteville State University	60
Fremont University	60
Galiano Career Academy	60
Genesis Career College	60
George Mason University	60
Georgia Military College	60
Guilford Technical Community College	60
HCI College	60

Hickey College	60
Hodges University	60
Illinois State University	60
IntelliTec College	60
Inter American University of Puerto Rico - San German Campus	60
Jefferson Community and Technical College	60
John F. Kennedy University	60
Kendall College	60
Lincoln College of New England	60
Lincoln Technical Institute - Hartford	60
Louisiana State University & Agricultural & Mechanical College	60
Mandl School	60
Metropolitan College of New York	60
Midstate College	60
Milan Institute of Cosmetology	60
Mississippi State University	60
Mississippi Valley State University	60
Monroe Community College	60
Nashville Auto-Diesel College	60
New England Institute of Technology	60
New Jersey City University	60
Northwestern State University	60
Northwood University	60
Oakland University	60
Ottawa University	60
Paine College	60
Park University	60
PCI Health Training Center	60
Peirce College	60
Pennsylvania Institute of Technology	60
Point Park University	60
Robert Fiance Beauty Schools	60
Saint Thomas University	60
San Francisco State University	60
School of Communication Arts of North Carolina	60
Shaw University	60
Southern University at New Orleans	60
Springfield College	60
SUNY Empire State College	60
Texas Tech University	60
Texas Woman's University	60
Tucson College	60
Tulsa Welding School	60
Universidad Ana G. Méndez - Gurabo Campus	60
University of Arkansas at Pine Bluff	60
University of Louisiana at Lafayette	60
University of Mississippi	60

University of Missouri - Kansas City	60
University of Oklahoma	60
University of Southernmost Florida	60
University of West Alabama	60
University of West Georgia	60
Valparaiso University	60
Video Symphony EnterTraining	60
Wake Technical Community College	60
West Virginia University	60
Western Illinois University	60
Whittier College	60
Widener University	60
Wilmington University	60
Apex Technical School	50
Armstrong State University	50
Associated Technical College	50
Atlanta's John Marshall Law School	50
Ball State University	50
Bay State College	50
Bellus Academy	50
Bowling Green State University	50
Brensten Education	50
Brown College of Court Reporting	50
Butler Business School	50
California State University, East Bay	50
California State University, Los Angeles	50
Cardinal Stritch University	50
Career Quest Learning Centers	50
Carnegie Career College	50
CBT Technology Institute	50
Central Florida Institute	50
Central State University	50
City Colleges of Chicago - Kennedy King College	50
Coastal Carolina University	50
College of Westchester (The)	50
Commonwealth University of Pennsylvania	50
Community College of Baltimore County	50
Coyne College	50
Darton State College	50
Dawn Career Institute	50
Des Moines Area Community College	50
DuBois Business College	50
Fairleigh Dickinson University	50
Forest Institute of Professional Psychology	50
Hampton University	50
Hollywood Institute	50
Hollywood Institute of Beauty Careers	50

Horry - Georgetown Technical College	50
Indiana University - Bloomington	50
Indiana University - Northwest	50
Indiana University of Pennsylvania	50
Iowa State University of Science & Technology	50
Jacksonville State University	50
Johnson C. Smith University	50
Joyce University of Nursing and Health Sciences	50
Kelsey - Jenney College	50
Kirkwood Community College	50
Lacy Cosmetology School	50
Lane College	50
Lansing Community College	50
LeMoyne-Owen College	50
Lewis University	50
Marylhurst University	50
Masters Institute	50
Metropolitan College	50
Metropolitan Community College	50
Miami University	50
Miles College	50
Minneapolis Community and Technical College	50
MTI College of Business and Technology	50
Nassau Community College	50
Navarro College	50
New College of California	50
New England College	50
New Mexico State University	50
Newbridge College - San Diego East	50
Newbury College	50
Northern Kentucky University	50
Northern Virginia Community College	50
Ohio Christian University	50
Ohio Media School	50
Omnitech Institute	50
Palm Beach State College	50
Pepperdine University	50
Performance Training Institute	50
Phillips Junior College	50
Portland State University	50
Quest College	50
Regina's College of Beauty	50
Regis University	50
Remington College - San Diego Campus	50
Saint Paul's College	50
Saint Xavier University	50
San Diego State University	50

San Jose State University	50
Savannah River College	50
Seton Hall University	50
Shorter University	50
Sonoran University of Health Sciences	50
Southeastern Louisiana University	50
Southern Illinois University Edwardsville	50
Southwest University at El Paso	50
St. Paul's School of Nursing	50
State University of New York at Buffalo	50
Stephen F Austin State University	50
Stillman College	50
Suburban Technical School	50
SUNY Buffalo State University	50
Tennessee Academy of Cosmetology	50
Texas A&M University - Commerce	50
Texas State Technical College	50
Thomas Edison State University	50
Tuskegee University	50
Tyler Junior College	50
Union Institute & University	50
Unitek College	50
University of Advancing Computer Technology	50
University of Bridgeport	50
University of California, Los Angeles	50
University of Central Arkansas	50
University of Central Oklahoma	50
University of Kentucky	50
University of La Verne	50
University of Louisville	50
University of Maryland - Eastern Shore	50
University of Massachusetts at Boston	50
University of Minnesota - Twin Cities	50
University of Missouri - Saint Louis	50
University of New Mexico	50
University of North Carolina -Greensboro	50
University of Tennessee - Martin	50
University of Texas at El Paso	50
University of the District of Columbia	50
University of Washington - Seattle	50
University of West Florida (The)	50
Upper Iowa University	50
Washington State University	50
West Virginia Business College	50
Westcliff University	50
Wichita Technical Institute	50
William Paterson University of New Jersey	50

Winston-Salem State University	50
Wright State University	50
Youngstown State University	50
YTI Career Institute	50
Adelphi University	40
Allied American University	40
American Career Institute	40
American School of Technology	40
Angley College	40
Antioch University	40
Arkansas Baptist College	40
Arlington Career Institute	40
Auburn University Montgomery	40
Aveda Institute - South Florida	40
Baltimore International College	40
Bluegrass Community & Technical College	40
Boise State University	40
Bowie State University	40
California Baptist University	40
California State University, Dominguez Hills	40
California State University, Fullerton	40
California State University, San Bernardino	40
Camelot College	40
Capitol City Trade & Technical School	40
Career Care Institute	40
Career Training Academy	40
Casa Loma College	40
Central Connecticut State University	40
Central Penn College	40
Centura Institute	40
Chapman University	40
Clark State College	40
Coastal Alabama Community College	40
College of DuPage	40
Columbia University in the City of New York	40
Community College of Allegheny County	40
Community College of Denver	40
Computer Learning Centers Chicago	40
Coppin State University	40
Dallas Baptist University	40
Dallas College	40
Delaware County Community College	40
Eastern Florida State College	40
Eastern Illinois University	40
Eastern International College	40
Eastern Kentucky University	40
Elegance International	40

Elizabeth City State University	40
Fayetteville Technical Community College	40
Ferris State University	40
Florida SouthWestern State College	40
Fordham University	40
Fountainhead College of Technology	40
Front Range Community College	40
G Skin & Beauty Institute	40
Gateway Community College	40
Georgia Career Institute	40
Georgia Piedmont Technical College	40
Glendale Community College	40
Grand Rapids Community College	40
Grand Valley State University	40
Hair Fashions by Kaye Beauty College	40
Harrison Career Institute-	40
Harvard University	40
Heald College, School of Business	40
Hudson Valley Community College	40
Institute of Allied Medical Professions	40
Institute of Production and Recording (The)	40
International School of Health, Beauty & Technology	40
Iowa Central Community College	40
Johns Hopkins University	40
Keystone Technical Institute	40
LA College International	40
La' James International College - Des Moines	40
Lamson College	40
Lane Community College	40
Langston University	40
Laurus College	40
LeTourneau University	40
Lincoln College	40
Louisiana State University in Shreveport	40
Masters of Cosmetology College	40
MCI Institute of Technology	40
Medical Professional Institute	40
Meridian College	40
Mesa Community College	40
Mid-America Christian University	40
Middle Georgia State University	40
Midwestern Career College	40
Mississippi Gulf Coast Community College	40
Missouri State University	40
Morthland College	40
Mount Saint Mary's University	40
MTA School, Resident School	40

MTI College	40
Musicians Institute	40
MyComputerCareer at Columbus	40
MyComputerCareer at Raleigh	40
Nashville State Community College	40
National University College-IBC Institute	40
New England Tractor Trailer Training School of Connecticut	40
New Life Business Institute	40
New Wave Hair Academy	40
Northampton County Area Community College	40
Northeastern Illinois University	40
Ohio Business College	40
Oklahoma State University	40
Oral Roberts University	40
Pacific College of Health and Science	40
Pacific Travel Trade School	40
Palm Beach Atlantic University	40
Palmer College of Chiropractic	40
Park West Barber School	40
Parkland College	40
Pennsylvania School Of Business	40
Phoenix College	40
Pikes Peak State College	40
Pima County Community College	40
Pinnacle College	40
PJ's College of Cosmetology	40
Purdue University Fort Wayne	40
Rochester Institute of Technology	40
Rockford Career College	40
Rowan University	40
Royal Beauty Careers	40
Saginaw Valley State University	40
Saint Augustine's University	40
Saint Joseph's College	40
Saint Joseph's University	40
Salon Professional Academy (The)	40
Sam Houston State University	40
Santa Fe College	40
Sawyer College	40
SCS Business and Technical Institute	40
Specs Howard School of Media Arts	40
St. Catharine College	40
State College of Florida, Manatee-Sarasota	40
State University of New York at Albany	40
State University of New York at Stony Brook	40
Superior Training Services	40
Syracuse University	40

Tarleton State University	40
Taylor Business Institute	40
Texas A&M University	40
Towson University	40
Trumbull Business College	40
Tulsa Community College	40
Universidad Autonoma de Guadalajara	40
University of Antelope Valley	40
University of Baltimore	40
University of Central Missouri	40
University of Colorado Denver	40
University of Denver	40
University of Detroit Mercy	40
University of Iowa	40
University of Kansas	40
University of Louisiana at Monroe	40
University of Maryland, College Park	40
University of Michigan - Flint	40
University of Missouri - Columbia	40
University of New Haven	40
University of New Orleans (The)	40
University of North Carolina at Pembroke	40
University of North Florida	40
University of Pittsburgh	40
University of San Francisco	40
University of Tennessee	40
University of Texas at Dallas	40
Utica University	40
Vantage College	40
Watterson College	40
Wesley College	40
West Virginia Junior College	40
Western Beauty Institute	40
Western Technical College	40
Xavier University of Louisiana	40
Yorktowne Business Institute	40
Academy for Nursing and Health Occupations	30
Academy of Hair Design	30
Adler University	30
Advanced Technology Institute	30
AdventHealth University	30
Akron Institute of Herzing University	30
Albany Technical College	30
Allen University	30
Alliance University	30
American College of Healthcare and Technology	30
American College of Traditional Chinese Medicine	30

American Institute of Business	30
American Institute of Trucking	30
American International College	30
American University (The)	30
Amridge University	30
Arizona Automotive Institute	30
Arkansas Tech University	30
Asher College	30
Atlanta Metropolitan State College	30
Auburn University	30
Auguste Escoffier School of Culinary Arts	30
Aurora University	30
Austin Community College	30
Avalon Institute	30
Bainbridge State College	30
Barber - Scotia College	30
Baylor University	30
Bennett College	30
Bergen Community College	30
Blinn College	30
Bloomfield College	30
Blue Cliff Career College	30
Bridgewater State University	30
Bryant and Stratton College	30
Calhoun Community College	30
California Aeronautical University	30
California College of Vocational Careers	30
California State Polytechnic University, Pomona	30
California State University, Bakersfield	30
California State University, Fresno	30
Cambria-Rowe Business College	30
Campbell University	30
Capri Institute of Hair Design	30
Career College of Northern Nevada	30
Career Networks Institute	30
Carolina Beauty College	30
CC's Cosmetology College	30
Central Georgia Technical College	30
Central Ohio Technical College	30
Central Washington University	30
Century College	30
Charles Stewart Mott Community College	30
Charleston Southern University	30
Chattanooga College - Medical, Dental and Technical Careers	30
Chattanooga State Community College	30
Cheyney University of Pennsylvania	30
Cincinnati Christian University	30

City University of Seattle	30
Claflin University	30
Clarion University of Pennsylvania	30
Clark College	30
Colorado State University	30
Community College of Aurora	30
Computer Learning Center of Anaheim	30
Computer Learning Centers San Francisco	30
Concordia College	30
Concordia College Alabama	30
Concordia University - Saint Paul	30
Cortiva Institute - Chicago	30
Culinary Institute of America	30
CUNY John Jay College of Criminal Justice	30
CUNY Lehman College	30
Delta College	30
Delta College of Arts & Technology	30
Digital Media Arts College	30
Dillard University	30
Duluth Business University	30
Duquesne University of the Holy Spirit	30
East Tennessee State University	30
Eastern College of Health Vocations	30
Eastern University	30
Eastern Washington University	30
Eastwick College	30
Eastwick College - Nutley Campus	30
Edward Waters University	30
Empire Beauty Schools	30
Empire College	30
Erie Business Center	30
Five Towns College	30
Florence - Darlington Technical College	30
Fort Hays State University	30
Francis Marion University	30
Gardner - Webb University	30
Gateway Community and Technical College	30
Gateway Technical College	30
Georgetown University	30
Globe Institute of Technology	30
Golden Gate University	30
Gordon State College	30
Great Lakes Institute of Technology	30
Gretna Career College	30
Gurnick Academy of Medical Arts	30
Hair Design School (The)	30
Harcum College	30

HEALD BUSINESS COLLEGE	30
Heald Institute of Technology	30
Health and Style Institute	30
Healthcare Career College	30
Healthy Hair Academy	30
Hennepin Technical College	30
High Desert Medical College	30
Hocking Technical College	30
Holmes Community College	30
Houston Christian University	30
Humphreys University	30
Idaho State University	30
Illinois Media School	30
Institute of Medical Education	30
Interactive College of Technology	30
International Air & Hospitality Academy	30
International School of Skin and Nailcare	30
ITI Technical College	30
Ivy Tech Community College of Indiana - Region 1	30
J Sargeant Reynolds Community College	30
Jackson College	30
Jacksonville Beauty Institute	30
Jacksonville University	30
Jefferson State Community College	30
Jolie Health and Beauty Academy	30
Kansas State University	30
Kentucky State University	30
Key College	30
Kutztown University of Pennsylvania	30
La Salle University	30
Lakeland Community College	30
Lawton School for Medical and Dental Assistants	30
Lesley University	30
LIM College	30
Limestone University	30
Lincoln Memorial University	30
Livingstone College	30
Logan University	30
Lon Morris College	30
Lorain County Community College	30
Loyola Marymount University	30
Lynn University	30
Macon State College	30
Madison Area Technical College	30
Marian University	30
Marshall University	30
McLennan Community College	30

MCPHS University	30
Medaille University	30
MedSpa Careers Institute	30
Mercyhurst University	30
Metro Business College	30
Metropolitan State University	30
Miami Media School	30
Midwest Institute	30
Minneapolis Business College	30
Minnesota State University, Mankato	30
Mississippi College	30
Mississippi University for Women	30
Missouri Southern State University	30
Missouri Technical School	30
Monmouth University	30
Montgomery County Community College	30
Morehouse College	30
MTI BUSINESS COLLEGE	30
Murray State University	30
National Education Center-Bauder College Campus	30
National Paralegal College	30
National University of Natural Medicine	30
Nicholls State University	30
Normandale Community College	30
North Carolina Wesleyan University	30
Northwest Career College	30
Ohio Technical College	30
Ohio Valley University	30
Oklahoma City Community College	30
Onondaga Community College	30
Oregon State University	30
Our Lady of The Lake University	30
Ozarks Technical Community College	30
Pacific Coast College	30
Parker University	30
Paul Mitchell The School Costa Mesa	30
Paul Mitchell the School Green Bay	30
Philadelphia University	30
Piedmont Technical College	30
PITC Institute	30
Pitt Community College	30
Polk State College	30
Pontifical Catholic University of Puerto Rico (The)	30
Pratt Institute	30
Premiere Career College	30
Prince George's Community College	30
Professional Careers Institute	30

Prospect College	30
Provo College	30
Pueblo Community College	30
Purdue University - North Central	30
Quincy College	30
Reading Area Community College	30
Remington College - New Orleans Campus	30
Rider University	30
Ridley-Lowell School of Business	30
Robert Morris University	30
Rocky Mountain College of Art + Design	30
Sacred Heart University	30
Saint Louis Community College	30
Saint Louis University	30
Saint Paul College - A Community & Technical College	30
Saint Peter's University	30
Salem University	30
Salon Success Academy	30
San Diego College	30
School of the Art Institute of Chicago	30
Sierra Valley College of Court Reporting	30
Simmons University	30
Skyline College - Richmond	30
South Coast College	30
Southeast Missouri State University	30
Southeastern Academy	30
Southern College	30
Southern Connecticut State University	30
Southwest Acupuncture College	30
Southwestern Illinois College	30
St. Catherine University	30
St. Joseph's University New York	30
Stanbridge University	30
Stockton University	30
Suffolk County Community College	30
Suffolk University	30
Sullivan College of Technology and Design	30
Sumner College	30
Taft University System (The)	30
Temple College	30
Tennessee Temple University	30
Texas A&M University - Corpus Christi	30
Texas A&M University - Kingsville	30
Texas Barber College	30
Texas College	30
Thomas Jefferson University	30
TONI&GUY Hairdressing Academy	30

Trinity Washington University	30
Tulane University	30
Union College	30
Union University	30
Universidad Ana G. Méndez - Carolina Campus	30
Universidad Ana G. Méndez - Cupey Campus	30
University of Arkansas	30
University of California, Davis	30
University of California, Irvine	30
University of California, Riverside	30
University of California, San Diego	30
University of Chicago (The)	30
University of Colorado Boulder	30
University of Connecticut	30
University of Hawaii at Manoa	30
University of Houston - Clear Lake	30
University of Indianapolis	30
University of Massachusetts - Amherst	30
University of Massachusetts - Dartmouth	30
University of Massachusetts - Lowell	30
University of Michigan	30
University of Michigan - Dearborn	30
University of Mount Olive	30
University of Nebraska at Omaha	30
University of Nevada , Reno	30
University of North Carolina at Wilmington (The)	30
University of Northern Colorado	30
University of Oregon	30
University of Saint Thomas	30
University of South Carolina Upstate	30
University of Tampa (The)	30
University of Tennessee - Chattanooga	30
University of Texas at Austin	30
University of Texas at Tyler	30
University of Texas Rio Grande Valley	30
University of the Incarnate Word	30
University of the Pacific	30
University of the Sciences in Philadelphia	30
University of Utah	30
Urbana University	30
USA Training Academy Home Study	30
Utah Valley University	30
Villanova University	30
Vincennes University	30
Virginia Polytechnic Institute & State University	30
Virginia Union University	30
Wards Corner Beauty Academy	30

Washburn University - Topeka	30
Washtenaw Community College	30
West Chester University of Pennsylvania	30
West Tennessee Business College	30
Western Hills School of Beauty & Hair Design	30
Wichita State University	30
Wilberforce University	30
Wiley College	30
William Carey University	30
Winthrop University	30
Abilene Christian University	20
Abraham Baldwin Agricultural College	20
Academy of Radio & TV Broadcasting	20
Academy Pacific Travel College	20
Adams State University	20
Adelphi Business College	20
Adirondack Community College - SUNY Office of Community Colleges	20
Advanced Career Training	20
Advanced College	20
Advanced Training Institute	20
Albertus Magnus College	20
Albizu University	20
Alverno College	20
American Academy McAllister Institute	20
American Academy of Hair Design	20
American Broadcasting School	20
American Business Institute	20
American Business Institute (Closed)	20
American Career Training Travel School	20
American College	20
American College of Medical Technology	20
American Hi-Tech Business Technology	20
American River College	20
American School of Business	20
American Sentinel University	20
Anderson University	20
Andover College	20
Anne Arundel Community College	20
Anoka-Ramsey Community College	20
Antelope Valley College	20
Antonelli Institute	20
Aquinas College	20
Arapahoe Community College	20
Arcadia University	20
Artistic Nails & Beauty Academy	20
Ashland University	20
Athens State University	20

ATI College	20
Augsburg University	20
Augusta State University	20
Augusta University	20
Austin's School of Spa Technology	20
Avalon School of Cosmetology	20
Aveda Institute Columbus	20
Averett University	20
Avila University	20
Award Beauty School	20
Bacone College	20
Baker University	20
Baldwin Wallace University	20
Baptist Memorial College of Health Sciences	20
Barclay Career School	20
Barclay College	20
Baton Rouge School of Computers	20
Bay Path University	20
Bel - Rea Institute of Animal Technology	20
Belmont Abbey College	20
Belmont University	20
Bene's Career Academy	20
Berklee College of Music	20
Binghamton University	20
Blake Austin College	20
Blake Business School	20
Bluefield State University	20
Boca Beauty Academy	20
Bold Beauty Academy	20
Bradley University	20
Brewton Parker College	20
Brick Computer Science Institute	20
Brightpoint Community College	20
Bristol University	20
Brittany Beauty School	20
Brookdale Community College	20
Bucks County Community College	20
Buena Vista University	20
Burlington College	20
Butler County Community College	20
California Healing Arts College	20
California Institute of Integral Studies	20
California State Polytechnic University, Humboldt	20
California State University, San Marcos	20
California State University, Stanislaus	20
California Western School of Law	20
Cambridge Junior College	20

Camden County College	20
Cameron University	20
Campbellsville University	20
Cape Fear Community College	20
Capri Beauty College	20
Career Colleges of Chicago	20
Carlow University	20
Case Western Reserve University	20
Catherine College	20
Catholic University of America (The)	20
CBD College	20
CCI Training Center	20
Cedar Crest College	20
Center for the Media Arts	20
Central Career School	20
Central Carolina Technical College	20
Central New Mexico Community College	20
Central Nursing College	20
Central Texas College District	20
Champlain College	20
Chandler - Gilbert Community College	20
Charles R. Drew University of Medicine and Science	20
Chatham University	20
Chattahoochee Valley Community College	20
Chemeketa Community College	20
Chestnut Hill College	20
Chowan University	20
CIT College of InfoMedical Technology	20
City College of New York - CUNY	20
City Colleges of Chicago - Malcolm X College	20
Claremont Graduate University	20
Clemson University	20
Cleveland Chiropractic College	20
Clover Park Technical College	20
College of Central Florida	20
College of Charleston	20
College of Coastal Georgia	20
College of Court Reporting	20
College of Mount Saint Vincent	20
College of Saint Mary	20
College of Saint Rose	20
College of Southern Idaho	20
College of Staten Island/CUNY	20
College of Western Idaho	20
Colorado Mesa University	20
Columbia College Hollywood	20
Commonwealth International University	20

Community College of Rhode Island	20
Compass College of Cinematic Arts	20
Concordia University Texas	20
Conservatory of Recording Arts & Sciences	20
Consolidated School of Business	20
Continental School of Beauty Culture	20
Cornerstone University	20
Cosmetology Career Institute	20
Crescent City School of Gaming & Bartending	20
CUNY Bernard M. Baruch College	20
CUNY Borough of Manhattan Community College	20
CUNY Brooklyn College	20
CUNY Hunter College	20
CUNY Medgar Evers College	20
CUNY Queens College	20
Curry College	20
CyberTex Institute of Technology	20
Davidson-Davie Community College	20
Davis College	20
Daytona College	20
DEFAULT SCHOOL FOR CONSOLIDATED LOANS	20
Delaware Valley Academy of Medical & Dental Assistants	20
Delta State University	20
Demarge College	20
Denver Technical College	20
Diesel Driving Academy	20
Dominican University	20
Dominican University New York	20
Douglas Education Center	20
Douglas J Aveda Institute	20
Drake Business School	20
Draughons Junior College	20
Drury University	20
Durham Beauty Academy	20
D'Youville University	20
East Georgia State College	20
East Mississippi Community College	20
East Stroudsburg University of Pennsylvania	20
Eastern Connecticut State University	20
Eastern Gateway Community College	20
Eastern Iowa Community College District	20
Eastwick College - Hackensack Campus.	20
Elaine Steven Beauty College	20
Elizabethtown Community and Technical College	20
Elmhurst University	20
Emerson College	20
Emory University	20

Empire Beauty School - Flagstaff	20
Empire Beauty School -Thornton	20
Erie Community College	20
Eternity Cosmetology School, Corp.	20
ETI School of Skilled Trades	20
Everett Community College	20
Evergreen State College (The)	20
Expertise Cosmetology Institute	20
Fairmont State University	20
Fashion Careers of California College	20
Fashion Institute of Technology	20
FastTrain of Fort Lauderdale	20
FastTrain of Miami	20
Fayette Beauty Academy	20
Felician University	20
Fielding Graduate University	20
Finger Lakes Community College - SUNY Office of Community Colleges	20
Finger Lakes School of Massage (The)	20
Fisher College	20
Fisk University	20
Flagler College	20
Florida Barber Academy	20
Florida Gulf Coast University	20
Fontbonne University	20
Forsyth Technical Community College	20
Fox College	20
Fox Valley Technical College	20
Franciscan Missionaries of Our Lady University	20
Franklin Pierce University	20
Fresno Pacific University	20
Friends University	20
Frontier Nursing University	20
Frostburg State University	20
Galen College of California	20
Generations College	20
George C. Wallace State Community College	20
Georgia Beauty Academy	20
Georgia College & State University	20
Georgia Institute of Cosmetology	20
Georgia Southwestern State University	20
Global Health College	20
Graceland University	20
Green Mountain College	20
Gwynedd Mercy University	20
Hair Academy	20
Harper College	20
Harris - Stowe State University	20

Hawaii Business College	20
Hawaii Pacific University	20
Hawkeye Community College	20
Heald College-School of Business	20
Healthcare Training Institute	20
Henderson State University	20
Heritage University	20
Hiwassee College	20
Hollywood Beauty College	20
Holy Names University	20
Hopkinsville Community College	20
Hunter Business School	20
Huston - Tillotson University	20
Illinois Institute of Technology	20
Immaculata University	20
Indian River State College	20
Indiana University - South Bend	20
Indiana University Southeast	20
Institute of Health and Technology	20
Interface College	20
International Academy	20
International Aviation & Travel Academy	20
International Culinary Center	20
Iona College	20
Iowa Western Community College	20
Ivy Tech Community College of Indiana - Region 6	20
Ivy Tech Community College of Indiana- Region 3	20
James Madison University	20
Jarvis Christian University	20
John Amico School of Hair Design	20
John Marshall Law School (The)	20
Johnson County Community College	20
Jolie Hair and Beauty Academy	20
Joliet Junior College	20
Kalamazoo Valley Community College	20
Kansas City Kansas Community College	20
KD Conservatory College of Film and Dramatic Arts	20
Kellogg Community College	20
Kilgore College	20
Knoxville College	20
La' James College of Hairstyling	20
Lackawanna College	20
Lake Erie College of Osteopathic Medicine	20
Lake Lanier School of Massage	20
Lakeland University	20
Lander University	20
Lehigh Carbon Community College	20

Lincoln Technical Institute - East Windsor	20
Lindsey Wilson College	20
Loma Linda University	20
Long Beach City College	20
Long Island Beauty School	20
Los Angeles Pacific University	20
Los Angeles Recording School	20
Louisiana Delta Community College	20
Louisiana State University at Alexandria	20
Louisiana Tech University	20
Loyola University New Orleans	20
Luzerne County Community College	20
MacMurray College	20
Macomb Community College	20
Madonna University	20
Magnolia College of Cosmetology	20
Mansfield Business College	20
Marist College	20
Marquette University	20
Martin University	20
Marymount Manhattan College	20
Marymount University	20
Marywood University	20
MBTI Business Training Institute	20
McKendree University	20
McNeese State University	20
Medical Prep Institute of Tampa Bay	20
Medical Training College	20
Medical University of Lublin	20
Medical University of the Americas	20
Med-Life Institute	20
MedQuest College	20
Memphis Institute of Barbering	20
Miami Regional University	20
MIAT College of Technology	20
Middlesex College	20
Midway University	20
Midwestern State University	20
Midwestern University	20
Millersville University of Pennsylvania	20
Mills College	20
Milwaukee Career College	20
Minnesota State Community and Technical College	20
Missouri Western State University	20
Mohawk Valley Community College - SUNY Office of Community Colleges	20
Molloy University	20
Montana State University - Billings	20

Montgomery College	20
Morehead State University	20
Morris College	20
Mount Saint Mary College	20
Mount St. Joseph University	20
Mt. Hood Community College	20
Mueller College	20
Naropa University	20
Nashville College of Medical Careers	20
National Aviation Academy	20
National Education Center Bryman Campus	20
National Education Center Kee Business College Campus	20
National Education Center National Institute of Technology Campus	20
National Graduate School of Quality Management (The)	20
National Holistic Institute	20
National Massage Therapy Institute	20
National Polytechnic College	20
National Technical Schools	20
National University of Health Sciences (The)	20
Neumann University	20
Neumont College of Computer Science	20
New England Culinary Institute	20
New England Tractor Trailer Training School of Massachusetts	20
New Jersey Institute of Technology	20
New York Career Institute	20
New York City College of Technology of the City University of New York	20
New York College of Health Professions	20
New York Film Academy	20
New York Law School	20
New York School for Medical & Dental Assistants	20
Nightingale College	20
North Adrian's College of Beauty	20
North American Trade Schools	20
North Carolina State University	20
North Coast College, The	20
North Hennepin Community College	20
North Idaho College	20
North Park University	20
Northeast Wisconsin Technical College	20
Northern Michigan University	20
NorthWest Arkansas Community College	20
Northwest Mississippi Community College	20
Northwest Missouri State University	20
Northwestern University	20
Norwich University	20
Nossi College of Art	20
Notre Dame de Namur University	20

Oakwood University	20
Ocean County College	20
Ohio Institute of Health Careers	20
Oklahoma City University	20
Oklahoma Health Academy	20
Oklahoma State University - Oklahoma City	20
Olivet Nazarene University	20
Omega Institute	20
Orangeburg - Calhoun Technical College	20
Orion Technical College	20
Orleans Technical College	20
Pace Institute	20
Pacific Oaks College	20
Pacific University	20
Pacifica Graduate Institute	20
Pasco - Hernando State College	20
Pat Goins Benton Road Beauty School	20
Paul Mitchell the School Atlanta	20
Paul Mitchell the School Dallas	20
Paul Mitchell The School East Bay	20
Paul Mitchell the School Houston	20
Paul Mitchell the School Memphis	20
Paul Mitchell The School Sacramento	20
Paul Mitchell The School Tinley Park	20
Paul Quinn College	20
PC Age	20
PCI College	20
Pearl River Community College	20
Peloton College	20
Pennsylvania College of Technology	20
Pfeiffer University	20
Philander Smith College	20
Phillips Graduate University	20
Piedmont University	20
Pine Manor College	20
Platt College - San Diego	20
Plaza College	20
Plymouth State University of the University System of New Hampshire	20
Point Loma Nazarene University	20
Point University	20
Porter and Chester Institute of Hamden	20
Prairie State College	20
Prescott College	20
Prince Institute - Rocky Mountains	20
Prince Institute - Southeast	20
Professional Business School	20
PTC Career Institute	20

Quinsigamond Community College	20
Radford University	20
Radians College	20
Regis College	20
Rhode Island College	20
Richland College	20
River Parishes Community College	20
Roger Williams University	20
Rose State College	20
Rosemont College	20
Rowan College of South Jersey	20
Russell Sage College	20
Rust College	20
Sacramento City College	20
SAE Institute of Technology	20
Saint Francis College	20
Saint Gregory's University	20
Salem State University	20
Salon Academy (The)	20
Salt Lake Community College	20
Samuel Merritt University	20
San Antonio College	20
San Jacinto Community College District	20
Saybrook University	20
School of Visual Arts	20
Schoolcraft College	20
Scottsdale Community College	20
Seattle University	20
Selma University	20
Shawnee State University	20
Shenandoah University	20
Shepherd University	20
Shirley Baker Career Institute	20
Siena Heights University	20
Sierra College	20
Skyline College	20
Slippery Rock University	20
Sofia University	20
Somerset Community College	20
South College-Asheville	20
South Louisiana Community College	20
Southeast Community College	20
Southeastern College (Jacksonville)	20
Southern Arkansas University	20
Southern California Institute of Technology	20
Southern California University of Health Sciences	20
Southern Institute of Cosmetology	20

Southern Methodist University	20
Southern Vermont College	20
Southern Wesleyan University	20
Southwest Institute of Healing Arts	20
Southwestern Assemblies of God University	20
Southwestern College	20
Spartanburg Community College	20
Spokane Community College	20
Spring Arbor University	20
St. Cloud State University	20
St. John Fisher University	20
St. Mary's University	20
State University of New York at Oswego (SUNY Oswego)	20
State University of New York College at Potsdam	20
Stetson University	20
Stevenson University	20
Studio Academy of Beauty (The)	20
Summit Institute	20
Summit Salon Academy	20
SUNY Broome Community College	20
SUNY College at Brockport	20
SUNY College at Old Westbury	20
SUNY College of Agriculture & Technology at Cobleskill	20
SUNY College of Agriculture & Technology at Morrisville	20
SUNY College of Technology at Canton	20
Swedish Institute	20
Tacoma Community College	20
Talladega College	20
Teachers College, Columbia University	20
Tennessee Technological University	20
Texas Christian University	20
Texas Southmost College	20
Texas Wesleyan University	20
Thomas University	20
Tidewater Tech	20
Toni & Guy Hairdressing Academy	20
Tougaloo College	20
Touro University Worldwide	20
Trainco Bus School	20
Trend Setters' Academy of Beauty Culture	20
Trevecca Nazarene University	20
Triangle Tech	20
Tri-County Technical College	20
Trine University	20
Trinity International University	20
TRITON COLLEGE	20
Tusculum University	20

United College of Business	20
United Schools	20
United States University	20
Universidad Central del Este	20
Universidad Iberoamericana (UNIBE)	20
University of Alabama in Huntsville	20
University of Alaska Anchorage	20
University of Arkansas at Fort Smith	20
University of Arkansas at Monticello	20
University of California, Berkeley	20
University of California, Santa Barbara	20
University of California, Santa Cruz	20
University of Charleston	20
University of Colorado Colorado Springs	20
University of Dayton	20
University of Delaware	20
University of Findlay (The)	20
University of Georgia	20
University of Hartford	20
University of Houston - Victoria	20
University of Idaho	20
University of Maine - Augusta	20
University of Maryland - Baltimore County	20
University of Maryland, Baltimore	20
University of Mobile	20
University of Montana (The)	20
University of Nebraska	20
University of New England	20
University of New Hampshire	20
University of North Alabama	20
University of North Carolina - Chapel Hill	20
University of North Georgia	20
University of Northwestern Ohio	20
University of Pennsylvania	20
University of Redlands	20
University of Rhode Island	20
University of Rio Grande	20
University of San Diego	20
University of Sarasota	20
University of South Carolina - Aiken	20
University of South Dakota	20
University of Southern Indiana	20
University of Southern Maine	20
University of St. Augustine for Health Sciences	20
University of St. Francis	20
University of the Cumberlands	20
University of the Southwest	20

University of Wisconsin - Madison	20
University of Wisconsin - Parkside	20
University of Wisconsin - Whitewater	20
Utah Tech University	20
Utica School of Commerce	20
Valley College	20
Valley College of Medical Careers	20
Valley Commercial College	20
Vanguard University of Southern California	20
Vaughn College of Aeronautics and Technology	20
Verve College	20
Vet Tech Institute	20
Virginia Intermont College	20
Virginia Peninsula Community College	20
Virginia University of Lynchburg	20
Virginia Western Community College	20
Volunteer Beauty Academy	20
Volunteer State Community College	20
Voorhees University	20
Waldorf University	20
Walnut Hill College	20
Warner University	20
Washington Adventist University	20
Waukesha County Technical College	20
Wayland Baptist University	20
Weber State University	20
Webster Career College	20
West Georgia Technical College	20
West Texas A&M University	20
West Virginia State University	20
Western Carolina University	20
Western Connecticut State University	20
Western New England University	20
Western New Mexico University	20
Western Oregon University	20
Western University of Health Sciences	20
Westmoreland County Community College	20
Wichita State University Campus of Applied Sciences and Technology	20
Wilkes University	20
Wingate University	20
Wolford College	20
World Medicine Institute	20
Xavier University	20
Yeshiva University	20
York Technical College	20
Zane State College	20
A. T. Still University of Health Sciences	10

Abcott Institute	10
Academy of Barbering Arts (The)	10
Academy of Cosmetology	10
Aims Community College	10
Albert Merrill School	10
Allegany College of Maryland	10
Alvareita's College of Cosmetology	10
Alvernia University	10
Amarillo College	10
Ambria College of Nursing	10
American Academy of Traditional Chinese Medicine	10
American College of Business	10
American College of Healthcare Sciences	10
American Health Institute	10
American Institute (The)	10
American Institute of Alternative Medicine	10
American Institute of Beauty	10
American National College	10
Ancilla Domini College	10
Andrew College	10
Andrews University	10
Angelo State University	10
Anoka Technical College	10
Arizona Institute of Electrolysis Div Unif School of AM	10
Art Center College of Design	10
Art Institute of Cincinnati (The)	10
Art Institute of Tucson (The)	10
Arthur's Beauty College	10
Ascension College	10
ATA Career Education	10
Atlantic Union College	10
Austin Business College	10
Aveda Arts & Sciences Institute Corpus Christi	10
Aveda Institute - Tallahassee	10
Ayers Career College	10
Azure College	10
Balin Inst of Techlgy	10
Barnes Business College	10
Barton College	10
Baton Rouge College	10
Bay State School of Technology	10
Beauty Institute Schwarzkopf Professional (The)	10
Bellefonte Academy of Beauty	10
Bethany University of the Assemblies of God	10
Beulah Heights University	10
Big Sandy Community and Technical College	10
BioHealth College	10

Biola University	10
Blue Ridge Community and Technical College	10
Bramson ORT College	10
Briar Cliff University	10
Brigham Young University - Idaho	10
Brillare Hairdressing Academy	10
Bristol Community College	10
Brittany Beauty Academy	10
Brookhaven College	10
Bryant & Stratton Business Institute - Syracuse	10
Business Informatics Center	10
Business Skills Institute	10
Butte College	10
Cabrini University	10
Caldwell University	10
California Institute	10
California Lutheran University	10
California Polytechnic State University	10
California State University, Chico	10
California State University, Monterey Bay	10
Calumet College of Saint Joseph	10
Cambridge Techl Inst	10
Cameron College	10
Canisius College	10
Cannella School of Hair Design	10
Capital University	10
Capitol City Careers	10
Career College of California	10
Carousel Beauty College	10
Carson - Newman University	10
Catawba College	10
Cedar Valley College	10
Center for Advanced Legal Studies	10
Center for Allied Health Education	10
Central Arizona College	10
Central Oregon Community College	10
Central Piedmont Community College	10
Century Schools	10
Cerritos Community College	10
Chaminade University of Honolulu	10
Charleston School of Law	10
Charter Oak State College	10
Chatfield College	10
Chicago Institute of Technology	10
Chippewa Valley Technical College	10
Christian Brothers University	10
Cinta Aveda Institute	10

City College of San Francisco	10
City Colleges of Chicago Harry S Truman College	10
Clackamas Community College	10
Cleary University	10
Cleveland State Community College	10
Coast Career Institute	10
College for Creative Studies	10
College of Our Lady of the Elms	10
College of Saint Joseph	10
College of Wilmington	10
Colorado State University-Pueblo	10
Columbia School of Broadcasting, Home Study	10
Community College of Beaver County	10
Computer Processing Inst	10
Cooper Career Institute	10
Copiah-Lincoln Community College	10
Corcoran College of Art and Design	10
Cortiva Institute - Seattle	10
Cortiva Institute - Tucson	10
Cosmetology and Spa Academy	10
Cosumnes River College	10
Court Reporting Institute,Inc	10
Crave Beauty Academy,LLC	10
Creighton University	10
Culinary Institute LeNotre	10
CUNY Bronx Community College	10
Daemen University	10
Davenport University - Eastern Region	10
Dayton School of Medical Massage	10
Del Mar College	10
Delaware Technical Community College	10
Denmark Technical College	10
DeSales University	10
Diversified Vocational College	10
D'Jay's Institute of Cosmetology and Esthiology	10
Dorsey School of Beauty	10
Drake University	10
Draughons College	10
Duke University	10
Durham Technical Community College	10
Dyersburg State Community College	10
Eagle Rock College	10
East West College of Natural Medicine	10
Eastern New Mexico University	10
Eastern Oregon University	10
Eastfield College	10
Edgecombe Community College	10

Elaine P. Nunez Community College	10
Elaine Sterling Institute(The)	10
Eldorado College	10
Elevate Salon Institute	10
Elgin Community College	10
Elmira College	10
Elon University	10
Emmanuel College	10
Empire Beauty School-Lakewood	10
Empire Beauty School-Littleton	10
Endicott College	10
Entourage Institute of Beauty and Esthetics	10
Estrella Mountain Community College	10
ETI Technical College of Niles	10
Evangel University	10
Evergreen Beauty and Barber College	10
FastTrain of Jacksonville	10
FastTrain of Tampa	10
Federico Beauty Institute	10
Finlandia University	10
First Institute	10
Fitchburg State University	10
Five Branches University	10
Florida Southern College	10
Forrest College	10
Fort Worth Beauty School	10
Framingham State University	10
Franklin College	10
Fresno City College	10
Gallipolis Career College	10
Gannon University	10
Gene Juarez Academy	10
General Communications	10
George Fox University	10
Georgia Highlands College	10
Georgia Institute of Technology	10
Georgia School of Bartending	10
Georgian Court University	10
Glen Dow Academy of Hair Design & Salons	10
Goldey-Beacom College	10
Gonzaga University	10
Grace Christian University	10
Granite State College	10
Great Falls College Montana State University	10
Green River College	10
Griffin College	10
Guilford College	10

Gulf Coast State College	10
Gupton-Jones College of Funeral Service	10
GUTI, The Premier Beauty and Wellness Academy	10
Gwinnett College-Sandy Springs	10
Hair Design School, The	10
Hair Expressions - Paul Mitchell Partner School	10
Hair Professionals Career College	10
Hamline University	10
Harding University	10
Harold Washington College	10
Heald College-School of Technology	10
Herkimer County Community College - SUNY Office of Community Colleges	10
HoHoKus School of Trade and Technical Sciences	10
Holy Family College	10
Holy Family University	10
Hope International University	10
Howard Community College	10
Howard Payne University	10
Huntingdon College	10
Huntington Junior College	10
Husson University	10
Indian Hills Community College	10
Indiana University - East	10
Inter American University of Puerto Rico - Metropolitan Campus	10
International Academy of Hair Design	10
International Barber & Style College	10
International Salon and Spa Academy	10
Interstate Business College	10
Inver Hills Community College	10
Ithaca College	10
Ivy Tech Community College of Indiana - Region 4	10
Ivy Tech Community College of Indiana - Region 5	10
Ivy Tech Community College of Indiana - Region 7	10
James A. Rhodes State College	10
Jay's Technical Institute	10
Jean Madeline Aveda Institute	10
Jefferson College	10
Jefferson Community College	10
Jones County Junior College	10
Jones Technical Institute	10
Jordan College	10
Joseph's College Cosmetology	10
Judson College	10
Kansas City University	10
Kansas Wesleyan University	10
Keene State College	10
Kenneth Shuler School of Cosmetology & Hair Design	10

Kenneth Shuler School of Cosmetology & Nails	10
Keuka College	10
Keystone College	10
King University	10
Kingsborough Community College/CUNY	10
KRS Computer & Business School	10
La Roche University	10
La Sierra University	10
Labouré College of Healthcare	10
Lake Superior College	10
Lamar Institute of Technology	10
Lambuth University	10
Lansdale School of Business	10
Lasell University	10
Laurel Technical Institute	10
Lawrence Technological University	10
Lee University	10
Lenoir-Rhyne University	10
Lewis College of Business	10
Life Chiropractic College West	10
Lincoln Land Community College	10
Lipscomb University	10
Los Angeles Pierce College	10
Los Angeles Trade-Technical College	10
Louisburg College	10
Louisiana College	10
Louisiana State University at Eunice	10
Lourdes University	10
Lower Columbia College	10
Lubbock Christian University	10
Lutheran School of Nursing	10
Manhattan College	10
Manhattan Institute (The)	10
Manhattanville College	10
Manor College	10
Marian Court College	10
Mary Baldwin University	10
Maryland Institute College of Art	10
Marymount California University	10
Massachusetts School of Law at Andover	10
Massasoit Community College	10
Mayfield College	10
Maysville Community and Technical College	10
McDougle Technical Institute	10
McMurry University	10
MediaTech Institute	10
Meharry Medical College	10

Memphis College of Art	10
Meredith College	10
Michael's School of Beauty	10
Micropower Career Institute	10
Middlesex Community College	10
Midland Career Institute	10
Midway Paris Beauty School	10
Millennium Training Institute	10
Millikin University	10
Misericordia University	10
Missouri Baptist University	10
Missouri Valley College	10
MJ's Beauty Academy	10
Modern Technology School	10
Montana State University Bozeman	10
Montreat College	10
Moore Career College	10
Moraine Park Technical College	10
Moraine Valley Community College	10
Morton College	10
MotoRing Technical Training Institute	10
Mount Aloysius College	10
Mount Mary University	10
Mount Vernon Nazarene University	10
Mountain State College	10
Mountain States Technical Institute	10
Mountain View College	10
Mountwest Community and Technical College	10
Mr Bernard's School of Hair Fashion	10
MSTA Business College (Closed)	10
MTI Business Schools (Closed)	10
Muskingum University	10
National Career Institute	10
National Hispanic University (The)	10
Nevada State College	10
New Hampshire Institute of Art	10
New Horizons Medical Institute	10
New York Automotive & Diesel Institute	10
Newport Business Institute	10
NewSchool of Architecture and Design	10
Niagara County Community College	10
North Central Texas College	10
North Dakota State University - Fargo	10
North Lake College	10
North Shore Community College	10
Northcentral Technical College	10
Northeast College of Health Sciences	10

Northeast Iowa Community College	10
Northeastern State University	10
Northern Essex Community College	10
Northern Vermont University	10
Northern Vermont University Lyndon	10
Northland Community and Technical College	10
Northwest College School of Beauty	10
Northwest Hair Academy	10
Northwestern Health Sciences University	10
Notre Dame College of Ohio	10
Notre Dame of Maryland University	10
NTMA Training Centers of Southern California	10
Oak Point University	10
Oakland City University	10
Ocean (The)	10
Ohio Dominican University	10
Oklahoma Christian University	10
Oklahoma State University Institute of Technology - Okmulgee	10
Olive-Harvey College	10
Onondaga Cortland Madison BOCES	10
Orange County Community College	10
Otterbein University	10
Owensboro Community & Technical College	10
P&A Scholars Beauty School	10
Pacific College	10
Pacific Union College	10
Palm Beach Academy of Health & Beauty	10
Palmer College of Chiropractic West	10
Panola College	10
Parks College	10
Paul Mitchell The School - Esani	10
Paul Mitchell the School - Little Rock	10
Paul Mitchell the School - Pasadena	10
Paul Mitchell the School Chicago	10
Paul Mitchell The School Cincinnati	10
Paul Mitchell The School Fayetteville	10
Paul Mitchell The School Gastonia	10
Paul Mitchell The School Jacksonville	10
Paul Mitchell The School Modesto	10
Paul Mitchell The School New Orleans	10
Paul Mitchell the School Salt Lake City	10
Paul Mitchell the School Temecula	10
PCCenter	10
Pellissippi State Community College	10
Penn Commercial Business/Technical School	10
Pensacola School of Massage Therapy & Health Careers	10
Phagans' School of Hair Design	10

Phillips Junior College Condie Campus	10
Phillips Junior College Hardbarger Campus	10
Phoenix Institute of Technology	10
Pierce College	10
Pierpont Community & Technical College	10
Pivot Point Academy	10
Plaza Beauty School	10
Ponce Paramedical College (POPAC)	10
Praxis Institute	10
Presentation College	10
Professional Career College	10
Professional Career Training Institute	10
Professional Hands Institute	10
Professional Skills Institute	10
Queens University of Charlotte	10
Queensborough Community College-CUNY	10
Quincy University	10
Quinnipiac University	10
Ramapo College of New Jersey	10
Ranken Technical College	10
Raphael's School of Beauty Culture	10
Rasmussen College - Mankato	10
Real Barbers College (The)	10
Regency Beauty Institute - Cleveland	10
Reinhardt University	10
Ringling College of Art and Design	10
Rio Hondo Community College	10
Riverside School of Aeronutics	10
Roane State Community College	10
Robert B. Miller College (The)	10
Roberts Wesleyan University	10
Rochester Community and Technical College	10
Rockland Community College	10
Rogers State University	10
Rogue Community College	10
Rosalind Franklin University of Medicine and Science	10
Roseman University of Health Sciences	10
Rowan College at Burlington County	10
Rowan-Cabarrus Community College	10
Saba University School of Medicine	10
SABER College	10
SAE Institute of Technology - Atlanta	10
Saint Johns River State College	10
Saint Mary's College of California	10
Saint Philip's College	10
Salon Professional Academy - Melbourne, The	10
San Diego Christian College	10

San Francisco Art Institute	10
San Joaquin Delta College	10
Santa Barbara City College	10
Sawyer College of Business	10
Sawyer School	10
Schenectady County Community College	10
Schiller International University	10
Shippensburg University of Pennsylvania	10
Shoreline Community College	10
Shorter College	10
Sierra Academy of Aeronautics-Airline Training Center	10
Simpson College	10
Sonoma State University	10
Sonoran Desert Institute	10
South Central College	10
South Dakota State University	10
South Georgia State College	10
South Mountain Community College	10
South Plains College	10
Southeast Technical College	10
Southeastern Beauty Schools	10
Southeastern Bible College	10
Southeastern Community College	10
Southeastern Oklahoma State University	10
Southern California Health Institute (SOCHI)	10
Southern California International College	10
Southern Crescent Technical College	10
Southern Maine Community College	10
Southern Nazarene University	10
Southern Oregon University	10
Southern Polytechnic State University	10
Southern State Community College	10
Southern Union State Community College	10
Southern West Virginia Community and Technical College	10
Southwest School of Business & Technical Careers	10
Southwestern Christian University	10
Southwestern Community College District	10
Southwestern Law School	10
Southwestern Michigan College	10
Southwestern Oklahoma State University	10
Spalding University	10
Spelman College	10
Spokane Falls Community College	10
Spring Hill College	10
Springfield Technical Community College	10
St. Bonaventure University	10
St. George's University, School of Veterinary Medicine	10

State University of New York at Farmingdale	10
State University of New York at New Paltz	10
State University of New York College at Plattsburgh	10
Stenograph Institute of Texas	10
Stevens - The Institute of Business & Arts	10
Stevens Institute of Technology	10
Sul Ross State University	10
Sunstate Academy	10
SUNY College at Purchase	10
SUNY Westchester Community College	10
Taylor College	10
TDDS Technical Institute	10
Tenaj Salon Institute	10
Terra State Community College	10
TESST College of Technology	10
Texas Chiropractic College	10
Thomas More University	10
Thunderbird School of Global Management	10
TIGI Hairdressing Academy Legacy	10
Tint School of Makeup & Cosmetology	10
Toledo Public Schools Adult and Continuing Education	10
Tompkins Cortland Community College	10
Travel & Trade Career Institute	10
Treasure Valley Community College	10
Trend College	10
Tribeca Flashpoint College	10
Trinity Valley Community College	10
Truckee Meadows Community College	10
Tufts University	10
UCAS University of Cosmetology Arts & Sciences	10
United States International University	10
Universal Career School	10
Universidad del Sagrado Corazon	10
Universidad Politecnica de Puerto Rico	10
University of Alaska Fairbanks	10
University of Arkansas for Medical Sciences	10
University of Dallas	10
University of Dubuque	10
University of Illinois at Springfield	10
University of Maine	10
University of Minnesota Duluth	10
University of Nebraska - Kearney	10
University of North Dakota	10
University of North Texas at Dallas	10
University of Northern Iowa	10
University of Saint Francis	10
University of Saint Joseph	10

University of Silicon Valley	10
University of the Arts (The)	10
University of the Potomac	10
University of Tulsa (The)	10
University of Wisconsin - Oshkosh	10
University of Wisconsin - Stevens Point	10
University of Wisconsin - Stout	10
University of Wisconsin - Superior	10
University of Wisconsin Colleges	10
University of Wyoming	10
Ursuline College	10
Utah State University	10
Vanderbilt University	10
Velvet Touch Academy of Cosmetology	10
Vet Tech Institute of Houston	10
Video Technical Institute	10
Virginia Wesleyan University	10
Vocational Training Center	10
Vogue Beauty and Barber School	10
Wade College	10
Wagner College	10
Wake Forest University	10
Walsh College of Accountancy & Business Administration	10
Warner Pacific University	10
Washington University in St. Louis	10
Watterson College Pacific	10
Waubonsee Community College	10
Webber International University	10
Wentworth Institute of Technology	10
West Kentucky Community and Technical College	10
West Liberty University	10
Western Iowa Tech Community College	10
Western Washington University	10
WestMed College	10
Westminster College	10
Wheeling University	10
Wilfred Academy of Hair & Beauty Culture	10
William Peace University	10
William Penn University	10
Willsey Institute	10
Wilshire Computer College	10
Woodbury University	10
Woodruff Medical and Wellness Training	10
Yakima Valley College	10
York College of Pennsylvania	10
YTI Career Institute - Altoona	10
YTI Career Institute - Capital Region	10

4-States Academy of Cosmetology	<10
4-States Okmulgee Academy of Cosmetology	<10
A - Technical College	<10
A & W Healthcare Educators	<10
A B Inst	<10
A Business Career Institute	<10
AAA Midwest Beauty College	<10
Aaron's Academy of Beauty	<10
ABC Beauty College	<10
ABC Technical & Trade Schools	<10
ABCO Technology	<10
Abdill Career College	<10
Aberystwyth University	<10
Abington Memorial Hospital Dixon School of Nursing	<10
Abraham Lincoln University	<10
Academy (The)	<10
Academy College	<10
Academy Di Capelli	<10
Academy Education Services	<10
Academy For Five Element Acupuncture	<10
Academy for Salon Professionals	<10
Academy for Salon Professionals (The)	<10
Academy of Aesthetic Arts	<10
Academy of Beauty Culture	<10
Academy of Beauty Professionals	<10
Academy of Business Careers	<10
Academy of Career Training	<10
Academy of Creative Hair Design	<10
Academy of Hair Design #4	<10
Academy of Hair Design (The)	<10
Academy of Hair Technology	<10
Academy of Interactive Entertainment	<10
Academy of Massage and Bodywork	<10
Academy of Massage Therapy	<10
Academy of Natural Therapy	<10
Academy of Palm Beach	<10
Academy of Professional Development	<10
Academy of Salon and Spa	<10
Academy of Scientific Hair Design	<10
Academy of Somatic Healing Arts (ASHA)	<10
Academy of Stenographic Arts	<10
Acaydia Spa and School of Aesthetics	<10
Access Careers	<10
AccuTech Career Institute	<10
Ace Cosmetology and Barber Training Center	<10
Ace Institute of Technology	<10
ACME Institute of Technology	<10

Acupuncture and Integrative Medicine College, Berkeley	<10
Acupuncture and Massage College	<10
Adrian College	<10
Adrians Beauty College of Turlock	<10
Adult & Community Education, Columbus City Schools	<10
Advance Beauty Techs Academy	<10
Advance Science International College	<10
Advanced Beauty College	<10
Advanced Career Institute	<10
Advanced Computing Institute	<10
Advanced Institute of Hair Design	<10
Advanced Training Center	<10
Advantage Career Institute	<10
Advocate Trinity Hospital School of Radiologic Technology	<10
Aesthetics Institute of Cosmetology	<10
Agnes Scott College	<10
Aiken School of Cosmetology and Barbering	<10
Aiken Technical College	<10
Ailano School of Cosmetology	<10
Ailey School (The)	<10
Aims Academy	<10
Al Tate Beauty College	<10
Alabama College of Osteopathic Medicine	<10
Alabama School of Nail Technology & Cosmetology	<10
Aladdin Beauty College #1	<10
Aladdin Beauty College #18	<10
Aladdin Beauty College #32	<10
Aladdin Beauty College #5	<10
Alameda Technical College	<10
Alamo City Barber College	<10
Alaska Bible College	<10
Alaska Career College	<10
Alaska Computer Institute	<10
Alaska Junior College	<10
Alaska Pacific University	<10
Albany College of Pharmacy and Health Sciences	<10
Albany Law School of Union University	<10
Albany Medical College	<10
Albany Schoharie Schenectady Saratoga BOCES Practical Nursing Program	<10
Albert Einstein College of Medicine	<10
Albion College	<10
Albright College	<10
Alderson Broaddus University	<10
Alexander Academy	<10
Alexandria School of Scientific Therapeutics	<10
Alexandria Technical and Community College	<10
Alfred University	<10

Alice Lloyd College	<10
All American Career College	<10
All Beauty College	<10
Allan Hancock College	<10
Allegheny College	<10
Allegiance Beauty School	<10
Allen College	<10
Allen County Community College	<10
Allentown Hosp Lehigh Valley Hospital Center School of Medical Techlgy	<10
Allgood Beauty Institute	<10
Alliance Computing Solutions	<10
Alliance Tractor Trailer Training Center	<10
Allied Career Center	<10
Allied College of Technical Sciences	<10
Allied Health Careers Institute	<10
Allied Inst of Techlgy	<10
Allied Medical and Technical Institute	<10
Allstate Institute of Technology	<10
Allure School of Cosmetology	<10
Alma College	<10
Alpena Community College	<10
Alpine College	<10
Alta Business and Professional Training Center	<10
Altoona Beauty School	<10
Alvin Community College	<10
Ambiance Beauty & Barber Academy	<10
American Academy of Art College	<10
American Academy of Cosmetology	<10
American Academy of Dramatic Arts	<10
American Academy of Dramatic Arts-West	<10
American Academy of Health and Beauty	<10
American Advanced Technicians Institute	<10
American Bartenders School	<10
American Beauty College	<10
American Beauty School	<10
American Business & Technology University	<10
American Business College	<10
American Career Academy	<10
American Career Schools	<10
American Careers Institute	<10
American Center for Career Training	<10
American Center for Technical Arts & Sciences	<10
American College of Acupuncture & Oriental Medicine	<10
American College of Barbering	<10
American College of Hair Design	<10
American College of Hairstyling-Cedar Rapids	<10
American College of Professional Education	<10

American Commerical College	<10
American Film Institute Conservatory	<10
American Graduate School in Paris	<10
American Institute for Paralegal Studies	<10
American Institute of Business & Technology	<10
American Institute of Design	<10
American Institute of Interior Design	<10
American Institute of Massage Therapy	<10
American Institute of Medical Sciences & Education	<10
American Institute of Medical Sonography	<10
American Institute of Pharmaceutical Technology	<10
American Jewish University	<10
American Massage & Bodywork Institute	<10
American Medical Academy	<10
American Medical Sciences Center	<10
American Nanny College	<10
American School of Cosmetology	<10
American Technical Center	<10
American Technical College	<10
American Technical College for Car Train	<10
American Technical Institute	<10
American Teller Schools of Arizona	<10
American Tour Management Institute	<10
American Trade School	<10
American Transportation College	<10
American Transportation Education Centers	<10
American University In Cairo (The)	<10
American University of Health Sciences	<10
American University of Puerto Rico	<10
American Video Repair Institute	<10
American Vocational Center	<10
American Weld Testing School	<10
Americo Technical Careers Institute	<10
AmesEd	<10
AMG School of Nursing	<10
Amherst Career Center	<10
AMS College	<10
Ams College Home Study Division	<10
Amtech Institute	<10
Ana G. Méndez University	<10
Anabaptist Mennonite Biblical Seminary	<10
Andover Newton Theological School	<10
Andover Tractor Trailer School Home Study Division	<10
Angeles College	<10
Angeles Institute	<10
Anglia Ruskin University	<10
Ann Marie's World of Beauty School	<10

Ann Webb Skin Institute	<10
Anna Maria College	<10
Another Level Barbering and Cosmetology School	<10
Anousheh School of Hair	<10
Antigua College International	<10
Antioch College	<10
Antioch School of Law	<10
Antonelli Medical & Professional Institute	<10
AOMA Graduate School of Integrative Medicine	<10
Apollo Business & Technical School	<10
Apollo Career Center	<10
Apollo College	<10
Apollo College of Medical & Dental Careers	<10
Appalachian Bible College	<10
Appalachian College of Pharmacy	<10
Appalachian School of Law	<10
Appalachian State University	<10
Arclabs	<10
Aristotle College of Medical and Dental Technology	<10
Arizona Academy of Beauty	<10
Arizona Academy of Beauty - North	<10
Arizona Career College (Closed)	<10
Arizona Christian University	<10
Arizona Computer Institute	<10
Arizona Culinary Institute	<10
Arizona School of Acupuncture and Oriental Medicine	<10
Arizona School of Integrative Studies	<10
Arizona Western College	<10
Arkansas Beauty College	<10
Arkansas Beauty School- Little Rock	<10
Arkansas Beauty School/Conway	<10
Arkansas Colleges of Health Education	<10
Arkansas Northeastern College	<10
Arkansas State University - Beebe	<10
Arkansas State University - Mountain Home	<10
Arkansas State University - Newport	<10
Arkansas State University Three Rivers	<10
Arkansas Technical School	<10
Arlington Baptist University	<10
Arlington Medical Institute	<10
Arnold International Univ of Cosmetology	<10
Arnold's Beauty School	<10
Arrojo Cosmetology School	<10
Art Academy of Cincinnati	<10
Art Institute of Boston	<10
Artisan College of Cosmetology (The)	<10
Artistic Beauty College	<10

Asbury Theological Seminary	<10
Asbury University	<10
Ashdown College of Health Sciences	<10
Asher Institute of Hampton	<10
Asher School of Business	<10
Asheville Buncombe Technical Community College	<10
Ashland Community and Technical College	<10
Ashland County - West Holmes Career Center - Adult Education	<10
ASI Career Institute	<10
ASM Beauty World Academy	<10
Asnuntuck Community College	<10
Aspen Beauty Academy - Laurel	<10
ASPIRA City College	<10
Associated Barber College of San Diego	<10
Associated Business Careers	<10
Associated Technical Institute	<10
Assumption University	<10
Astral Academy of Hair	<10
Astrodome Career Centers	<10
ATDS Praire Hill	<10
Atelier Esthetique Institute of Esthetics	<10
Athena Career Academy	<10
Atlanta Beauty & Barber Academy	<10
Atlanta College of Art	<10
Atlanta College of Medical & Dental Careers	<10
Atlanta Institute of Music and Media	<10
Atlanta Medical Institute	<10
Atlanta School of Massage	<10
Atlantic Cape Community College	<10
Atlantic Institute of Oriental Medicine	<10
Atlantic University College	<10
Atlantis University	<10
Auburn Career Center	<10
Audio Recording Technology Institute	<10
Augusta School of Massage	<10
Augusta Technical College	<10
Augustana College	<10
Augustana University	<10
Aultman College of Nursing and Health Sciences	<10
Austin College	<10
Austin Kade Academy	<10
Austin School of Beauty Culture	<10
Automation Academy	<10
Automotive Technical Institute	<10
Automotive Training Center	<10
Avalon Vocational Technical Institute	<10
Avalon Vocational-Technical Inst	<10

Avance' Beauty College	<10
Avant Gard The School	<10
Avanti Hair Tech	<10
Ave Maria College	<10
Ave Maria School of Law	<10
Ave Maria University	<10
Aveda Arts & Sciences Institute Baton Rouge	<10
Aveda Arts & Sciences Institute Lafayette	<10
Aveda Arts & Sciences Institute Minneapolis	<10
Aveda Arts & Sciences Institute New York	<10
Aveda Fredric's Institute	<10
Aveda Institute Chapel Hill	<10
Aveda Institute Denver	<10
Aveda Institute Des Moines	<10
Aveda Institute Las Vegas	<10
Aveda Institute Maryland	<10
Aveda Institute of New Mexico (The)	<10
Aveda Institute Portland	<10
Aveda Institute Provo	<10
Aveda Institute Tucson	<10
Avenue Academy, A Cosmetology Institute (The)	<10
Avenue Five Institute	<10
Avery James College	<10
Avi Career Training	<10
Avtech Institute	<10
Axis Career Institute	<10
Babson College	<10
Baile School of Broadcasting	<10
Bailie School of Broadcast	<10
Bakersfield College	<10
Baldwin Beauty Schools	<10
Baltimore City Community College	<10
Baltimore Studio of Hair Design	<10
Bancroft School of Massage Therapy	<10
Baptist Bible College	<10
Baptist Christian College	<10
Baptist College of Florida (The)	<10
Baptist Health College Little Rock	<10
Baptist Health System School of Health Professions	<10
Baptist Theological Seminary at Richmond	<10
Barat College	<10
Barber Institute of Texas	<10
Barber School (The) by Tim Hite	<10
Barber School of Pittsburgh	<10
Barber Tech Academy	<10
Bard College	<10
Barna College of Health Sciences	<10

Barnard College	<10
Barone Beauty Academy	<10
Barrett & Company School of Hair Design	<10
Barstow Community College	<10
Barton County Community College	<10
Bates College	<10
Bates Technical College	<10
Baton Rouge Beauty College	<10
Baton Rouge General Medical Center	<10
Bauder Fashion College	<10
Bay Area College of Nursing	<10
Bay Area Legal Academy	<10
Bay Area Medical Academy	<10
Bay De Noc Community College	<10
Bay Vly Tech	<10
Baytown Technical School	<10
BCI	<10
Beacon Career Institute	<10
Beacon College	<10
Beacon University	<10
Beal University	<10
Beau Monde Academy of Barbering and Cosmetology	<10
Beaufort County Community College	<10
Beauty Academy	<10
Beauty Academy of South Florida	<10
Beauty and Health Institute	<10
Beauty School of Middletown	<10
Beauty Technical College	<10
Beaver Falls Beauty Academy	<10
Beck School of Practical Nursing	<10
BELBO Beauty Institute	<10
Bella Capelli Academy A Paul Mitchell Partner School	<10
Bella Cosmetology and Barber College	<10
Bellarmine University	<10
Bellevue College	<10
Bellin College	<10
Bellingham Beauty School	<10
Bellingham Technical College	<10
Belmont College	<10
Beloit College	<10
Bemidji State University	<10
Benedict School of Languages and Commerce	<10
Benedictine College	<10
Ben-Gurion University of the Negev	<10
Benjamin Franklin Cummings Institute	<10
Bennett Career Institute	<10
Bentley University	<10

Bergen County Technical Schools	<10
Berk Trade & Business School	<10
Berkeley City College	<10
Berkeley School of Theology	<10
Berkshire Community College	<10
Berne University	<10
Berry College	<10
Bessemer State Technical College	<10
Best Care College	<10
Beta Technical Schools	<10
Bethany College	<10
Bethany Global University	<10
Bethel College	<10
Bethesda University	<10
Betty Owen Schools	<10
Beverly Hills Design Institute	<10
Beyond The Basics School of Cosmetology	<10
Big Bend Community College	<10
Bill and Sandra Pomeroy College of Nursing at Crouse Hospital	<10
Bill Hills College of Cosmetology	<10
Birmingham-Southern College	<10
Birthingway College of Midwifery	<10
Birthwise Midwifery School	<10
Bishop College	<10
Bishop State Community College	<10
Bismarck State College	<10
BJ's Beauty & Barber College	<10
Black Hawk College	<10
Black Hills State University	<10
Black River Technical College	<10
Blackburn University	<10
Blackhawk Technical College	<10
Blades School of Hair Design	<10
Blantos College	<10
Bliss College	<10
Blue Island School of Cosmetology	<10
Blue Mountain Christian University	<10
Blue Mountain Community College	<10
Blue Ridge Community College	<10
Bluefield College	<10
Blush School of Makeup	<10
Bly's School of Cosmetology	<10
BNS Technical Institute	<10
Boardwalk & Marina Casino Dealer School of Atlantic City	<10
Bob Jones University	<10
Boca Raton Institute	<10
BOCES ONADAGA & MADISON CO OCC ED C	<10

BOCES Rensselaer School of Practical Nursing	<10
Boise Barber College a d.MARTiN Academy	<10
Boise Bible College	<10
Bojack Academy of Beauty Culture	<10
Bon Secours Memorial College of Nursing	<10
Bond University	<10
Bonnie Joseph Academy of Cosmetology & Barbering	<10
Border Institute of Technology	<10
Boricua College	<10
Bos-Man's Barber College	<10
Boston Architectural College	<10
Boston College	<10
Boston Conservatory	<10
Boston Graduate School of Psychoanalysis	<10
Bournemouth University	<10
Bradford College	<10
Brandeis University	<10
Branell Inst	<10
Branell Institute	<10
Branford Academy of Hair & Cosmetology	<10
Brannon Bus Inst	<10
Braxton School of Business	<10
Brescia University	<10
Brevard Barber College	<10
Brevard College	<10
Briarcliff College	<10
Bridgemont Community and Technical College	<10
Bridges Beauty College	<10
BridgeValley Community and Technical College	<10
Bridgewater College	<10
Brigham Young University	<10
Brigham Young University - Hawaii	<10
Brillare Beauty Institute	<10
Brookline Technical Institute	<10
Brooklyn Law School	<10
Brooklyn Training Center	<10
Broome Delaware Tioga BOCES Program of Practical Nursing	<10
Brown Aveda Institute	<10
Brown Beauty Barber School	<10
Brown University	<10
Brownson Technical School	<10
Brunel University London	<10
Bryan College of Health Sciences	<10
Bryan Institute	<10
Bryant & Stratton Business Institute - Rochester	<10
Bryant & Stratton Business Institute-Albany	<10
Bryant University	<10

Bryman School	<10
Bryn Athyn College of the New Church	<10
Bryn Mawr College	<10
Buchanan Beauty College	<10
Bucknell University	<10
Buckner Barber School	<10
Bucks County School of Beauty Culture	<10
B-Unique Beauty & Barber Academy	<10
Bunker Hill Community College	<10
Burdett College	<10
Burnett International College	<10
Burrell College of Osteopathic Medicine	<10
Bushnell University	<10
Business & Banking Institute	<10
Business Career Institute	<10
Business Etcetera Institute of Technology	<10
Business Training Institute	<10
Butera School of Art	<10
Butler Technology and Career Development Schools	<10
Butler University	<10
Cabarrus College of Health Sciences	<10
Cabot College	<10
Cabrillo College	<10
Cactus Academy (The)	<10
Caguas College of Technology & Science	<10
Cains Barber College	<10
Cairn University	<10
CALC, Institute of Technology	<10
Caldwell Community College & Technical Institute	<10
Calif School of Professor Psychiatrist Main Campus	<10
California Beauty College	<10
California Business Institute	<10
California Career College	<10
California Career Institute	<10
California Christian College	<10
California College of Barbering and Cosmetology	<10
California College of Podiatric Medicine	<10
California College of the Arts	<10
California Hair Design Academy	<10
California Health Sciences University	<10
California Institute of the Arts	<10
California Intercontinental University	<10
California Learning Center	<10
California Miramar University	<10
California Nurses Educational Institute	<10
California Paramedical & Technical College	<10
California Paramedical and Technical College	<10

California School of Court Reporting	<10
California School of Modern Sciences	<10
California School of Professional Psychology - Fresno	<10
California School of Professional Psychology, Alameda	<10
California School of Professional Psychology, Los Angeles	<10
California Southern University	<10
California State University Channel Islands	<10
California State University Maritime Academy	<10
California Technical Academy	<10
California Trade Technical Schools	<10
California University of Management and Sciences	<10
Calvary University	<10
Calvin University	<10
Cambridge Business School	<10
Cambridge College of Cosmetology	<10
Cameo Beauty Academy	<10
Canada College	<10
Canadian College of Acupuncture and Oriental Medicine	<10
Canton City School District Adult Career & Technical Education	<10
Cape Cod Community College	<10
Cape Girardeau Career and Technology Center	<10
Capilo School of Hair Design	<10
Capital Area Career Center	<10
Capital City Business College	<10
Capital Community College	<10
Capitol Beauty School	<10
Capitol Business College	<10
Capitol City Junior College	<10
Capitol Court Reporting & Captioning Institute	<10
Capitol Technology University	<10
Capri College	<10
Capri Cosmetology Learning Center	<10
Capri Oak Forest Beauty College	<10
Capri School of Beauty Culture	<10
Capstone College	<10
Cardiac and Vascular Institute of Ultrasound	<10
Cardiff University	<10
Career & Technology Education Centers of Licking County	<10
Career Academy of Beauty	<10
Career Academy of Hair Design	<10
Career Beauty College	<10
Career Blazers Learning Center	<10
Career Development Institute	<10
Career Educational Institute	<10
Career Institute	<10
Career Institute (The)	<10
Career Institute of America	<10

Career One Technical Training Corp	<10
Career Opportunities School	<10
Career Point Business School	<10
Career School of NY	<10
Career Tech	<10
Career Tech Institute	<10
Career Techl Inst	<10
Career Training Center	<10
Careercom College of Business	<10
Careers Unlimited	<10
Carey Technical Institute	<10
Caribbean University	<10
Carl Albert State College	<10
Carl Sandburg College	<10
Carmichael Beauty College	<10
Carnegie Institute	<10
Carnegie Mellon University	<10
Carolina Career College	<10
Carolina Christian College	<10
Carolina College of Hair Design	<10
Carolina School of Broadcasting	<10
Carolina University	<10
Carroll College	<10
Carroll University	<10
Cars Vocational Training School	<10
Carson City Beauty Academy	<10
Carsten Institute of Cosmetology	<10
Carthage College	<10
Carthage R-9 School District/Carthage Technical Center	<10
Carver Bible College	<10
Casal Aveda Institute	<10
Cascade Business College	<10
Cascadia College	<10
Casco Bay College	<10
Cashier Training Institute	<10
Casper College	<10
Castleton University	<10
Catawba Valley Community College	<10
Catherine Hinds Institute of Esthetics	<10
Catherine McAuley College	<10
Cattaraugus/Allegany/Erie/Wyoming BOCES	<10
Cayce/Reilly School of Massage	<10
Cayuga Community College	<10
Cazenovia College	<10
CBM Education Center	<10
CCIC Beauty College	<10
CDE Career Institute	<10

CDI Career Developement Institute	<10
CDI Career Development Inst	<10
CDI Career Development Institute	<10
CDI Careerr Development Institute	<10
Cecil College	<10
Cedarville University	<10
Celebrity School of Beauty	<10
Celebrity Stylist Beauty School	<10
CEM College	<10
Centenary College of Louisiana	<10
Centenary University	<10
Center for Neurosomatic Studies	<10
Center for the Healing Arts	<10
Center for Ultrasound Research & Education	<10
CenterPoint Massage & Shiatsu Therapy School & Clinic	<10
Centra College	<10
Central Alabama Community College	<10
Central Baptist College	<10
Central Bible College	<10
Central California School of Continuing Education	<10
Central Christian College of Kansas	<10
Central Christian College of The Bible	<10
Central City Business Institute	<10
Central Coast College	<10
Central College	<10
Central Community College	<10
Central Lakes College	<10
Central Louisiana Technical Community College	<10
Central Maine Community College	<10
Central Methodist University	<10
Central New England College	<10
Central Oklahoma College	<10
Central Pennsylvania Institute of Science and Technology	<10
Central School of Practical Nursing	<10
Central State Massage Academy	<10
Central Susquehanna LPN Career Center	<10
Central Wyoming College	<10
Central YMCA Community College (Closed)	<10
Centre College of Kentucky	<10
Centro de Estudios Avanzados de Puerto Rico y el Caribe	<10
Centro De Estudios Universitarios Xochicalco	<10
Certified Welding & Trade School	<10
Chabot College	<10
Chadron State College	<10
Chaffey Community College	<10
Chamberlayne School & Chamberlayne Junior College (Closed)	<10
Champion Beauty College	<10

Champion Christian College	<10
Champion Institute of Cosmetology	<10
Charles A. Jones Career and Education Center	<10
Charles Academy of Beauty Culture	<10
Charles Allan Academy of Beauty Culture	<10
Charles D Murdock Institute	<10
Charles of Italy Beauty College	<10
Charles Stuart School	<10
Charleston Cosmetology Institute	<10
Charleston School of Beauty Culture	<10
Charlotte Christian College and Theological Seminary	<10
Charms Beauty School	<10
Charzanne Beauty College	<10
Chase College	<10
Chattahoochee Technical College	<10
Chauffeurs Training School	<10
Cheeks Beauty Academy	<10
Cheryl Fell's School of Business	<10
Cheseapeake Business Inst of Virginia	<10
Chester College of New England	<10
Chester County Intermediate Unit Practical Nursing Program	<10
Cheyenne Aero Technical	<10
Chicago City-Wide College	<10
Chicago ORT Technical Institute	<10
Chicago Professional College	<10
Chicago Technological College	<10
Chicago Truck Driving School	<10
Chipola College	<10
Christ College of Nursing and Health Sciences	<10
Christ Hospital School of Nursing	<10
Christine Valmy International School forEsthetics, Skin Care & Make-up	<10
Christine Valmy International School of Esthetics & Cosmetology	<10
Church Divinity School of the Pacific	<10
Churchman Business School	<10
Cincinnati College of Mortuary Science	<10
Cincinnati Metropolitan College	<10
Cincinnati School of Court Reporting and Business	<10
Cisco College	<10
Cisoria Academy of Cosmetology	<10
Citadel, The Military College of South Carolina	<10
Citizens School of Nursing	<10
Citrus College	<10
City College of Colorado Springs	<10
City Technical Institute	<10
City, University of London	<10
Claremont Lincoln University	<10
Claremont School of Theology	<10

Clarendon College	<10
Clarion County Career Center Practical Nursing	<10
Clark University	<10
Clarke University	<10
Clarks Summit University	<10
Clarkson College	<10
Clarkson University	<10
Classic Beauty College	<10
Classic Beauty Colleges	<10
Clatsop Community College	<10
Clayton Univ	<10
Clearwater Christian College	<10
Clemens College	<10
Cleveland Institute of Art (The)	<10
Cleveland Institute of Electronics	<10
Cleveland Institute of Music (The)	<10
Cleveland Institute of Technology	<10
Cleveland University-Kansas City	<10
Clifton School of Business	<10
Climate Control Institute	<10
Clinton College	<10
Clinton Community College - SUNY Office of Community Colleges	<10
Clinton-Essex-Warren-Washington BOCES	<10
Cloud County Community College	<10
Clovis Community College	<10
Cloyd's Beauty School #1	<10
Coachella Valley Beauty College	<10
Coalition of African American Nurses	<10
Coastal Bend College	<10
Coastal College	<10
Coastal Training Institute	<10
Coastline Community College	<10
Coba Academy	<10
Cobb Beauty College	<10
Cochise College	<10
Cochran School of Nursing - St. John's Riverside Hospital	<10
Cocoa Beach Beauty School	<10
Coconino County Community College	<10
Coe College	<10
Coffeyville Community College	<10
Coker University	<10
Colby College	<10
Colby Community College	<10
Colby-Sawyer College	<10
Colegio Tecnico Metropolitano	<10
Colgate University	<10
Collectiv Hair Dressing Academy	<10

Colleen O'Hara's Beauty Academy	<10
College America	<10
College for Early Childhood Educators (The)	<10
College of Alameda	<10
College of Biblical Studies-Houston	<10
College of Cosmetology	<10
College of Eastern Idaho	<10
College of Hair Design	<10
College of Hair Design Careers	<10
College of Idaho (The)	<10
College of Insurance (The)	<10
College of Lake County	<10
College of Marin	<10
College of New Jersey (The)	<10
College of Saint Benedict	<10
College of Saint Scholastica	<10
College of San Mateo	<10
College of Southern Maryland	<10
College of the Americas of Tulsa	<10
College of the Canyons	<10
College of the Florida Keys (The)	<10
College of the Holy Cross	<10
College of the Mainland	<10
College of the Palm Beaches	<10
College of the Redwoods	<10
College of the Sequoias	<10
College of the Siskiyous	<10
College of Visual Arts	<10
College of William & Mary	<10
Collins Career Technical Center	<10
Collins School of Cosmetology	<10
Colorado Chinese Medicine University	<10
Colorado College	<10
Colorado Mountain College	<10
Colorado Northwestern Community College	<10
Colorado School of Healing Arts	<10
Colorado School of Mines	<10
Colorado School of Trades	<10
Columbia - Greene Community College - SUNY Office of Cmnty Colleges	<10
Columbia Basin College	<10
Columbia Central University	<10
Columbia College of Business	<10
Columbia Gorge Community College	<10
Columbia International University	<10
Columbia Junior College	<10
Columbia State Community College	<10
Columbia University School of Arts	<10

Columbia University School of Gen Studies	<10
Columbus College of Art & Design	<10
Columbus Technical College	<10
Commercial College of Baton Rouge	<10
Commercial College of Shreveport	<10
Commercial Divers International	<10
Commercial Drive Institute	<10
Commercial Programming Unlimited	<10
Commonwealth College, Norfolk	<10
Commonwealth Institute of Funeral Service	<10
Commonwealth International	<10
Community Christian College	<10
Community College of Vermont	<10
Community Enhancement Services	<10
Compass Career College	<10
Compton College	<10
Computer Business College	<10
Computer Communications Institute	<10
Computer Dynamics Institute	<10
Computer Processing Institute	<10
Concho Career Institute	<10
Concord Law School	<10
Concord University	<10
Concorde Career Inst	<10
Concordia College - Moorhead	<10
Concordia Theological Seminary	<10
Conemaugh Memorial Medical Center	<10
Connecticut Academy	<10
Connecticut Business Institute	<10
Connecticut College	<10
Connecticut Institute of Art	<10
Connecticut Institute of Hair Design	<10
Connecticut Training Center	<10
Connors State College	<10
Construction Training Center	<10
Consumer Electronics Training Center	<10
Continental Beauty College	<10
Continental Beauty College (Closed)	<10
Continental College of Beauty & Barber Styling	<10
Continentale Beauty School	<10
Contra Costa College	<10
Contra Costa Medical Career College	<10
Converse University	<10
Cooper Union for the Advancement of Science & Art (The)	<10
Copper Mountain College	<10
Coral Ridge Training School	<10
Corban University	<10

Corinth Academy of Cosmetology	<10
Cornell College	<10
Cornell University	<10
Corning Community College - SUNY Office of Community Colleges	<10
Cornish College of the Arts	<10
Cortez W Peters Business College of Chicago	<10
Cortiva Institute - Boston	<10
Cortiva Institute - Charlottesville	<10
Cortiva Institute - Scottsdale	<10
Cortiva Institute - Somerset School of Massage Therapy	<10
Cortiva Institute-Colorado	<10
Cosmetic Arts Institute	<10
Cosmetology Academy of Texarkana	<10
Cosmetology Careers Unlimited	<10
Cosmetology Careers Unlimited College of Hair, Skin, and Nails	<10
Cosmetology School of Arts & Sciences	<10
Cosmix School of Makeup Artistry	<10
Cosmo Beauty Academy	<10
Cottey College	<10
County College of Morris	<10
County Schools Home Study	<10
Court Reporting Academy & School of Profesional Studies	<10
Court Reporting Institute	<10
Covenant College	<10
Covenant School of Nursing and Allied Health	<10
Cowley County Community College & Area Vocational Technical School	<10
Cox College	<10
Cozmo Beauty School	<10
Craft Institute (The)	<10
Cranbrook Academy of Art	<10
Crandall Junior College	<10
Cranfield University	<10
Cranford College	<10
Craven Community College	<10
Creative Center (The)	<10
Creative Circus (The)	<10
Creative Images Institute of Cosmetology	<10
Creative School of Beauty	<10
Creative Touch Cosmetology School	<10
Credence Institute of Beauty	<10
Crestwood Career Academy	<10
Crevier's School of Cosmetology	<10
Criss College	<10
Crossroads Bible College	<10
Crossroads College	<10
Crowder College	<10
Crowley's Ridge College	<10

Crown Business Institute Miami	<10
Crown Business Institute Nyc	<10
CR'U Institute of Cosmetology and Barbering	<10
CSC Institute	<10
CTK Healthcare & Career Institute	<10
Cuesta College	<10
Culinary Arts Institute of Louisiana	<10
Culinary Institute of New Orleans	<10
Culinary School of Washington	<10
Culinary Tech Center	<10
Culpeper Cosmetology Training Center	<10
Culver-Stockton College	<10
Cumberland County College	<10
Cumberland University	<10
CUNY Bernard Baruch School of Business	<10
CUNY Graduate School & University Center	<10
CUNY LaGuardia Community College	<10
CUNY School of Law	<10
CUNY York College	<10
Cut Beauty School (The)	<10
Cutting Edge Academy	<10
Cutting Edge Hairstyling Academy	<10
Cuyahoga Valley Career Center	<10
Cuyamaca College	<10
Cypress College	<10
D&S School of Cosmetology	<10
Dahan Institute of Massage Studies	<10
Dahl's College of Beauty	<10
Dakota College at Bottineau	<10
Dakota County Technical College	<10
Dakota State University	<10
Dakota Wesleyan University	<10
Dalenas College of Beauty	<10
Dallas Barber & Stylist College	<10
Dallas Christian College	<10
Dallas Institute of Funeral Service	<10
Dallas Theological Seminary	<10
Dalton Institute of Esthetics and Cosmetology	<10
Dalton State College	<10
Dana College	<10
Daniel Freeman Hospital Paramedic School	<10
Danville Area Community College	<10
Danville Community College	<10
Daoist Traditions College of Chinese Medical Arts	<10
Davenport Barber Styling College	<10
Davenport University - Central Region	<10
David Demuth Institute of Cosmetology	<10

David Pressley Professional School of Cosmetology	<10
David's Academy of Beauty	<10
Davines Professional Academy of Beauty and Business	<10
Davis & Elkins College	<10
Day Spa Career College	<10
DCI Career Institute	<10
De Anza Community College	<10
Dean College	<10
Dean Institute of Technology	<10
Debbie's Alabama Beauty College	<10
Debbies School of Beauty Culture	<10
Debbie's School of Beauty Culture	<10
Dee Boya Institute of Fashion	<10
Defiance College	<10
Dekalb Beauty College	<10
Delaware Chenango Madison Otsego BOCES	<10
Delaware County Institute of Training	<10
Delaware County Technical School	<10
Delaware Technical Community College	<10
Delaware Technical Community College - Owens Campus	<10
Delaware Valley University	<10
Del-Mar-Va Beauty Academy	<10
Deloux School of Cosmetology Escondido	<10
Delta Beauty College	<10
Delta Career College	<10
Delta Career Institute	<10
Delta College of Business & Technology	<10
Delta Connection Academy	<10
Delta Junior College	<10
Denmark College	<10
Denver College of Nursing	<10
Denver Institute of Technology	<10
DePauw University	<10
Des Moines Area Community College Ankeny	<10
Des Moines University - Osteopathic Medical Center	<10
Design Institute of San Diego	<10
Designer Barber & Stylist School	<10
Designer's Beauty Academy	<10
Design's School of Cosmetology	<10
Destination Academy for Spa and Salon Professionals	<10
Detroit Business Institute	<10
Detroit Business Institute - Downriver	<10
Detroit Institute Of Commerce	<10
Dewey University	<10
DeWolff Hairstyling and Cosmetology Institute	<10
Dickinson College	<10
Dickinson Warren College	<10

Diesel Institute of America	<10
Diesel Truck Driver Train School	<10
DigiPen Institute of Technology	<10
Digital Film Academy	<10
DiGrigoli School of Cosmetology	<10
Divers Institute of Technology	<10
Divine Mercy University	<10
Doane University	<10
Dodge City Community College	<10
Dolce The Academy	<10
Dominican University of California	<10
Dominion College	<10
Dominion School of Hair Design	<10
Don Roberts Beauty School	<10
Don Roberts School of Hair Design	<10
Dongguk University Los Angeles	<10
Donnelly College	<10
Doolin Technical College	<10
D'or Beauty College	<10
D'Or School of Cosmetology	<10
Dordt University	<10
Dorothea B Lane School	<10
Dorothea Hopfer School of Nursing At The Mount Vernon Hospital (The)	<10
Douglas J Aveda Institute-Chicago	<10
Dr William M Scholl College of Podiatric Medicine at Finch University	<10
Drake School of Manhattan	<10
Drake School of the Bronx	<10
Drake School of Westchester	<10
Draughon Business College	<10
Draughon College	<10
Draughon Training Institute	<10
Draughons Business College	<10
Draughon's College of Business	<10
Dret School	<10
Drew University	<10
DSU Training Institute	<10
Du Quoin Beauty College	<10
DuCret School of the Arts	<10
Dudley Beauty College	<10
Dudley Hall Car Inst	<10
Dunwoody College of Technology	<10
Durham College of San Antonio	<10
Dutchess BOCES School of Practical Nursing	<10
Dutchess Community College	<10
DuVall's School of Cosmetology	<10
DVST Career Academy	<10
Earlham College	<10

Eason's Inst of Techlgy	<10
East Arkansas Community College	<10
East Central College	<10
East Central Community College	<10
East Central University	<10
East Coast Bible College	<10
East Los Angeles College	<10
East Ohio College	<10
East Texas Baptist University	<10
East West College of The Healing Arts	<10
Eastern Hills Academy of Hair Design	<10
Eastern Jackson County College of Allied Health	<10
Eastern Maine Community College	<10
Eastern Mennonite University	<10
Eastern Nazarene College	<10
Eastern Oklahoma State College	<10
Eastern School of Acupuncture and Traditional Medicine	<10
Eastern School of Technology	<10
Eastern Suffolk BOCES	<10
Eastern Technical School	<10
Eastern Virginia Career College	<10
Eastern Virginia Medical School	<10
Eastern West Virginia Community & Technical College	<10
Eastern Wyoming College	<10
Eastland-Fairfield Career and Technical Schools	<10
East-West Healing Arts Institute	<10
Ecclesia College	<10
Eckerd College	<10
eClips School of Cosmetology and Barbering	<10
Edgewood College	<10
EDIC College	<10
Edinboro University of Pennsylvania	<10
Edison State Community College	<10
Edmonds College	<10
Edmondson Junior College	<10
EDP University of Puerto Rico	<10
Education America-Topeka Technical College	<10
Education Dynamics Institution	<10
Educational Centers of America	<10
Educational Services for Health Occupations	<10
Educators of Beauty College of Cosmetology	<10
EduMed Partners	<10
Edutek Professional College	<10
Edutek Professional Colleges	<10
Edward Via Virginia College of Osteopathic Medicine	<10
El Camino College	<10
El Paso Community College	<10

Electronic Computer Programming Inst	<10
Electronic Institutes	<10
Electronic Program Institute of Omaha	<10
Electronic Technical Institute	<10
Elite Academy of Beauty Arts	<10
Elite Academy of Cosmetology	<10
Elite College of Cosmetology	<10
Elite Cosmetology School	<10
Elite School of Cosmetology	<10
Elizabeth Grady School of Esthetics and Massage Therapy	<10
Elizabeth Seton College	<10
Elizabethtown College	<10
Elkin's Inst in Dallas	<10
Elkins Institute	<10
Elkins Institute of Jacksonville	<10
Ellis Medicine, The Belanger School of Nursing	<10
Ellsworth Community College	<10
Elsa Cooper Institute of Court Reporting	<10
Emory & Henry College	<10
Emory College of Puerto Rico	<10
Emperor's College of Traditional Oriental Medicine	<10
Empire Beauty School -Arvada	<10
Empire Career Center	<10
Empire Technical School	<10
Empire Technical School of New Jersey	<10
Employment Solutions	<10
Emporia State University	<10
Ensign College	<10
Enterprise State Community College	<10
Epic Bible College	<10
Episcopal Divinity School	<10
Erasmus University Rotterdam (EUR)	<10
Eric Fisher Academy	<10
Erie 1 Board of Cooperative Educational Services	<10
Erie Community College - North Campus	<10
Erie Institute of Technology	<10
Erikson Institute	<10
Erskine College	<10
Erwin Technical College	<10
Escuela Hotelera de San Juan	<10
ESI Career Center	<10
ESI Technology Training Center	<10
Essex College of Business	<10
Essex Community College	<10
Essex County College	<10
Estelle Harman Actor's Workshop	<10
Estelle Skin Care and Spa Institute	<10

Estes Institute of Cosmetology Arts & Sciences	<10
Esthetic Institute (The)	<10
Eugenio Maria De Hostos School of Law	<10
Eureka College	<10
Euro Hair School	<10
European Beauty Culture College	<10
European Graduate School (EGS)	<10
European Massage Therapy School (The)	<10
Expert Solutions Technical College	<10
Exposito School of Hair Design	<10
Ezell's Cosmetology School, LLC	<10
Fairfax University of America	<10
Fairfield University	<10
Faith International University	<10
Faith Theological Seminary	<10
Falcon Institute of Health and Science	<10
Family of Faith Christian University	<10
Faris Technical Institute	<10
Faust Institute of Cosmetology	<10
Fayette County Career & Technical Institute	<10
Fayetteville Beauty College	<10
Feather River College	<10
Federal Truck Driving School	<10
Federico North Fresno Beauty College	<10
Felbry College-School of Nursing	<10
Ferrum College	<10
Fila Academy (The)	<10
FINE Mortuary College	<10
Finger Lakes- Geneva General	<10
First Business School (The)	<10
First Class Cosmetology School	<10
First School for Careers	<10
Fischer Technical College	<10
Fiser's College of Cosmetology	<10
Flagler Career Institute	<10
Flair Beauty College	<10
Flamingo Beauty College	<10
Flathead Valley Community College	<10
Fleet Business School	<10
Flight Safety Academy	<10
Flinders University	<10
Flint Hills Technical College	<10
Flint Institute of Barbering	<10
Florida Academy	<10
Florida Academy of Cosmetology Arts & Sciences	<10
Florida Beauty College	<10
Florida Christian College	<10

Florida College of Integrative Medicine	<10
Florida Education Institute	<10
Florida Gateway College	<10
Florida Institute of Recording, Sound and Technology	<10
Florida Institute of Traditional Chinese Medicine	<10
Florida Institute of Ultrasound	<10
Florida International Training Institute	<10
Florida School of Business	<10
Florida School of Massage	<10
Florida School of Traditional Midwifery	<10
Folsom Lake College	<10
Fond du Lac Tribal & Community College	<10
Foothill College	<10
Fort Lewis College	<10
Fort Scott Community College	<10
Fosbre Academy of Hair Design	<10
Foster's Cosmetology and Barber College	<10
Foundation College	<10
Fountain of Youth Academy of Cosmetology	<10
Fran Brown College of Beauty	<10
Francis Tuttle Technology Center School District No. 21	<10
Franciscan University of Steubenville	<10
Francois D. College of Hair Skin & Nails	<10
Frank Phillips College	<10
Franklin & Marshall College	<10
Franklin Beauty School	<10
Franklin Career College	<10
Franklin College of Indiana	<10
Franklin County Career and Technology Center	<10
Franklin School of Cosmelotogy & Hair Design	<10
Franklin Technology Center	<10
Frederick Community College	<10
Frederick's Beauty College	<10
Freed-Hardeman University	<10
French Academy of Cosmetology	<10
Ft Lauderdale School of Allied Health Careers	<10
Fuller Theological Seminary	<10
Fullerton College	<10
Furman University	<10
FVI School of Nursing and Technology	<10
G.A. Beauty & Barber School	<10
Gadsden Business College	<10
Gainesville State College	<10
Galaxy Medical College	<10
Gallaudet University	<10
Galveston College	<10
Garces Commercial College	<10

Garden City Community College	<10
Garden State Science and Technology Institute	<10
Garrett - Evangelical Theological Seminary	<10
Garrett College	<10
Gary Manuel Aveda Institute	<10
Gaston College	<10
Gateway Electronics Inst	<10
Gateway Technical Institute	<10
Gavilan College	<10
GDS Institute	<10
General Education & Training Home Study	<10
General Education & Training Resident Program	<10
Genesee Community College	<10
Genesee-Livingston-Steuben-Wyoming BOCES	<10
Genesis Vocational Training	<10
Geneva College	<10
Gentle Healing School of Massage	<10
George Rogers Clark College	<10
Georgetown College	<10
Georgetown School of Science & Arts (Closed)	<10
Georgia Christian University	<10
Georgia Northwestern Technical College	<10
Germanna Community College	<10
Ghent Beauty Academy	<10
Gill-Tech Academy of Hair Design	<10
Gino Robair Beauty College	<10
Glasgow Caledonian University	<10
Glasgow School of Art	<10
Glenville State University	<10
Glenwood Beauty Academy	<10
Glitz School of Cosmetology	<10
Global Business Institute	<10
Global Tech College	<10
Gloria Francis School of Make-up Artistry	<10
Goddard College	<10
Gogebic Community College	<10
Golden State College of Court Reporting & Captioning	<10
Golden State School	<10
Golden West College	<10
Goldfarb School of Nursing at Barnes-Jewish College	<10
Goldsmiths College - University of London	<10
Good Samaritan College of Nursing and Health Science	<10
GoodFellas Barber College	<10
Gordon College	<10
Gordon Phillips Beauty School	<10
Gordon Phillips School of Beauty Culture	<10
Goshen College	<10

Goucher College	<10
Gould's Academy	<10
GP Institute of Cosmetology	<10
Grabber School of Hair Design	<10
Grace College and Theological Seminary	<10
Grace School of Theology	<10
Grace University	<10
Graduate School of Political Management	<10
Graham Hospital School of Nursing	<10
Graham Webb International Academy of Hair	<10
Grand Island College	<10
Grand View University	<10
Gratz College	<10
Grays Harbor College	<10
Grayson College	<10
Great Basin College	<10
Great Bay Community College	<10
Great Lakes Christian College	<10
Great Lakes Techl Inst	<10
Great Lakes Truck Driving School	<10
Great Oaks Career Campuses-Scarlet Oaks	<10
Greater Altoona Career & Technology Center	<10
Greater Johnstown Area Vocational Technical School	<10
Greene County Career Center	<10
Greenfield Community College	<10
Greensboro College	<10
Greenville University	<10
Grenoble Ecole de Management	<10
Griffin Bellevue Business College	<10
Grossmont College	<10
Grove School of Music	<10
Gustavus Adolphus College	<10
Guthrie Academy	<10
Hagerstown Business College	<10
Hagerstown Community College	<10
Hair Academy (The)	<10
Hair Academy II	<10
Hair Academy The	<10
Hair Design Institute at Livingston Street	<10
Hair Dynamics Education Center	<10
Hair Professionals School of Cosmetology	<10
Hairbenders School of Hairstyling	<10
Hairmasters Institute of Cosmetology	<10
Hairstyling Institute of Charlotte	<10
Halifax Community College	<10
Hall Institute of Technology	<10
Hammel College	<10

Hampden Sydney College	<10
Hampshire College	<10
Hampton Roads School of Technology	<10
Hamrick School	<10
Hands On Therapy	<10
Hannah E Mullins School of Practical Nursing	<10
Hannibal - LaGrange University	<10
Hannibal Career and Technical Center	<10
Hanover College	<10
Hanover Public School District Practical Nursing Program	<10
Hardin-Simmons University	<10
Harford Community College	<10
Hargest Vocational Technical College	<10
Harley's Beauty & Barber Career Institute	<10
Harrington Institute of Interior Design	<10
Harrisburg University of Science and Technology	<10
Hartford Modern School of Welding	<10
Hartford School of Music (The)	<10
Hartford Techl Inst	<10
Hartwick College	<10
Hausman Computer Associates School of Computer Programming	<10
Hawaii College of Oriental Medicine	<10
Hawaii Community College	<10
Hawaii Medical College	<10
Hawaii Transportation System	<10
Hazard Community and Technical College	<10
Hazelden Graduate School of Addiction Studies	<10
Hazleton Area Career Center	<10
HDS Truck Driving Institute	<10
Headmasters School of Hair Design	<10
Headquarters Academy of Hair Design (The)	<10
Head's West Kentucky Beauty College	<10
Healing Arts Center	<10
Healing Hands School of Holistic Health	<10
Health Care Training Institute	<10
Health Opportunity Technical Center	<10
Health Works Institute	<10
Healthcare Institute (The)	<10
Heartland Community College	<10
Heidelberg University	<10
Heights Beauty College	<10
Helena College University of Montana	<10
Helena Dye & Flanary Beauty College	<10
Helene Fuld College of Nursing	<10
Hellenic College & Holy Cross Greek Orthodox School of Theology	<10
Helma Institute of Massage Therapy	<10
Helms College	<10

Henderson Community College	<10
Hendrix College	<10
Henri's School of Hair Design	<10
Henry Cogswell College	<10
Heritage Christian University	<10
Heritage Valley Health System	<10
Hesston College	<10
Hickox School of Information Technology	<10
Hicks Academy of Beauty Culture	<10
High Point University	<10
High Tech High Graduate School of Education	<10
Highland Community College	<10
Highland Park Community College	<10
Highline College	<10
Hilbert College	<10
Hill College	<10
Hill Institute	<10
Hillsdale Beauty College	<10
Hinton Barber and Beauty College	<10
Hiram College	<10
Hobart and William Smith Colleges	<10
Hogan Institute of Cosmetology and Esthetics	<10
Hollins University	<10
Holliston Junior College	<10
Hollywood Cultural College	<10
Holy Cross College	<10
Holyoke Community College	<10
Homestead Schools	<10
Honolulu Community College	<10
Hood College	<10
Hope College of Arts and Sciences	<10
Horizon University	<10
Hospitality Career Center	<10
Hospitality Institute	<10
Hoss Lee Academy	<10
Hostos Community College of the City University of New York	<10
Hot Springs Beauty College	<10
Houghton University	<10
Housatonic Community College	<10
House of Heavilin Beauty College	<10
House of Michael Beauty Academy	<10
Houston Allied Health Careers	<10
Houston Graduate School of Theology	<10
Houston International College Cardiotech Ultrasound School	<10
Houston School of Carpentry	<10
Houston's Training and Education Center (H-TEC)	<10
Howard County Junior College District	<10

Hudson County Community College	<10
Hudson Valley School of Advanced Aesthetic Skin Care	<10
Hult International Business School	<10
Huntingdon County Career and Technology Center	<10
Huntington University	<10
Huntington University of Health Sciences	<10
Huntsville Bible College	<10
Huntsville Business Institute, LLC	<10
Huron School of Nursing	<10
Huron University	<10
Hutchinson Community College	<10
HVAC Technical Institute	<10
Hypnosis Motivation Institute	<10
I.T.S. Academy of Beauty	<10
Iade American Schools	<10
Ibero American College	<10
Icahn School of Medicine at Mount Sinai	<10
ICOHS College	<10
Ideal Beauty Academy	<10
Ideal School for Health Careers	<10
Illinois Central College	<10
Illinois College	<10
Illinois College of Optometry	<10
Illinois Eastern Community Colleges	<10
Illinois Eastern Community Colleges - Lincoln Trail College	<10
Illinois School of Commerce	<10
Illinois Technical College	<10
Illinois Valley Community College	<10
Illinois Wesleyan University	<10
ImageWorks Academy of Hair Design	<10
Independence Community College	<10
Indiana Barber/Stylist College	<10
Indiana County Technology Center	<10
Indiana University - Kokomo	<10
Industrial Management & Training Institute	<10
Infinity Career College	<10
Infinity College	<10
Inst of Audio/Video Engineering	<10
Inst of Cosmetology Oakland	<10
Inst of Developmental Technology	<10
Inst of Security & Techlgy	<10
Installer Institute	<10
Institut D'Etudes Politiques De Paris	<10
Institute for Doctoral Studies in the Visual Arts	<10
Institute for Health Education (The)	<10
Institute For Therapeutic Massage	<10
Institute of Advanced Medical Esthetics	<10

Institute of Beauty and Wellness (The)	<10
Institute of Business & Medical Technology	<10
Institute of Business & Technology	<10
Institute of Computer Science	<10
Institute of Culinary Education	<10
Institute of Hair Design	<10
Institute of Health Sciences	<10
Institute of Medical and Business Careers	<10
Institute of Medical Ultrasound	<10
Institute of Naturopathic Education and Research	<10
Institute of New Cinema Artists of Chicago	<10
Institute of Professional Careers	<10
Institute of Taoist Education and Acupuncture	<10
Instituto de Education Universal	<10
Instituto Tecnologico de Santo Domingo	<10
Integrity College of Health	<10
Intensive Trainers Institute	<10
Inter American University of Puerto Rico - Aguadilla Campus	<10
Inter American University of Puerto Rico - Arecibo Campus	<10
Inter American University of Puerto Rico - Bayamon Campus	<10
Inter American University of Puerto Rico - Fajardo Campus	<10
Inter American University of Puerto Rico - Guayama Campus	<10
Inter American University of Puerto Rico - Ponce Campus	<10
Inter American University of Puerto Rico - School of Law	<10
Interamerican Business Institute	<10
Interboro Institute	<10
Interdenominational Theological Center	<10
Interior Design Inst	<10
INTERMEDIATE SCHOOL DISTRICT 102	<10
International Academy of Style	<10
International American University	<10
International B Naturale Beauty School	<10
International Baptist College and Seminary	<10
International Beauty Academy	<10
International Beauty Education Center	<10
International Career Inst	<10
International Career Institute	<10
International College of Beauty Arts & Sciences	<10
International College of Broadcasting	<10
International Cosmetology Academy	<10
International Dealers School	<10
International Diving Institute	<10
International Hair and Barber Academy	<10
International Institute of Chinese Medicine	<10
International Institute of Cosmetology	<10
International Institute of Transporation Resources	<10
International Junior College	<10

International Professional School of Bodywork	<10
International School of Beauty	<10
International Space University	<10
International Training	<10
International Training Careers	<10
International Training Center	<10
International Training Center (Closed)	<10
Iowa Lakes Community College	<10
Iowa School of Beauty	<10
Iowa Wesleyan University	<10
Irene's Myomassology Institute	<10
Irvine Valley College	<10
Island Drafting & Technical Institute	<10
Itasca Community College	<10
Itawamba Community College	<10
Ivy Tech Community College of Indiana - Region 10	<10
Ivy Tech Community College of Indiana - Region 11	<10
Ivy Tech Community College of Indiana - Region 12	<10
Ivy Tech Community College of Indiana - Region 13	<10
Ivy Tech Community College of Indiana - Region 14	<10
Ivy Tech Community College of Indiana - Region 2	<10
Ivy Tech Community College of Indiana - Region 9	<10
J D Academy of Salon and Spa	<10
J. Everett Light Career Center	<10
J. Michael Harrold Beauty Academy	<10
Jacksonville Business and Careers Institute	<10
James Albert School of Cosmetology	<10
James Cook University	<10
James Martin Adult Health Occupations	<10
James Sprunt Community College	<10
Jamestown Community College	<10
Jay Truck Driver Training Center	<10
Jefferson Business College (Closed)	<10
Jefferson College of Health Sciences	<10
Jefferson County DuBois Area Vocational Technical School	<10
Jefferson Lewis BOCES Program of Practical Nursing	<10
Jefferson Regional School of Nursing	<10
Jenks Beauty College	<10
Jenny Lea Academy of Cosmetology	<10
Jett College of Cosmetology & Barbering	<10
Jewish Theological Seminary of America (The)	<10
JFK Medical Center Muhlenberg Harold B. and Dorothy A. Snyder Schools	<10
JGM Cosmetology Institute	<10
JNA Institute of Culinary Arts	<10
Joe Blasco Makeup Artist Training Center	<10
Joe Kubert School of Cartoon & Graphic Art (The)	<10
John Amico School of Hair Design 2	<10

John Amicos School of Hair Design	<10
John Amico's School of Hair Design	<10
John Brown University	<10
John Carroll University	<10
John Paolo's Xtreme Beauty Institute, Goldwell Products Artistry	<10
John Patrick University of Health and Applied Sciences	<10
John Paul the Great Catholic University	<10
John Wesley International Barber and Beauty College	<10
John Wesley University	<10
John Wood Community College	<10
Johnny Matthew's Hairdressing Training School	<10
John's Beauty College	<10
Johnson College	<10
Johnson University	<10
Johnston Community College	<10
Jolei's Hair Institute	<10
Jolie Hair Academy	<10
Jon Louis School of Beauty	<10
Jose Maria Vargas University	<10
Josefs School of Hair Design	<10
Josef's School of Hair, Skin & Body	<10
JPS Institute for Health Career Development	<10
JRenee College	<10
Judson University	<10
Juilliard School (The)	<10
Jung Tao School of Classical Chinese Medicine	<10
Juniata College	<10
JZ Trend Academy Paul Mitchell Partner School	<10
K&G 5 Star Barber College	<10
Kaiser Permanent Anesthesia School	<10
Kaizen Beauty Academy	<10
Kalamazoo College	<10
Kane Business Institute	<10
Kankakee Academy of Hair Design	<10
Kankakee Community College	<10
Kansas Christian College	<10
Kansas City Art Institute	<10
Kansas City Business College	<10
Kapiolani Community College	<10
Kaskaskia College	<10
Kasturba Medical College	<10
Katherine Gibbs School	<10
Kauai Community College	<10
Kaw Area Technical School	<10
Kay Harvey Hairdressing Academy	<10
KCK Beauty & Barber Academy	<10
Keck Graduate Institute of Applied Life Sciences	<10

Keene Beauty Academy	<10
Keith Metro Hair Academy	<10
Kennebec Valley Community College	<10
Kenneth Shuler School of Cosmetology	<10
Kenny's Academy of Barbering	<10
Kenosha College of Cosmetology	<10
Kensington Business Institute	<10
Kentucky Career Institute	<10
Kentucky Christian University	<10
Kentucky Wesleyan College	<10
Kettering College	<10
Kettering University	<10
Keune Academy by 124	<10
Key Power Technical Institute	<10
Keyskills Learning	<10
Kiamichi Technology Center	<10
Kilian Community College	<10
Kings College	<10
King's College (The)	<10
King's College London	<10
King's University (The)	<10
Kingston University	<10
Kinyon - Campbell Business School	<10
Kirtland Community College	<10
Kishwaukee College	<10
Klamath Community College	<10
Knapp College of Business	<10
Knox College	<10
Knox County Career Center	<10
Krissler Business Institute	<10
KT's College of Hair Design	<10
Kussad Institute of Court Reporting	<10
Kuyper College	<10
L T International Beauty School	<10
L. E. Fletcher Technical Community College	<10
L3Harris Aerosim Academy	<10
La Belle Beauty Academy	<10
La Belle Beauty School	<10
LA LAN 2000 Computer Training Center	<10
Lab Paul Mitchell Partner School (The)	<10
LaBarberia Institute of Hair	<10
Labaron Hairdressing Academy	<10
Labette Community College	<10
L'Academie de Cuisine	<10
Ladera Career Paths Training Centers	<10
LaGrange College	<10
Laguna College of Art and Design	<10

La'James International College	<10
Lake Area Technical College	<10
Lake College	<10
Lake Erie College	<10
Lake Forest College	<10
Lake Forest Graduate School of Management	<10
Lake Land College	<10
Lake Michigan College	<10
Lake Region State College	<10
Lake Superior State University	<10
Lake Washington Institute of Technology	<10
Lakeland College of Business	<10
Lakeland Medical & Dental Academy	<10
Lakes Region Community College	<10
Lakeshore Technical College	<10
Lakeside School of Massage Therapy	<10
Lake-Sumter State College	<10
Lakeview College of Nursing	<10
Lakewood School of Therapeutic Massage	<10
Lamar State College - Orange	<10
Lamar State College - Port Arthur	<10
Lamson Junior College	<10
Lancaster Beauty School	<10
Lancaster Bible College	<10
Lancaster County Career and Technology Center	<10
Lancaster School of Cosmetology & Therapeutic Bodywork	<10
Landmark College	<10
Laney College	<10
Laramie County Community College	<10
Laredo College	<10
Largo Beauty Academy	<10
Larry's Barber College	<10
Las Positas College	<10
LaSalle Tech	<10
Lassen College	<10
Last Minute Cuts School of Barbering and Cosmetology	<10
Latin Beauty Academy	<10
Laurel Beauty Academy	<10
Laurel Business Institute	<10
Laurel Ridge Community College	<10
Laurel Technical College	<10
Laurenwood College(Closed)	<10
Lavonnes Academy of Beauty	<10
Lavonnes Academy of Beauty Capital Hill	<10
Lavonnes Lane Beauty Academy (closed)	<10
Lawrence & Company College of Cosmetology	<10
Lawrence County Career and Technical Center	<10

Lawrence Memorial Hospital School of Nursing	<10
Lawrence University	<10
Lawton Career Institute	<10
Le Cordon Bleu	<10
Le Moyne College	<10
Learning Bridge Career Institute	<10
Learning Institute for Beauty Sciences	<10
Lebanese American University	<10
Lebanon College	<10
Lebanon County Career and Technology Center	<10
Lebanon Valley College	<10
Lederwolff Culinary Academy	<10
Lee College	<10
Lees School of Cosmetology	<10
Lees-McRae College	<10
Leeward Community College	<10
LeGrand Institute of Cosmetology	<10
Lehigh Technical School	<10
Lehigh University	<10
Lehigh Valley Barber & Beauty Academy	<10
Lenape Technical School	<10
Leon Studio One School of Beauty Knowledge	<10
Leone School of Technology	<10
L'esprit Academy	<10
Levittown Beauty Academy	<10
Lewis & Clark College	<10
Lewis and Clark Community College	<10
Lewis International School	<10
Lewis-Clark State College	<10
Lexington Baptist College	<10
Lexington College	<10
Lexington Community Community	<10
Lexington Healing Arts Academy	<10
Lia Schorr Institute of Cosmetic Skin Care Training (The)	<10
Liberty Academy of Business	<10
Liberty Training Institute	<10
Liceo De Arte y Tecnología	<10
Life Pacific University	<10
Lighthouse Career Institute	<10
Lil Lou's Beauty and Barber College	<10
Lincoln Christian University	<10
Lincoln School of Commerce	<10
Lincoln Technical Inst	<10
Linfield University	<10
Linn-Benton Community College	<10
Lionel University	<10
Lock Haven University of Pennsylvania	<10

Lockyear College	<10
London South Bank University	<10
Long Beach College of Business	<10
Long Island Business Institute	<10
Long Island College Hospital - School of Nursing	<10
Long Island Nail Skin & Hair Institute	<10
Long Island University - Brooklyn	<10
Long Island University - Southampton College	<10
Long Technical College	<10
Longwood University	<10
Lorain County JVS Adult Career Center	<10
Loraines Academy & Spa	<10
Loras College	<10
Los Angeles Broadcasters	<10
Los Angeles City College	<10
Los Angeles College of Music	<10
Los Angeles Harbor College	<10
Los Angeles Mission College	<10
Los Angeles ORT Technical Institute	<10
Los Angeles Pacific College	<10
Los Angeles Southwest College	<10
Los Angeles Valley College	<10
LOS MEDANOS COL	<10
Los Medanos College	<10
Louisiana Business College	<10
Louisiana Culinary Institute	<10
Louisiana Institute of Technology	<10
Louisiana School of Professions	<10
Louisiana State University Health Sciences Center	<10
Louisiana Technical College - Lamar Salter Campus	<10
Louisiana Training Center	<10
Love Beauty School	<10
Lowell Academy Hair Styling Institute	<10
Loyalist College of Applied Arts & Technology	<10
Loyola Law School	<10
Loyola University Maryland	<10
Loyola University School of Dentistry	<10
Lu Ross Academy	<10
Luther College	<10
Luther Rice College & Seminary	<10
Luther Seminary	<10
Lycoming College	<10
Lyle's College of Beauty	<10
Lyme Academy College of Fine Arts	<10
Lynndale Fundamentals of Beauty School	<10
Lyon College	<10
Lytle's Redwood Empire Beauty College	<10

Macon Beauty School	<10
Madison Cosmetology College	<10
Madison Oneida BOCES Practical Nursing Program	<10
Madisonville Community College	<10
Magee Brothers Beauty School	<10
Magna Inst	<10
Maharishi International University	<10
Maine College of Art	<10
Maine College of Health Professions	<10
Maine Maritime Academy	<10
Maine State Academy of Hair Design	<10
Make-Up Designory	<10
Malone University	<10
Manchester Community College	<10
Manchester Metropolitan University (The)	<10
Manchester University	<10
Manhattan Area Technical College	<10
Manhattan Career Institute	<10
Manhattan Christian College	<10
Manhattan School of Music	<10
Manhattan Technical Institute	<10
Mansfield Beauty Schools	<10
Mansfield Business College Canton Center	<10
Mansfield Business School	<10
Mansfield School of Business	<10
Mansfield University of Pennsylvania	<10
Maranatha Beauty College	<10
Margaret's Hair Academy	<10
Margate School of Beauty	<10
Maria College	<10
Marian Health Careers Center	<10
Marietta College	<10
Marinello Schools of Beauty	<10
Marion Adult Education & Career Training Center	<10
Marion Technical College	<10
MarJon School of Beauty	<10
Marlboro College	<10
Mars Hill University	<10
Marshalltown Community College	<10
Martin College	<10
Mary Holmes College	<10
Marycrest College	<10
Marycrest International University	<10
Maryland Beauty Academy	<10
Maryland Beauty Academy of Essex	<10
Maryland College of Art & Design	<10
Maryland Drafting Institute	<10

Maryland University of Integrative Health	<10
Marymount College	<10
Maryville College	<10
Mason Anthony School of Cosmetology Arts & Sciences	<10
Massachusetts Bay Community College	<10
Massachusetts College of Art and Design	<10
Massachusetts College of Liberal Arts	<10
Massachusetts Maritime Academy	<10
Massachusetts School of Barber & Mens Hair	<10
Massachusetts School of Barbering	<10
Massage Therapy Training Institute	<10
Massey Business College	<10
Master Educators Beauty School	<10
Master's University and Seminary (The)	<10
Mater Dei College	<10
May Technical College	<10
Mayo Clinic College of Medicine and Science	<10
Mayville State University	<10
MCCANN SCHOOL OF BUSINESS	<10
McCarrie Schools of Health Sciences & Technology	<10
McCarthys Business Institute	<10
McCormick Theological Seminary	<10
McDaniel College	<10
McGill University	<10
McHenry County College	<10
McKenzie College	<10
McKim Technical Institute	<10
MCP Hahnemann University	<10
McPherson College	<10
Meadows Business College	<10
Meadows College of Business	<10
Mech Tech College	<10
Med Academy	<10
Med Help Training School	<10
Medacom College	<10
Med-Assist School of Hawaii	<10
Medical Allied Career Center	<10
Medical Arts Training Center	<10
Medical Career and Technical College	<10
Medical Career College	<10
Medical Career Institute	<10
Medical Careers Institute	<10
Medical Institute of Minnesota	<10
Medical Institute of Palm Beach	<10
Medical Training Institute	<10
Medical University of Lodz	<10
Medical University of Ohio - Toledo	<10

Medical University of Silesia (The)	<10
Medical University of South Carolina	<10
Medtech Health Care Training	<10
MedVance Institute's Port St. Lucie School of Practical Nursing	<10
Melbourne Beauty School	<10
Memphis Pro Truck Driver Training Company	<10
Mendocino College	<10
Menlo College	<10
Mercer County Career Center	<10
Mercer County Community College	<10
Mercy College of Health Sciences	<10
Mercy College of Ohio	<10
Meredith Manor International Equestrian Centre	<10
Meridian Community College	<10
Meridian Institute of Surgical Assisting	<10
Meridian University	<10
Merit College	<10
Merrell University of Beauty Arts & Science	<10
Merrimack College	<10
Merritt College	<10
Merryfield Academy of Animal Technology	<10
Merryfield School of Pet Grooming	<10
Mesabi Range College	<10
Messenger College	<10
Messiah University	<10
Methodist College	<10
Methodist University	<10
Metils Welding School	<10
Metro Auto Electronics Training Institute	<10
Metro Barber College	<10
Metro Beauty Academy	<10
Metro College	<10
Metro Technical Institute	<10
Metroplex Beauty School	<10
Metroplitan Business College	<10
Metropolitan Beauty Academy	<10
Metropolitan Business College	<10
Metropolitan Careeer Institute	<10
Metropolitan Learning Institute	<10
Metropolitan Technical Institute	<10
Metropolitan Technical Institute & Business College	<10
MGH Institute of Health Professions	<10
Miami Ad School	<10
Miami Lakes Educational Center and Technical College	<10
Miami Technical Institute	<10
Miami Valley Career Technology Center	<10
Michael K. Galvin Beauty & Business Academy	<10

Michael's School of Hair Design & Esthetics	<10
Michigan Career Institute	<10
Michigan College of Beauty-Troy	<10
Michigan Computer Institute	<10
Michigan Jewish Institute	<10
Michigan ParaProfessional Training Institute	<10
Michigan School of Psychology	<10
Michigan State University College of Law	<10
Michigan Technological University	<10
Micro Technolgy Institute	<10
Mid City College	<10
Mid Michigan College	<10
Mid South School of Beauty	<10
Mid State College	<10
Mid-America College of Funeral Service	<10
MidAmerica Nazarene University	<10
Middle Georgia Technical College	<10
Middle Tennessee School of Anesthesia	<10
Middlebury College	<10
Mid-East Career and Technology Centers - Adult Education	<10
Midfield Institute of Cosmetology	<10
Midland College	<10
Midland University	<10
Mid-Plains Community College	<10
Mid-State Technical College	<10
Midtown School of Business	<10
Midwest Barber College	<10
Midwest Career College	<10
Midwest College of Oriental Medicine	<10
Midwest Institute of Massage Therapy	<10
Midwestern Baptist Theological Seminary	<10
Midwives College of Utah	<10
Milady School of Cosmetology	<10
Mile High College	<10
Miles Community College	<10
Millennia Atlantic University	<10
Miller Motte Business College	<10
Millerhawkins Business College	<10
Miller-Motte Business College	<10
Milligan University	<10
Millsaps College	<10
Milwaukee College of Business	<10
Milwaukee Institute of Art & Design	<10
Milwaukee School of Engineering	<10
Mind Body Institute	<10
Mineral Area College	<10
Minneapolis College of Art & Design	<10

Minneapolis Technical College	<10
Minnesota North College	<10
Minnesota School of Cosmetology	<10
Minnesota State College Southeast	<10
Minnesota State University Moorhead	<10
Minnesota West Community and Technical College	<10
Minot State University	<10
MiraCosta College	<10
Mission College	<10
Mississippi Barber Academy	<10
Mississippi Institute of Aesthetics, Nails, & Cosmetology	<10
Missouri College of Cosmetology North	<10
Missouri State University - West Plains	<10
Missouri University of Science and Technology	<10
Mitchell College	<10
Mitchell Community College	<10
Mitchell Hamline School of Law	<10
Mitchell Technical College	<10
Mitchell's Academy	<10
MIXED Institute of Cosmetology & Barber	<10
Moberly Area Community College	<10
Model College of Hair Design	<10
Modern Beauty Academy	<10
Modern Beauty School	<10
Modern College of Design (The)	<10
Modern Welding School	<10
Mohave Community College	<10
Mojave Barber College	<10
Moler - Pickens Beauty College	<10
Moler Barber College	<10
Moler Hollywood Beauty Academy	<10
Monmouth College	<10
Monroe County Community College	<10
Montana State University - Northern	<10
Montana Technological University	<10
Montcalm Community College	<10
Montclair Hospital LLC	<10
Montebello Beauty College	<10
Montefiore School of Nursing	<10
Monterey Institute of International Studies	<10
Monterey Peninsula College	<10
Montgomery Beauty School	<10
Montserrat College of Art	<10
Moody Bible Institute	<10
Moore College of Art and Design	<10
Moorpark College	<10
Moravian University	<10

More Tech Institute	<10
Morehouse School of Medicine	<10
Moreno Valley College	<10
Morgan Community College	<10
Morgantown Beauty College	<10
Morningside University	<10
Morris County School of Technology	<10
Morrison Institute of Technology	<10
Morse School of Business	<10
Mosdos Chiddushei Harim Institutions	<10
Motlow State Community College	<10
Motorcycle Mechanics Institute	<10
Mount Holyoke College	<10
Mount Marty University	<10
Mount Mercy University	<10
Mount San Antonio College	<10
Mount Senario College	<10
Mount Sinai Phillips School of Nursing	<10
Mount Wachusett Community College	<10
Mountain Gateway Community College	<10
Mr JS Hair Academy	<10
Mr Rich's Beauty College	<10
Mr. Bela's School of Cosmetology	<10
Mr. John's School of Cosmetology, Esthetics & Nails	<10
Ms Roberts Academy of Beauty Culture	<10
MT CARMEL HOSP SCH OF NURSING	<10
MT Training Center	<10
Mt. San Jacinto College	<10
MTA Resident School	<10
MTA School	<10
MTD College	<10
Muhlenberg College	<10
Muir Technical College	<10
Multnomah University	<10
Mundus Institute	<10
Municipal Training Center	<10
Murray State College	<10
Muskegon College	<10
Muskegon Community College	<10
MyComputerCareer at Indianapolis	<10
Myotherapy Institute	<10
Myotherapy Massage College	<10
MyrAngel Beauty Institute	<10
Mystros Barber Academy	<10
Napa Valley College	<10
Nash Community College	<10
Nashua Community College	<10

Nashville Barber and Style Academy	<10
Nassau School	<10
Nasson Institute	<10
Nathan Layne Institute of Cosmetology	<10
National Academy For Paralegal Studies	<10
National Aviation Academy - New England	<10
National Beauty College	<10
National Beauty School	<10
National Broadcasting School	<10
National Business Academy	<10
NATIONAL BUSINESS INSTITUTE	<10
National Business School Automotive Division	<10
National Career Academy	<10
National Career College	<10
National Career School	<10
National College of Technology	<10
National Conservatory of Dramatic Arts	<10
National Education Center - Arkansas College of Technology Campus	<10
National Education Center - Bryman Campus	<10
National Education Center - Capitol Hill Campus	<10
National Education Center Kentucky College of Technology Campus	<10
National Education Center National Institute of Tech Campus	<10
National Education Center National Institute of Technology	<10
National Education Center Temple School Campus	<10
National Education Center, Bryman Campus	<10
National Education Center-Sawyer Campus	<10
National Education Ctr-Temple School Campus	<10
National Inst of Techlgy	<10
National Institute of Massotherapy -	<10
National Institute of Technology	<10
National Labor College	<10
National Park College	<10
National Personal Training Institute of Colorado	<10
National Personal Training Institute of Columbus	<10
National Polytechnic College of Science	<10
National School of Health Technology	<10
National Technical College	<10
National Technical Institute	<10
National Technicals Schools	<10
National Tractor Trailer School	<10
National Training	<10
National Training Systems	<10
National Training Systems - Correspondence School	<10
National University of Ireland, Galway	<10
Natural Images Beauty College	<10
Nazarene Bible College	<10
Nazareth College of Rochester	<10

Nebraska Christian College	<10
Nebraska Custom Diesel Drivers Training	<10
Nebraska Methodist College of Nursing & Allied Health	<10
Nebraska Wesleyan University	<10
Neely Business College	<10
Neosho Beauty College	<10
Neosho County Community College	<10
Nettleton Career College	<10
Nevada Career School	<10
Nevada Gaming School	<10
New Age Training	<10
New Beginning College of Cosmetology	<10
New Beginnings Beauty Academy	<10
New Castle School of Trades	<10
New Community Career and Technical Institute	<10
New Concept Massage & Beauty School	<10
New Concepts School of Cosmetology	<10
New Dimensions Beauty Academy	<10
New England Conservatory of Music	<10
New England Law | Boston	<10
New England School of Acupuncture	<10
New England School of Communications	<10
New England School of Photography	<10
New England Tractor Trailer Training School	<10
New Hampshire Institute for Therapeutic Arts	<10
New Hope Christian College	<10
New Mexico Highlands University	<10
New Mexico Institute of Mining & Technology	<10
New Mexico Junior College	<10
New Professions Technical Institute	<10
New River Community and Technical College	<10
New River Community College	<10
New School Center for Media	<10
New Technology University	<10
New World College of Beauty	<10
New World Institute	<10
New York Business School	<10
New York College of Podiatric Medicine	<10
New York College of Traditional Chinese Medicine	<10
New York Conservatory For Dramatic Arts (The)	<10
New York International Beauty School	<10
New York Medical Career Training Center	<10
New York Medical College	<10
New York Paralegal School	<10
New York School Of Computer Technology	<10
New York School of Esthetics & Day Spa	<10
New York School of Interior Design	<10

New York Theological Seminary	<10
Newberry College	<10
Newberry School of Beauty	<10
Newberry Schools of Beauty	<10
Newbridge College - Monterey Park	<10
Newman University	<10
NHTI - Concord's Community College	<10
Niagara University	<10
Nichols Career Center	<10
Nichols College	<10
Nicolet Area Technical College	<10
Nielsen Electronics Institute	<10
Nightingale Medical Institute	<10
NIMA National Institute of Medical Aesthetics	<10
North American Baptist College	<10
North American College	<10
North American Education Ctr	<10
North American Institute of Aviation of South Carolina	<10
North American University	<10
North Arkansas College	<10
North Bennet Street School	<10
North Central College	<10
North Central Missouri College	<10
North Central Opportunities Industrialization Center	<10
North Central State College	<10
North Central University	<10
North Country Community College	<10
North County College	<10
North Dakota State College of Science	<10
North Florida Cosmetology Institute	<10
North Georgia Technical College	<10
North Greenville University	<10
North Haven Academy, LLC	<10
North Hills School of Health Occupations	<10
North Iowa Area Community College	<10
North Seattle College	<10
North Technical Education Center	<10
Northcoast Medical Training Academy	<10
Northeast Alabama Community College	<10
Northeast Career Schools	<10
Northeast Community College	<10
Northeast Institute	<10
Northeast Institute of Education	<10
Northeast Mississippi Community College	<10
Northeast Ohio Medical University	<10
Northeast State Community College	<10
Northeast Technical Institute	<10

Northeast Texas Community College	<10
Northeastern Junior College	<10
Northeastern Oklahoma A & M College	<10
Northern Alberta Institute of Technology (NAIT)	<10
Northern Arizona Institute of Technology	<10
Northern California Institute of Cosmetology	<10
Northern Career Institute	<10
Northern Maine Community College	<10
Northern New Mexico College	<10
Northern Oklahoma College	<10
Northern State University	<10
Northern Technical College	<10
Northern Tier Career Center	<10
Northern Wyoming Community College District	<10
Northland College	<10
Northpoint Bible College	<10
Northshore Technical Community College	<10
Northside Beauty Care Academy	<10
Northwest - Shoals Community College	<10
Northwest Arkansas Aviation Technologies Center	<10
Northwest Beauty School	<10
Northwest College	<10
Northwest College of Art & Design	<10
Northwest Florida State College	<10
Northwest HVAC/R Association & Training	<10
Northwest Institute of Acupuncture & Oriental Medicine	<10
Northwest Iowa Community College	<10
Northwest Kansas Technical College	<10
Northwest Missouri Community College	<10
Northwest Nazarene University	<10
Northwest Regional Technology Institute	<10
Northwest Schools	<10
Northwest State Community College	<10
Northwest Technical College - Bemidji	<10
Northwest Technical Institute	<10
Northwest University	<10
Northwest Vista College	<10
Northwestern Connecticut Community College	<10
Northwestern Institute of Health and Technology	<10
Northwestern Michigan College	<10
Northwestern Oklahoma State University	<10
Northwestern Technological Institute	<10
Northwood Technical College	<10
Notre Dame College	<10
Notter School of Pastry Arts	<10
NRI Institute of Health Sciences	<10
Nuvani Institute	<10

O\E Learning Center	<10
Oak Hills Christian College	<10
Oakbridge Academy of Arts	<10
Oakland College of Court Reporting	<10
Oakland College of Dental Medical Assistants	<10
Oakton Community College	<10
O'Briens Aveda Institute	<10
Occupational Safety Training Institute	<10
Ocean County Vocational - Technical Schools	<10
Ocean State Business Institute	<10
Oceanside College of Beauty	<10
Oconee Fall Line Technical College	<10
Odessa College	<10
Oehrlein School of Cosmetology	<10
Ogeechee Technical College	<10
Oglethorpe University	<10
Ohio College of Business and Technology	<10
Ohio College of Massotherapy	<10
Ohio College of Podiatric Medicine	<10
Ohio Hi-Point Career Center	<10
Ohio Institute of Allied Health	<10
Ohio Medical Career College	<10
Ohio Mid-Western College	<10
Ohio Northern University	<10
Ohio School of Career Technology	<10
Ohio School of Financial Education	<10
Ohio State Beauty Academy	<10
Ohio State College of Barber Styling	<10
Ohio State School of Cosmetology	<10
Ohio Wesleyan University	<10
Oklahoma Baptist University	<10
Oklahoma Horseshoeing School	<10
Oklahoma Junior College	<10
Oklahoma Junior College of Business & Technology	<10
Oklahoma Panhandle State University	<10
Oklahoma School of Photography	<10
Oklahoma State University Center for Health Sciences	<10
Oklahoma Wesleyan University	<10
Old Town Barber College	<10
Oliver Finley Academy of Cosmetology	<10
Olivet College	<10
Olympic College	<10
Omaha College of Health Careers	<10
Omaha School of Massage and Healthcare of Herzing University	<10
Omega Graduate School	<10
Omega Institute of Cosmetology	<10
Omega Studios' School of Applied Recording Arts & Sciences	<10

Omni College	<10
Omni Technical School	<10
O'More College of Design	<10
One Stop Academy	<10
Onondaga School of Therapeutic Massage	<10
Opelousas School of Cosmetology	<10
Orange Coast College	<10
Orange County Business College	<10
Orange Park International School of Beauty	<10
Orange Ulster BOCES School of Practical Nursing	<10
Oregon College of Art & Craft	<10
Oregon College of Oriental Medicine	<10
Oregon Institute of Technology	<10
Oregon Polytechnic Institute	<10
Orion Institute	<10
Orlando Academy of Beauty Culture	<10
Orlo School of Hair Design and Cosmetology (The)	<10
Orm Word Processing Training School	<10
Osceola Technical College	<10
Otero College	<10
Otis College of Art and Design	<10
Ouachita Baptist University	<10
Oxford Academy of Hair Design	<10
Oxnard College	<10
Ozark Christian College	<10
Ozarka College	<10
Pace Business School(The)	<10
Pacific Coast Techl Inst	<10
Pacific Coast Technical InstituteINSTITUTE	<10
Pacific Coast Trade School	<10
Pacific Life Bible College	<10
Pacific Lutheran University	<10
Pacific Northwest College of Art	<10
Pacific Rim Christian University	<10
Paier College	<10
Palladium Technical Academy	<10
Palm Beach Beauty & Barber School	<10
Palmetto Beauty School	<10
Palo Alto College	<10
Palo Alto University	<10
Palomar College	<10
Palomar Institute of Cosmetology	<10
Panache Academy of Beauty	<10
Paradise Valley Community College	<10
Paralegal Institute	<10
Paramount Beauty Academy	<10
Paris II Educational Center	<10

Paris Junior College	<10
Parisian Beauty Academy Paul Mitchell Partner School	<10
Parisian Spa Institute	<10
Park Avenue School of Cosmetology	<10
Parks College of Saint Louis University	<10
Paroba College of Cosmetology	<10
Parsons School of Design	<10
Pasadena City College	<10
Passaic County Community College	<10
Pat Goins Jonesboro Beauty School	<10
Pat Goins Ruston Beauty School	<10
Pat Wilson's Beauty College	<10
Pathway Vocational Academy	<10
Patricia Stevens Career College	<10
Patricia Stevens Fashion College	<10
Patsy And Rob's Academy of Beauty	<10
Patten University	<10
Paul D. Camp Community College	<10
Paul Mitchell The School - Delaware	<10
Paul Mitchell The School Grand Rapids	<10
Paul Mitchell The School - Jersey Shore	<10
Paul Mitchell the School - Louisville	<10
Paul Mitchell The School - Madison	<10
Paul Mitchell the School Albuquerque	<10
Paul Mitchell The School Ardmore	<10
Paul Mitchell The School Arkansas	<10
Paul Mitchell The School Austin	<10
Paul Mitchell The School Boise	<10
Paul Mitchell The School Cleveland	<10
Paul Mitchell The School Colorado Springs	<10
Paul Mitchell The School Columbus	<10
Paul Mitchell the School Danbury	<10
Paul Mitchell the School Denver	<10
Paul Mitchell The School Farmington Hills	<10
Paul Mitchell The School Fresno	<10
Paul Mitchell The School Great Lakes	<10
Paul Mitchell The School Honolulu	<10
Paul Mitchell The School Huntsville	<10
Paul Mitchell The School Indianapolis	<10
Paul Mitchell the School Knoxville	<10
Paul Mitchell The School Lansing	<10
Paul Mitchell the School Las Vegas	<10
Paul Mitchell The School Lexington	<10
Paul Mitchell The School Miami	<10
Paul Mitchell the School Milwaukee	<10
Paul Mitchell the School Missouri Columbia	<10
Paul Mitchell the School Murfreesboro	<10

Paul Mitchell The School Normal	<10
Paul Mitchell the School NYC	<10
Paul Mitchell The School Overland Park	<10
Paul Mitchell the School Phoenix	<10
Paul Mitchell the School Portland	<10
Paul Mitchell The School Raleigh	<10
Paul Mitchell the School Rapid City	<10
Paul Mitchell The School Reno	<10
Paul Mitchell The School Rexburg	<10
Paul Mitchell the School Richland	<10
Paul Mitchell the School Roanoke	<10
Paul Mitchell The School San Jose	<10
Paul Mitchell the School Santa Barbara	<10
Paul Mitchell the School Schenectady	<10
Paul Mitchell The School Sherman Oaks	<10
Paul Mitchell The School Spokane	<10
Paul Mitchell The School Springfield	<10
Paul Mitchell The School St Louis	<10
Paul Mitchell The School Tulsa	<10
Paul Mitchell The School Wichita	<10
Paul Smith's College of Arts & Sciences	<10
Payne Theological Seminary	<10
Pazazz Hair School	<10
PB Cosmetology Education Centre	<10
PC Tech Learning Center	<10
PCI Academy	<10
Pearlands Innovative School of Beauty	<10
Peninsula College	<10
Penn Ohio College	<10
Pennsylvania Academy of Cosmetology Arts & Sciences	<10
Pennsylvania Academy of the Fine Arts	<10
Pennsylvania College of Art & Design	<10
Pennsylvania College of Health Sciences	<10
Pennsylvania College Of Straight Chiropractic	<10
Pennsylvania Gunsmith School	<10
Pennsylvania Highlands Community College	<10
Penrose Academy	<10
Pensacola State College	<10
Pentecostal Theological Seminary	<10
Perry Technical Institute	<10
Peru State College	<10
Phagans' Beauty College	<10
Phagans' Central Oregon Beauty College	<10
Phagans' Grants Pass College of Beauty	<10
Phagans' Medford Beauty School	<10
Phagans' Newport Academy of Cosmetology Careers	<10
Phagans' School of Beauty	<10

Pharr Vocational School	<10
Philadelphia College of Osteopathic Medicine	<10
Philadelphia Drama Workshop Studio	<10
Philadelphia Technician Training Institute	<10
Philadlephia School of Office Technologies	<10
Phillips Business School	<10
Phillips College	<10
Phillips College Inland Empire Campus	<10
Phillips College of Atlanta	<10
Phillips College of Chicago	<10
Phillips Colleges	<10
Phillips Community College of the University of Arkansas	<10
Phillips Hairstyling Institute	<10
Phillips Junior College At Birmingham	<10
Phillips Junior College Mobile	<10
Phillips Junior College of Memphis	<10
Phillips Junior College of Spartanburg	<10
Phillips Junior College of Spokane	<10
Phillips School of Business and Technology- Dallas	<10
Phillips University	<10
Phoenix Educational Systems of Pensacola	<10
Piccolo School of Hair Design	<10
Pickaway Ross County Joint Vocational School District	<10
Pickens Technical College	<10
Piedmont Virginia Community College	<10
Pike County Career Technology Center	<10
Pike Lincoln Technical Center	<10
Pillar College	<10
Pillsbury Baptist Bible College	<10
Pinchot University	<10
Pine Technical and Community College	<10
Pinnacle Institute of Cosmetology	<10
Pittsburg State University	<10
Pittsburgh Beauty Academy	<10
Pittsburgh Institute of Aeronautics	<10
Pittsburgh Institute of Mortuary Science	<10
Plaza School of Technology	<10
Plaza Three Academy	<10
Polaris Career Center - Adult Education Department	<10
Politechnical Institute of Florida	<10
Polytechnic Institute	<10
Polytechnic Institute of New York University	<10
Polytechnical Inst	<10
Pompano Academy of Aeronautics	<10
Ponca City Beauty College	<10
Ponce College of Technology	<10
Ponce Health Sciences University	<10

Pontiac Business Institute	<10
Pontificia Universidad Catolica Madre y Maestra	<10
Port Huron Cosmetology College	<10
Portage Lakes Career Center	<10
Porter & Chester Institute	<10
Portfolio Center	<10
Portland Actors Conservatory	<10
Poteau Beauty College	<10
Potomac State College of West Virginia University	<10
Poznan University of Medical Sciences	<10
Pratt Community College	<10
Preferred College of Nursing	<10
Preferred College of Nursing, Los Angeles	<10
Premier Barber Institute	<10
Preparing People Barber Styling College	<10
Presbyterian College	<10
Presidio Graduate School	<10
Prestige Health & Beauty Sciences Academy	<10
Princeton Techl Inst	<10
Princeton Theological Seminary	<10
Printing Trades School	<10
Pro Beauty Academy (The)	<10
Pro Drive	<10
Pro Way Hair School	<10
Professional Beauty School	<10
Professional Business College	<10
Professional Career Centers	<10
Professional Cosmetology Education Center	<10
Professional Culinary Academy	<10
Professional Golfers Career College	<10
Professional Institute of Beauty	<10
Professional Massage Training Center	<10
Professional Training Academy of Esthetic & Beauty	<10
Professional Training Inst (Closed)	<10
Profile Institute of Barber-Styling	<10
Progressive Training Centers	<10
Prospect Hall School of Business	<10
Protege Academy	<10
Providence College	<10
Pryor Beauty College	<10
PSI Institute of Washington	<10
PTC Career Inst Cleveland	<10
PTC Career Institue of Washington	<10
Pueblo College of Business & Technology	<10
Puerto Rico Tech Junior College	<10
Puget Sound Christian College	<10
Puget Sound Inst of Techlgy	<10

Pulse Beauty Academy	<10
Quality College of Culinary Careers	<10
Queen City College	<10
Queen Mary University of London	<10
Queen's University of Belfast (The)	<10
Quest Career College	<10
Rainy River Community College	<10
Ralph Amodei International Institute of Hair Design & Technology	<10
Randall University	<10
Randolph - Macon College	<10
Randolph College	<10
Randy Rick Beauty Academy	<10
Ranger College	<10
Raphael Recanati International School, The Interdisciplinary Center	<10
Raritan Valley Community College	<10
Rasmussen College - Eagan	<10
Rasmussen College - Eden Prairie	<10
Ravenscroft Beauty College	<10
Ray J's College of Hair	<10
Ray-Mar Beauty Academy	<10
Reading Hospital School of Health Sciences	<10
Red Rocks Community College	<10
Redlands Community College	<10
Reed College	<10
Reedley College	<10
Reformed Presbyterian Theological Seminary	<10
Reformed University	<10
Refrigeration School (The)	<10
Regent's University London	<10
Relay Graduate School of Education	<10
Renaissance Academie	<10
Rend Lake College	<10
Rensselaer Polytechnic Institute	<10
Research Medical Center	<10
RETS Electronic Institute	<10
RETS Electronic Institution	<10
RETS Institute of Technology	<10
Revell Training Center	<10
Rhode Island Island School of Photography	<10
Rhode Island School of Design	<10
Rhodes College	<10
Rice College	<10
Richard Bland College	<10
Richard J Daley College-City Colleges of Chicago	<10
Richland Community College	<10
Richmond, The American International University in London	<10
Rickerson Beauty Academy #5	<10

Rickersons Beauty Academy #3	<10
Ridgewater College	<10
Riggs Lemar Beauty College	<10
Riley College	<10
Rio Grande Valley College	<10
River Valley Community College	<10
River Valley Cosmetology Institute	<10
Riverland Community College	<10
Riverside City College	<10
Riverside County Office of Education	<10
Rivertown School of Beauty, Barber, Skin Care and Nails	<10
Rivier University	<10
Rizzieri Aveda School for Beauty and Wellness	<10
Roanoke-Chowan Community College	<10
Rob Roy Academy	<10
Robert Fiance Hair Design Inst	<10
Robert Fiance Inst of FL	<10
Robert Gordon University	<10
Robert Morris College	<10
Robert Paul Academy of Cosmetology Arts & Sciences	<10
Roberts Beauty Training Center	<10
Roberts Institute of Hair Design of Brooklyn	<10
Robeson Community College	<10
Robinson Business College	<10
Rochester General-Isabella Graham Hart School of Practical Nursing	<10
Rochester University	<10
Rock Valley College	<10
Rockford University	<10
Rockhurst University	<10
Rocky Mountain College	<10
Rocky Mountain University of Health Professions	<10
Rocky Vista University	<10
Roehampton University	<10
Rolla Technical Institute Center	<10
Rollins College	<10
Roman Academy of Beauty Culture	<10
Romar Academy of Stylemasters	<10
Romar Beauty Academy	<10
Romar Beauty School	<10
Romar Hairstyling Academy	<10
Rome Academy of Cosmetology	<10
Ron Thomas School of Cosmetology	<10
Ron Thomas School of Cosmetology III	<10
Rose Bruford College of Theatre and Performance	<10
Rose Training Institute	<10
Rosedale Technical College	<10
Rose-Hulman Institute of Technology	<10

Ross Technical Institute	<10
Rosston College	<10
Roswell Beauty College of Cosmetology Arts & Sciences	<10
Roswell College of Cosmetology	<10
Roxborough Memorial Hospital	<10
Royal Business School (Closed)	<10
Royal College of Art	<10
Royal College of Surgeons in Ireland	<10
Royal Veterinary College (The), University of London	<10
Royale Beauty College	<10
Royale College of Beauty and Barbering	<10
RTP Hispanic American College	<10
Ruben's Five Star Academy	<10
Rudae's School of Beauty Culture	<10
Rudolf Steiner College	<10
Rudy & Kelly Academy, A Paul Mitchell Partner School	<10
Ruesing University Of Beauty	<10
Rush University	<10
Russell Sage Junior College	<10
Rutgers University Jersey City	<10
RWM Fiber Optics	<10
Ryerson University	<10
Sabina's Beauty Academy	<10
Sabrina's Beauty Academy (CLOSED)	<10
Sacramento County Regional Occupational Program	<10
Sacramento Ultrasound Institute	<10
Saddleback College	<10
SAE Institute of Technology - Miami	<10
SAE Institute of Technology, Los Angeles	<10
SAE Institute of Technology, New York	<10
Safford College of Beauty Culture	<10
Saint Ambrose University	<10
Saint Anselm College	<10
Saint Charles Borromeo Seminary	<10
Saint Charles Community College	<10
Saint Elizabeth Medical Center	<10
Saint Elizabeth School of Nursing	<10
Saint Elizabeth University	<10
Saint Francis University	<10
Saint James Mercy Hospital School of Radiologic Sciences	<10
Saint John's School of Business	<10
Saint Joseph's College of Nursing at St Joseph's Hospital Health Cente	<10
Saint Joseph's School of Nursing	<10
Saint Louis Christian College	<10
Saint Luke's College of Health Sciences	<10
Saint Martin's University	<10
Saint Mary of the Plain College	<10

Saint Mary of the Woods College	<10
Saint Mary's College	<10
Saint Mary's College of Maryland	<10
Saint Mary's University of Minnesota	<10
Saint Michael's College	<10
Saint Olaf College	<10
Saint Thomas Aquinas College	<10
Saint Vincent College & Seminary	<10
Saint Vincent's College	<10
Salem College	<10
Salisbury University	<10
Salish Kootenai College	<10
Salon & Spa Institute	<10
Salon 496 Barber Academy	<10
Salon Boutique Academy	<10
Salon Professional Academy of Elgin (The)	<10
Salon Professional Academy of Kenosha (The)	<10
Salus University	<10
Salve Regina University	<10
Samford University	<10
Samra University of Oriental Medicine	<10
San Antonio Court Reporting Institute	<10
San Bernardino Valley College	<10
San Diego City College	<10
San Diego Culinary Institute	<10
San Diego Golf Academy	<10
San Diego Mesa College	<10
San Diego Miramar College	<10
San Francisco College of Mortuary Sciences	<10
San Francisco Conservatory of Music	<10
San Francisco Film School	<10
San Francisco Institute of Esthetics & Cosmetology	<10
San Joaquin College of Law	<10
San Jose City College	<10
San Juan Bautista School of Medicine	<10
San Juan College	<10
Sandra Academy of Salon Services	<10
Sanford Business College	<10
Santa Ana College	<10
Santa Barbara and Ventura Colleges of Law (The)	<10
Santa Barbara College of Oriental Medicine	<10
Santa Clara University	<10
Santa Fe Community College	<10
Santa Monica College	<10
Santa Rosa Junior College	<10
Santiago Canyon College	<10
Sarah Lawrence College	<10

Sarasota Beauty School	<10
Sarasota School of Massage Therapy	<10
Sauk Valley Community College	<10
Savannah Technical College	<10
Sawyer Business School	<10
Sawyer College at Ponoma	<10
Sawyer School of Elizabeth	<10
Schilling - Douglas School of Hair Design	<10
School for Allied Health Professionals	<10
School of Architecture (The)	<10
School of Communication Arts	<10
School of Court Reporting (The)	<10
School of Hair Design	<10
School of The Museum of Fine Arts	<10
Schreiner University	<10
Schuyler Steuben Chemung Tioga Allegany BOCES	<10
Schuylkill Institute of Business & Technology	<10
Schuylkill Technology Centers	<10
Scientific College of Beauty / Barbering	<10
Scioto County Career Technical Center	<10
Scott College of Cosmetology	<10
SCS Business & Technical Institute	<10
Searcy Beauty College	<10
Seattle Central College	<10
Seattle Film Institute	<10
Seattle Institute of East Asian Medicine	<10
Seattle Opportunities Industralization Ctr	<10
Seattle Pacific University	<10
Seattle School of Theology and Psychology (The)	<10
Sebring Career Schools	<10
Seminole State College	<10
Seneca College of Applied Arts & Technology	<10
Sessions College for Professional Design	<10
Seton Hill University	<10
Setting the Standard Barbering and Natural Hair Academy	<10
Sevier Valley Applied Technology Center	<10
Seward County Community College	<10
Shampoo Academy of Hair	<10
Sharp Edgez Barber Institute	<10
Shasta College	<10
Shear Ego International School of Hair Design	<10
Shear Excellence Hair Academy	<10
Shear Finesse Beauty Academy	<10
Shear Perfection Academy of Cosmetology	<10
Sheldon Jackson College	<10
Shelton State Community College	<10
Sherman College of Straight Chiropractic	<10

Sherman Kendall's Academy of Beauty Arts And Sciences	<10
Sherrill's University of Barber & Cosmetology	<10
Shimer College	<10
Shore Beauty School	<10
Si Tanka University	<10
Sidney's Hairdressing College	<10
Siena College	<10
Sierra College of Business	<10
Sierra Nevada College	<10
Signature Healthcare Brockton Hospital School of Nursing	<10
Silicon Valley University	<10
Simdex Techl Inst	<10
Simmons Institute of Funeral Service	<10
Simmons School	<10
Simpson University	<10
SIT	<10
Skagit Valley College	<10
Skidmore College	<10
Skin Science Institute of Laser & Esthetics	<10
Skinworks School of Advanced Skincare	<10
Smith College	<10
Snead State Community College	<10
Snow College	<10
Solano Community College	<10
SOLEX College	<10
Soma Institute - The National School of Clinical Massage Therapy	<10
Somerset County Technical Institute	<10
Sonoma College	<10
Sotheby's Institute of Art - NY	<10
South Arkansas Community College	<10
South Baylo University	<10
South Central Career Center	<10
South Central Career College	<10
South Central Louisiana Technical College	<10
South Dakota School of Mines and Technology	<10
South Florida Institute of Technology	<10
South Hills Beauty Academy	<10
South Hills School of Business & Technology	<10
South Puget Sound Community College	<10
South Texas College of Law Houston	<10
South Texas Training Center	<10
South West Academy of Technology	<10
Southcentral Kentucky Community and Technical College	<10
Southeast Arkansas College	<10
Southeast Culinary & Hospitality College	<10
Southeast Kentucky Community and Technical College	<10
Southeast Missouri Hospital College of Nursing and Health Sciences	<10

Southeast School of Cosmetology	<10
Southeast Texas Career Institute	<10
Southeast Texas Techl Inst	<10
Southeastern Business Academy	<10
Southeastern Esthetics Institute	<10
Southeastern Regional Vocational Technical School	<10
Southeastern Technical College	<10
Southern Adventist University	<10
Southern Arkansas University Tech	<10
Southern Bus Schools	<10
Southern California College of Chiropractic	<10
Southern California Institute of Architecture (The)	<10
Southern California Seminary	<10
Southern Career Institute	<10
Southern Catholic College	<10
Southern College of Optometry	<10
Southern College of Technology	<10
Southern Institution of Business	<10
Southern Methodist College	<10
Southern Nevada University of Cosmetology	<10
Southern New England School of Law	<10
Southern Ohio College	<10
Southern School of Beauty	<10
Southern Texas Careers Academy	<10
Southern Utah University	<10
Southern Virginia University	<10
Southern Vocational Technical Institute	<10
Southern Westchester BOCES	<10
Southside College of Health Sciences	<10
Southwest Baptist University	<10
Southwest College	<10
SOUTHWEST COMPUTER COLLEGE INC	<10
Southwest Institute of Technology	<10
Southwest Minnesota State University	<10
Southwest School of Medical Assistants	<10
Southwest Technical College	<10
Southwest Texas Junior College	<10
Southwest Wisconsin Technical College	<10
Southwestern Adventist University	<10
Southwestern Business University	<10
Southwestern Christian College	<10
Southwestern College of Business	<10
Southwestern Community College	<10
Southwestern Oregon Community College	<10
Southwestern Professional Institute	<10
Southwestern University	<10
SOVAH School of Health Professions	<10

SOWELA Technical Community College	<10
Spa School (The)	<10
Spa Tech Institute	<10
Sparks College	<10
Spartan Health Sciences University School of Medicine	<10
Spartanburg Methodist College	<10
Special School District of St. Louis County	<10
Spencer Business & Technical Institute	<10
Spencer College	<10
Spertus College of Judaica	<10
Spoon River College	<10
Spring Garden College	<10
Springfield Beauty Academy	<10
Springfield College Illinois	<10
Springfield College of Beauty	<10
St George's Hospital Medical School	<10
St Johns University College Of Pharmacy	<10
St Norbert College	<10
St. Andrews Presbyterian College	<10
St. Clair County Community College	<10
St. Cloud Technical and Community College	<10
St. Edward's University	<10
St. Joseph School of Nursing	<10
St. Lawrence University	<10
St. Luke's College	<10
St. Luke's Hospital of Bethlehem, PA	<10
St. Matthew's University School of Medicine	<10
Stage One The Hair School	<10
Stage One, The Hair School	<10
Standard Healthcare Services, College of Nursing	<10
Stanford University	<10
Star College of Cosmetology	<10
Starting Points	<10
State Barber Styling College	<10
State Beauty Academy	<10
State Career School	<10
State College of Beauty Culture	<10
State Fair Community College	<10
State Technical College of Missouri	<10
State University of New York Downstate Medical Center	<10
State University of New York Polytechnic Institute	<10
Staunton School of Cosmetology	<10
Stefans Beauty College	<10
Stella and Charles Guttman Community College	<10
Stellar Career College	<10
StenoTech Career Institute	<10
Stenotype Institute of Springfield	<10

Stephens College	<10
Stephens Institute of Hair Design	<10
Sterling College	<10
Steven Papageorge Hair Academy	<10
STEVENS HENAGER COL CEN OFFICE	<10
Stevens Henager College All Campuses	<10
Stevens Henager College Main Campus	<10
Stillwater Beauty Academy	<10
Strand College of Hair Design	<10
Stratford School	<10
Stratford Schools (The)	<10
Strayer Business College	<10
Studio Arts College International	<10
Studio Seven Fashion Career College	<10
Stylemasters College of Hair Design	<10
Styletrends Barber and Hairstyling Academy	<10
Success Institute of Business	<10
Sue Bennett College	<10
Sullivan County Community College - SUNY Office of Community Colleges	<10
Sullivan Educational Centers	<10
SUM Bible College & Theological Seminary	<10
Summit Beauty School	<10
Summit Salon Academy - Gainesville	<10
Summit Salon Academy - Portland	<10
Summit Salon Academy Kansas City	<10
Summit Salon Academy Kokomo	<10
Sunbridge College	<10
Suncoast II The Tampa Bay School of Massage Therapy	<10
SUNY at Fredonia	<10
SUNY College at Geneseo	<10
SUNY College at Oneonta	<10
SUNY College of Environment Science & Forestry	<10
SUNY College of Technology at Alfred	<10
SUNY College of Technology at Delhi	<10
SUNY Cortland	<10
SUNY Fulton-Montgomery Community College	<10
SUNY Maritime College	<10
Super Shapes College of Cosmetology	<10
Susquehanna University	<10
Sussex County Community College	<10
Swansea University	<10
Sweet Briar College	<10
Sylvain Melloul International Hair Academy	<10
Sylvia's International School of Beauty	<10
Syracuse City School District	<10
Systems Technology Institute	<10
Tabor College	<10

TAD Technical Institute	<10
Tad Technical Institute - Kansas City	<10
Tampa College St Petersburg Campus	<10
Tarkio College	<10
Taylor Andrews Academy Of Hair Design	<10
Taylor Andrews Academy-St. George	<10
Taylor Business Inst (Closed)	<10
Taylor University	<10
Techl Education in Culinary and Health	<10
TechMission	<10
Technical Career Institute	<10
Technical College of the Lowcountry - Beaufort Campus	<10
Technical College of the Rockies	<10
Technical Education Center	<10
Technical Health Careers School	<10
Technical Training Center	<10
Techno-Dent Training Center	<10
Technology Center	<10
TechSkills - Charlotte	<10
Tel Aviv University	<10
Tempe Technical Institute	<10
Temple (The): A Paul Mitchell Partner School	<10
Tennessee Career College	<10
Tennessee Career Institute	<10
Tennessee College of Applied Technology Ripley	<10
Tennessee College of Applied Technology-Memphis	<10
Tennessee School of Beauty	<10
Tennessee Wesleyan University	<10
Texarkana College	<10
Texas A & M University - Texarkana	<10
Texas A&M International University	<10
Texas A&M University - Central Texas	<10
Texas A&M University System Health Science Center	<10
Texas A&M University-San Antonio	<10
Texas Aero Technology	<10
Texas Agricultural & Mechanical University at Galveston	<10
Texas County Technical Institute	<10
Texas Health and Science University	<10
Texas Health School	<10
Texas Healthtech Institute	<10
Texas Institute	<10
Texas Lutheran University	<10
Texas Schools	<10
Texas State Technical College Harlingen	<10
Texas State Technical College Marshall	<10
Texas State Technical College West Texas	<10
Texas Tech University Health Sciences Center	<10

Texas Vocational School	<10
Texcel Career Center	<10
Textures Institute of Cosmetology	<10
Thaddeus Stevens College of Technology	<10
Thames Valley State Technical College	<10
Theatre of Arts	<10
Thiel College	<10
Thomas College	<10
Three Rivers College	<10
Three Rivers Community College	<10
Tiffin Academy of Hair Design	<10
Tillamook Bay Community College	<10
Tobe-Coburn School For Fashion Careers	<10
Toccoa Falls College	<10
Today's Training Center	<10
Toledo Academy of Beauty	<10
Tomorrow's Image Barber & Beauty Academy of Virginia	<10
Total Cosmetology Training Center	<10
Total Image Beauty Academy	<10
Total Transformation Institute of Cosmetology	<10
Tracey-Warner School	<10
Training Domain (The)	<10
Transformed Barber & Cosmetology Academy	<10
Transport Careers Home Stdy	<10
Transwestern Inst	<10
Travel Institute	<10
Travel Institute of the Pacific	<10
Travel University International	<10
Trebas Institute of Rec Arts	<10
Trend Barber College	<10
Trend Beauty College	<10
Trend Benders Academy	<10
Trend Setters School	<10
TrendMasters Academy of Cosmetology	<10
Trendsetters of FL. School of Beauty & Barbering	<10
Trenz Beauty Academy	<10
Trinidad State College	<10
Trinity Baptist College	<10
Trinity Bible College and Graduate School	<10
Trinity Christian College	<10
Trinity College	<10
Trinity College of Florida	<10
Trinity College of Vermont	<10
Trinity Evangelical Divinity School	<10
Trinity Lutheran College	<10
Trinity Lutheran Seminary	<10
Trinity School of Health and Allied Sciences	<10

Trinity University	<10
Triple Cities School of Beauty Culture	<10
Tri-Rivers Career Center	<10
Tri-State College	<10
Tri-State College of Acupuncture	<10
Tri-State Cosmetology Institute	<10
Tri-State Institute of Hair Design	<10
Tri-State Semi Driver Training	<10
TriState Travel School	<10
Trocaire College	<10
Troy State University Montgomery	<10
Truett McConnell University	<10
Truman State University	<10
Trumbull Career and Technical Center-Adult Training Center	<10
Tucson College of Beauty	<10
Tulare Beauty College	<10
Tunxis Community College	<10
Turning Point Beauty College	<10
Twin City Beauty College	<10
Tyndale University	<10
U.S. Truck Driver Training School	<10
Ulster County BOCES School of Practical Nursing	<10
Ulster County Community College	<10
Ultissima Beauty Institute at Bensonhurst	<10
Ultissima Beauty Institute At Massapequa(Closed)	<10
Ultissma Beauty Inst Brentwood	<10
Ultissma Beauty Institute (CLOSED)	<10
ULTRASOUND DIAGNOSTIC SCHOOL	<10
Umpqua Community College	<10
Unified Schools of America-Compton Campus	<10
Unified Schools of America-Lawdale	<10
Unilex College	<10
Union Technical Institute (Closed)	<10
United Business Institute	<10
United Career Center	<10
United College	<10
United Electronics Inst	<10
United Electronics Institute	<10
United Medical and Business Institute	<10
United States Sports Academy	<10
United States Truck Driving School	<10
United Theological Seminary	<10
Unity College	<10
Unity Cosmetology College	<10
Universal Acadamy Of Hair Design	<10
Universal Barber College	<10
Universal Spa Training Academy	<10

Universal Therapeutic Massage Institute	<10
Universal Training Institute	<10
Universidad Adventista De Las Antillas	<10
Universidad Católica Nordestana	<10
Universidad Central de Bayamón	<10
Universidad Central del Caribe	<10
Universidad de Ciencias Medicas (UCIMED)	<10
Universidad de Monterrey	<10
Universidad Federico Henriquez Y Cardajal	<10
Universidad Nacional Autonoma de Mexico	<10
Universidad Nacional Pedro Henriquez Urena	<10
Universitat Jaume I de Castello (UJI)	<10
University College Dublin, National University of Ireland, Dublin	<10
University of Aberdeen	<10
University of Aesthetics & Cosmetology	<10
University of Aesthetics & Cosmetology (The)	<10
University of Alaska Southeast	<10
University of Arkansas Community College at Batesville	<10
University of Arkansas Community College at Morrilton	<10
University of Arkansas Community College Rich Mountain	<10
University of Arkansas System eVersity	<10
University of Birmingham (The)	<10
University of Bradford	<10
University of Bristol	<10
University of British Columbia	<10
University of California, Hastings College of the Law	<10
University of California, Merced	<10
University of California, San Francisco	<10
University of Cambridge - Murray Edwards College	<10
University of Central Texas	<10
University of Colorado at Denver	<10
University of Copenhagen	<10
University of Cosmetology	<10
University of Debrecen	<10
University of Dublin Trinity College	<10
University of Dundee	<10
University of Durham	<10
University of East Anglia	<10
University of East London	<10
University of East-West Medicine	<10
University of Edinburgh	<10
University of Evansville	<10
University of Fort Lauderdale	<10
University of Glasgow	<10
University of Guam	<10
University of Hawaii - West Oahu	<10
University of Hawaii at Hilo	<10

University of Hawaii Maui College	<10
University of Health Sciences and Pharmacy in St. Louis	<10
University of Holy Cross	<10
University of Jamestown	<10
University of Kansas Medical Center	<10
University of Keele	<10
University of Kent	<10
University of Leeds	<10
University of Leicester	<10
University of Limerick	<10
University of Liverpool (The)	<10
University of London - School of Oriental & African Studies	<10
University of London - University College London	<10
University of Lynchburg	<10
University of Maine - Farmington	<10
University of Maine - Fort Kent	<10
University of Management and Technology (The)	<10
University of Manchester (The)	<10
University of Mary	<10
University of Mary Hardin-Baylor	<10
University of Mary Washington	<10
University of Maryland Munich Campus	<10
University of Medicine & Dentistry of New Jersey	<10
University of Melbourne	<10
University of Minnesota - Crookston	<10
University of Minnesota Morris	<10
University of Montana Western (The)	<10
University of Montevallo	<10
University of Mount Union	<10
University of Nebraska All Campuses	<10
University of Nebraska Medical Center	<10
University of New Hampshire School of Law	<10
University of North Carolina Asheville	<10
University of North Carolina School of the Arts	<10
University of North Texas Health Science Center at Fort Worth	<10
University of Northumbria at Newcastle	<10
University of Northwestern- St Paul	<10
University of Notre Dame	<10
University of Nottingham	<10
University of Oklahoma Health Sciences Center	<10
University of Oslo	<10
University of Otago	<10
University of Pikeville	<10
University of Portland	<10
University of Providence	<10
University of Puerto Rico - Aguadilla	<10
University of Puerto Rico - Bayamón	<10

University of Puerto Rico - Carolina	<10
University of Puerto Rico - Central Administration	<10
University of Puerto Rico - Humacao University College	<10
University of Puerto Rico - Mayaguez	<10
University of Puerto Rico - Medical Science Campus	<10
University of Puerto Rico - Ponce	<10
University of Puerto Rico - Rio Piedras Campus	<10
University of Puget Sound	<10
University of Queensland (The)	<10
University of Richmond	<10
University of Rochester	<10
University of Saint Andrews	<10
University of Saint Mary	<10
University of Science & Arts of Oklahoma	<10
University of Scranton	<10
University of Sioux Falls	<10
University of Sound Arts	<10
University of South Australia	<10
University of South Carolina - Lancaster	<10
University of South Carolina - Salkehatchie	<10
University of South Carolina - Sumter	<10
University of South Carolina - Union	<10
University of South Carolina Beaufort	<10
University of South Dakota Springfield	<10
University of Southampton	<10
University of Spa & Cosmetology Arts	<10
University of Stirling	<10
University of Sydney	<10
University of Tennessee Health Science Center	<10
University of Tennessee Southern	<10
University of Texas Dallas	<10
University of Texas Health Science Center at Houston	<10
University of Texas Health Science Center at San Antonio	<10
University of Texas Health Science Center at Tyler (The)	<10
University of Texas M.D. Anderson Cancer Center	<10
University of Texas Medical Branch at Galveston	<10
University of Texas of the Permian Basin	<10
University of Texas Southwestern Medical Center (The)	<10
University of the Arts London	<10
University of The Arts London IDO - Central Saint Martins College	<10
University of the Ozarks	<10
University of the Pacific McGeorge School of Law	<10
University of the Virgin Islands	<10
University of the West of England, Bristol	<10
University of Toronto	<10
University of Valley Forge	<10
University of Vermont and State Agricultural College	<10

University of Virginia	<10
University of Virginia's College at Wise (The)	<10
University of Wales Trinity Saint David	<10
University of West London (The)	<10
University of West Los Angeles	<10
University of Western States	<10
University of Westminster	<10
University of Windsor	<10
University of Wisconsin - Eau Claire	<10
University of Wisconsin - Green Bay	<10
University of Wisconsin - LaCrosse	<10
University of Wisconsin - Platteville	<10
University of Wisconsin - River Falls	<10
UNKNOWN	<10
Unlimited Cosmetology School	<10
UPMC Jameson School of Nursing	<10
UPMC Shadyside	<10
Upper Valley Career Center	<10
Upsala College	<10
UR Beauty & Barber Academy	<10
Urban Barber College	<10
Ursinus College	<10
USA Hair Academy #1	<10
Utah State University - College of Eastern Utah	<10
Valdosta Academy of Beauty Culture	<10
Valley Beauty School	<10
Valley City State University	<10
Valley Forge Military College	<10
Valley Grande Institute for Academic Studies	<10
Valor Christian College	<10
Van Nuys College of Business	<10
Vance - Granville Community College	<10
VanderCook College of Music	<10
Vanguard Institute of Technology	<10
Vantage College - San Antonio	<10
Vatterott Educational Centers	<10
VEEB Nassau County School of Practical Nursing	<10
Vee's School of Beauty Culture	<10
Venango County Area Vocational Technical School	<10
Vennard College	<10
Ventura Adult and Continuing Education	<10
Ventura College	<10
Venus Beauty Academy	<10
Vera Slater Beauty School	<10
Vermilion Community College	<10
Vermont College of Fine Arts	<10
Vermont Law and Graduate School	<10

Vermont Technical College	<10
Vernon College	<10
Vibe Barber College	<10
Vicksburg School of Cosm	<10
Victor Valley Community College	<10
Victoria Beauty and Barber College	<10
Victoria College	<10
Victoria's Academy of Cosmetology	<10
Victorias Beauty College	<10
Victory Career College	<10
Villa Maria College of Buffalo	<10
Vincennes Beauty College	<10
Virginia Careers Academy	<10
Virginia College at Pensacola	<10
Virginia Schools	<10
Visible Changes University	<10
Visible Music College	<10
Vista Del Mar School of Court Reporting	<10
Viterbo University	<10
Vocational Institute	<10
Vocational Institute of Florida	<10
Vogue Beauty College #12	<10
Vogue College - San Antonio	<10
Vogue College of Cosmetology	<10
Vogue College of Cosmetology #21	<10
Vogue College of Cosmetology #25	<10
Vogue College School of Hair Design #16	<10
Vogue School of Hair Design #6	<10
Vrije Universiteit Amsterdam	<10
Wade Gordon Hairdressing Academy	<10
Walla Walla Community College	<10
Walla Walla University	<10
Walsh University	<10
Walter Jay M.D. Institute, An Educational Center	<10
Walters State Community College	<10
Warren County Career Center	<10
Warren County Community College	<10
Warren Wilson College	<10
Wartburg College	<10
Washington and Jefferson College	<10
Washington Barber College	<10
Washington Beauty Academy	<10
Washington Bible College	<10
Washington Saratoga Warren Hamilton Essex BOCES	<10
Washington School of Secretaries	<10
Washington State Community College	<10
Watkins College of Art, Design & Film	<10

Watterson School of Business and Technology	<10
Wave Leadership College	<10
Waycross College	<10
Wayne - Finger Lakes BOCES	<10
Wayne Community College	<10
Wayne State College	<10
Waynesburg University	<10
Waynesville Career Center	<10
Weatherford College	<10
Webb's Barber School of Arts	<10
Welch College	<10
Wells College	<10
WellSpring School of Allied Health	<10
Wenatchee Valley College	<10
Wentworth Military Academy and College	<10
Wentworth Technical School	<10
Wesley Biblical Seminary	<10
Wesleyan College	<10
Wesleyan University	<10
West Hills College Lemoore	<10
West Hills Community College	<10
West Kentucky Technical College	<10
West Los Angeles College	<10
West Shore Community College	<10
West Side Institute of Technology	<10
West Valley College	<10
West Virginia Northern Community College	<10
West Virginia School of Osteopathic Medicine	<10
West Virginia University - Parkersburg	<10
West Virginia University Institute of Technology	<10
West Virginia Wesleyan College	<10
Westchester College of Nursing & Allied Health	<10
Western Area Career & Technology Center	<10
Western Business Institute	<10
Western Colorado University	<10
Western Dakota Technical College	<10
Western Mass Precision Institute	<10
Western Nevada College	<10
Western Oklahoma State College	<10
Western Pennsylvania Hospital School of Medical Technology	<10
Western Pennsylvania Hospital School of Nursing	<10
Western Piedmont Community College	<10
Western School of Beauty Culture	<10
Western Seminary	<10
Western Suffolk BOCES	<10
Western Texas College	<10
Western Truck School	<10

Western Wyoming Community College	<10
Westfield State University	<10
Westlake Institute of Technology	<10
Westland College	<10
Westmar University	<10
Westminster Choir College	<10
Westminster Theological Seminary	<10
Westmont College	<10
Westwood Educational	<10
Wharton County Junior College	<10
Whatcom Community College	<10
Wheelock College	<10
White Mountains Community College	<10
Whitworth University	<10
Wichita Business College	<10
Wilbur Wright College	<10
Wilfred Academy	<10
Wilfred Academy of Hair & Beauty Culture	<10
Wilfred Academy of Hair and Beauty Culture	<10
Wilfred Academy of Hair Design & Beauty Culture	<10
Wilkes Barre Area Career and Technical Center Practical Nursing Prgm	<10
Wilkes Community College	<10
Willamette University	<10
Willfred's Frederic Hairstyling	<10
William James College	<10
William Jessup University	<10
William Jewell College	<10
William Marsh Rice University	<10
William Tyndale College	<10
William Woods University	<10
Williams Baptist University	<10
Williston State College	<10
Wilma Boyd Career Schools	<10
Wilmington College	<10
Wilson College	<10
Wilson Community College	<10
Windward Community College	<10
Winner Institute of Arts & Sciences	<10
Winona State University	<10
Winonah's International School of Cosmetology	<10
Wiregrass Georgia Technical College	<10
Wisconsin Lutheran College	<10
Wittenberg University	<10
Wofford College	<10
Women's Techl Institute	<10
Woodbridge Business Institute	<10
Wooster Business College	<10

Worcester Polytechnic Institute	<10
Worcester State University	<10
Word of Life Bible Institute	<10
WorldClass Academy of Beauty Careers	<10
Worsham College of Mortuary Science	<10
Wright Beauty Academy	<10
Wright Beauty College	<10
Wright Business School	<10
Wright Institute (The)	<10
Wytheville Community College	<10
Xcell Academy A Paul Mitchell School	<10
Xenon International Academy II	<10
Xenon International Academy IV	<10
Yale University	<10
Yavapai College	<10
York County Community College	<10
York County School of Technology	<10
York Institute	<10
York University	<10
Young Americans College of the Performing Arts (The)	<10
Young Cosmetology College	<10
Young Harris College	<10
Youngstown College of Massotherapy (The)	<10
Y's Hair International	<10
Yuba College	<10
Yukon Beauty College	<10
Z Hair Academy	<10
Zenzis Beauty College	<10
ZMS The Academy	<10

*Case count is rounded to the nearest 10.

Question. A list of all group discharge applications the Department has received from State attorneys general including the date submitted, by whom, the school/programs, the number of covered borrowers, and the status of each application.

Answer. Information regarding the group discharge requests from attorneys general is provided in the enclosed file.

Group Submissions by Attorneys General Seeking Relief for Constituents as of July 28, 2023

SCHOOL/SCHOOL GROUP	DIPLOMA PROGRAM(S) IF APPLICABLE	ATTORNEY GENERAL	STATE	STATUS	SUBMISSION DATE
American Career Institute		Maura Healy	Massachusetts	Granted	7/20/16
Anthem University		Lori Swanson	Minnesota	Resolved Through Sweet	5/3/16
CEHE	Submission for discharge for students who enrolled in Colorado between 2006-2021	Phillip J. Weiser	Colorado	Granted	6/30/22
Corinthian Colleges, Inc.		Maura Healy	Massachusetts	Granted	11/30/15
Corinthian Colleges, Inc.		Brad Schimel	Wisconsin	Granted	2/4/16
Corinthian Colleges, Inc.	• Dental Assistant • Electrician • Massage Therapy • Medical Administrative Assistant • Medical Assistant • Medical Insurance Billing and Coding • Pharmacy Technician	Lisa Madigan Kwame Raoul	Illinois	Granted	12/16/16
Corinthian Colleges, Inc.		Bob Ferguson	Washington	Granted	12/20/16
Corinthian Colleges, Inc.	Submission for discharge for students enrolled at programs covered by the Department's job placement rate misrepresentation findings.	Lisa Madigan Bob Ferguson Maura Healy Xavier Becerra George Jepsen Matthew Dean Douglas Chin Tom Miller Andy Beshear Brian E. Frosh Janet T. Mills Lori Swanson Jim Hodd Hector Balderas Eric T. Schneiderman Ellen F. Rosenblum Josh Shapiro Mark R. Herring Karl A. Racine	Illinois Washington Massachusetts California Connecticut Delaware Hawaii Iowa Kentucky Maryland Maine Minnesota Mississippi New Mexico New York Oregon Pennsylvania Virginia District of Columbia	Granted	6/5/2017
Court Reporting Institute	Submission for discharge for students enrolled at CRI's Seattle and Tacoma campuses and enrolled in the court reporting program.	Bob Ferguson	Washington	Partially Granted	11/21/16
Education Corporation of America (Virginia College, Brightwood, Brightwood Career Institute, Golf Academy of America and Ecotech Institute)	Submission for discharge for students enrolled between June 2016 and its closure in December 2018.	Josh Shapiro Brian E. Frosh Rob Bonta Phillip J. Weiser Jason Miyares Steve Marshall	Pennsylvania Maryland California Colorado Virginia Alabama	Under Consideration	4/28/22
Globe University & Minnesota School of Business		Lori Swanson	Minnesota	Granted	6/7/16
Illinois Institute of Art and Art Institute of Colorado	Submission requests students have any federal student loan used to pay for schooling at the affected campuses from January 1, 2018 onward discharged and any amounts paid on those loans refunded.	Kwame Raoul Phil Weiser	Illinois Colorado	Granted	6/3/19
ITT Technical Institute	Submission for discharge for all borrowers who enrolled at ITT between 2007 and 2010 (or who assumed federal loan debt for another person who enrolled at ITT between 2007 and 2010). During this time, ITT misled students about the value of an ITT degree using its Value Proposition Document.	Phillip J. Weiser Ellen F. Rosenblum Keith Ellison Karl A. Racine Bob Ferguson Gurbir S. Grewal Thomas J. Donovan, Jr. Stephen H. Levins Brian E. Frosh Lawrence G. Wasden Kwame Raoul Josh Shapiro Tom Miller Mark Herring Aaron M. Frey Derek Schmidt Hector Balderas Josh Stein Letitia James Maura Healey Douglas Peterson Joshua L. Kaul William Tong Aaron D. Ford Herbert Slatery, III	Colorado Oregon Minnesota District of Columbia Washington New Jersey Vermont Hawaii Maryland Idaho Illinois Pennsylvania Iowa Virginia Maine Kansas New Mexico North Carolina New York Massachusetts Nebraska Wisconsin Connecticut Nevada Tennessee	Granted	4/1/2021
Kaplan University	• Medical Assistant • Medical Billing and Coding	Maura Healy	Massachusetts	Granted	5/6/2016
Lincoln Technical Institute	• Criminal Justice	Maura Healy	Massachusetts	Under Consideration	1/14/16
New England Institute of Art/EDMC	Submission for borrowers who attended from 1999-2015	Maura Healey	Massachusetts	Under Consideration	3/25/22
Westwood College	• Criminal Justice	Lisa Madigan Kwame Raoul	Illinois	Granted	12/13/16
Westwood College		Phil Weiser	Colorado	Granted	8/27/2020
Charlotte School of Law		Josh Abram	North Carolina	Under Consideration	8/23/2022

The table provides a list of all attorneys general submissions related to groups of borrowers for which the attorneys general seek a borrower defense discharge as of July 28, 2023. These requests all predate the 2023 borrower defense regulation

and are not third party requests as defined by that regulation. To date the Department has not received any third party requests under the 2023 regulation. The table includes the submission date, the attorneys general, the school, and the diploma program, if applicable. If a diploma program is not provided for a submission, the submission was not limited to a specific program.

Please note that last year this chart included Premier Education Group submissions made by the Massachusetts Attorney General. These submissions are not on this chart because these submissions were packets of individual applications and not requests for group relief. However all of these applications have been approved for relief under the terms of the Sweet v. Cardona settlement. Similarly, the Anthem submission made by the Minnesota Attorney General consisted of affidavits submitted by borrowers. These affidavits were treated as applications which were approved for relief under the terms of the Sweet settlement.

Additionally, please note that under the Department's regulations, it is within the Secretary's discretion to create a group discharge process and define the parameters of the group. The Department cannot provide the number of borrowers that are covered by these requests because the Department defines its own parameters when forming a group. The groups above that are listed as granted all represent Department created groups that were as broad or broader than what was requested. The Court Reporting Institute is listed as partially granted because the Department has approved individual applications that fall within the request, but due to the time period of when the school operated, Department data cannot identify all students who fall within the request. Individual applications submitted by attorneys general have been, and will continue to be, considered under the individual application review process.

Question. For each of the years 2016, 2017, 2018, 2019, 2020, 2021, 2022, and 2023, what are the total dollar amounts of Federal student loans (interest and principal) covered by each group discharge application from a State attorney general?

Answer. At this time, the Department cannot narrow its reporting to individual applications submitted by attorneys general. Most of the attorney general submissions did not specifically identify the borrowers covered by their group requests, and the Department is currently working to identify the borrowers at issue.

Question. How many of the applications referenced in (e) are pending? How many have been granted? How many have been denied? Please provide a list of each.

Answer. Please see the AG group submission list provided in (d).

Question. For each of the years 2016, 2017, 2018, 2019, 2020, 2021, 2022, and 2023, how many borrowers covered by a group discharge application are in default on their Federal student loans?

Answer. At this time, the Department cannot narrow its reporting to individual applications submitted by attorneys general. Most of the attorney general submissions did not specifically identify the borrowers covered by their group requests, and the Department is currently working to identify the borrowers at issue.

Question. For each of the years 2016, 2017, 2018, 2019, 2020, 2021, 2022, and 2023, how many loans of the borrowers covered by a group discharge application have been certified by the Department for Treasury offset? What are the total dollar amounts collected through the Treasury Offset Program on defaulted student loans covered by each group discharge application from a State attorney general?

Answer. At this time, the Department cannot narrow its reporting to individual applications submitted by attorneys general. Most of the attorney general submissions did not specifically identify the borrowers covered by their group requests, and the Department is currently working to identify the borrowers at issue.

Question. For each of the years 2016, 2017, 2018, 2019, 2020, 2021, 2022, and 2023, how many borrowers covered by a group discharge application have been subject to an administrative wage garnishment order put in place by the Department?

Answer. At this time, the Department cannot narrow its reporting to individual applications submitted by attorneys general. Most of the attorney general submissions did not specifically identify the borrowers covered by their group requests, and the Department is currently working to identify the borrowers at issue.

Question. The current borrower defense form is 25 pages and is difficult for student loan borrowers to navigate without an attorney. Does the Department intend to initiate a regulatory review process to update the borrower defense form? Please elaborate on timing.

Answer. The Department is currently in the process of updating the borrower defense application form and expects to publish an updated version that is compliant with the borrower defense regulations published on November 1, 2022 (87 FR 65904). This process will be completed in July 2023.

Question. The for-profit college industry drastically increased its enrollment during the Great Recession. In many cases, low-value colleges preyed on out-of-work

adults, promising them an education that would lead to well-paying jobs—only to leave those students with a mountain of debt and no credential of value. Enrollment peaked in 2011 at more than three million students in the for-profit sector. The Harkin investigation, which was conducted by the Senate Committee on Health, Education, Labor, and Pensions, showed that students were "churned" through these schools, with more than 50 percent of for-profit students leaving within 4 months. Schools like Westwood, Corinthian, and ITT Tech lied to prospective students about their employment outcomes and took their money, only to shutter precipitously, leaving those students without good options to complete their degrees. The Biden Administration has taken some important steps to right those wrongs, discharging student loans for borrowers who were not able to graduate. I particularly appreciate that the students from Westwood, which closed in 2016, finally have been granted relief; however, many other borrowers from many other institutions that similarly closed after taking advantage of students have not seen the relief they deserve, even when there have been investigations of those schools that have found widespread predatory conduct.

When can borrowers who attended but could not graduate from colleges like Charlotte School of Law, Vatterott, schools run by the CEHE, schools run by the Dream Center, and schools run by ECA expect to receive the same group relief as students from Westwood?

Answer. The Department is continuing to review evidence available to it to determine when a group discharge may or may not be appropriate. This includes considering requests for group discharges already received. If a group discharge was issued, it would apply equally to borrowers who graduated and those who did not.

Question. The Department granted borrower defense discharges for borrowers who attended Westwood in August 2023, more than 7 years after Westwood precipitously shuttered its doors.

Although I applaud the Department's actions to provide this deserved relief to former Westwood students, the notices to Westwood borrowers were not sent out until the end of March 2023, 7 months after the Department initially made its announcement Furthermore, as of March 29, 2023, no Westwood borrower had seen their loans discharged on their account.

Please provide additional context for the delay in providing notices to Westwood borrowers.

Answer. Over the past year, the U.S. Department of Education has announced discharges for over 1.1 million borrowers. As part of that process, the Department has had to manage the unprecedented flow of discharge requests that are being sent to servicers for processing while also appropriately timing the notification to borrowers of their discharge.

All impacted Westwood borrowers have not been required to make payments during this time period, have not accrued any additional interest, and will receive a full discharge of their applicable loans and, if warranted, a full refund of payments previously made to the Department. Westwood borrowers will also continue to have their loans paused even if their discharges have not been processed by the time loans return to repayment.

Question. Please provide the number of Westwood borrowers whose loan balance has been cleared on their account. Please provide the number of Westwood borrowers who are still waiting to see their balance clear.

Answer. As of mid-July 2023, approximately 44k Westwood borrowers had their discharges processed, and approximately 34K borrowers' discharges are pending.

Question. In a previous response, the Department informed me that the time it takes between notification and discharge varies for each borrower based on a variety of circumstances, including whether the borrower previously consolidated their loans. Please provide the average amount of time it takes for a borrower to see their balance clear after the receiving a notice from the Department.

Answer. For those Westwood borrowers with discharges processed, the average time between the borrower notification and the discharge being processed was 62 days.

Question. Please provide a list detailing the number of borrowers who have seen full discharge, disaggregated by institution where borrowers have been granted borrower defense group discharge (e.g. Corinthian, ITT Tech, Westwood, DeVry, and Marinello School of Beauty).

Answer. As of mid-July 2023, group discharges have been fully processed for:

—246k Corinthian borrowers

—128k ITT borrowers

—44k Westwood borrowers

—25k Marinello borrowers

There is not a group discharge associated with DeVry.

Question. The Department previously notified me and other Members of Congress that former Secretary DeVos had decided not to extend the closed school discharge look-back period for students who attended schools owned by ECA. As the Department previously has stated, "during the months of March, April, and May 2018, ACICS placed many locations of ECA on either campus-level show-cause or campus-level compliance warning due to student achievement rates" and on "May 8, 2018, ACICS placed ECA on show-cause due to adverse action by another agency." Actions toward the removal of accreditation are a clear example of exceptional circumstances as provided under 34 CFR § 685.214. In that same notification, the Department noted that former Secretary DeVos had not yet reached a decision on the request made by me and other Members of Congress, to extend the look back period for Vatterott students which also met the exceptional circumstances bar in the law. Will the Department reconsider these decisions?

Answer. The Department is committed to exercising the exceptional circumstances authority for closed school discharges when the Secretary determines it is warranted. We are continuing to review past closures to identify any instances where an exceptional circumstance did occur.

Question. Please provide a list of all institutions for which the Department currently holds a letter of credit or other surety and the amount of such letter of credit or other surety.

Answer. Enclosed is an Excel file containing data on the Letters of Credit (LOC) and other surety that the Department held as of December 31, 2022, derived from LOC data recorded in the Department's eZ-Audit system and Postsecondary Education Participants System, and which was provided to an advocacy group in response to a FOIA request. As of December 31, 2022, the Department held LOCs and other surety from 308 distinct institutions, totaling nearly $599 million in financial protection. The first tab of the Excel file contains institutional and other data regarding the LOCs held by the Department as of December 31, 2022. The second tab provides the field definitions and descriptions of the reasons why a LOC was requested from a listed institution. The report does not provide historical context for the LOCs held as of December 31, 2022, in cases where FSA may have required an institution to renew or amend a previously provided LOC. In a limited number of cases, the report also identifies and includes funds held on deposit by the Department in lieu of a LOC.

[The Department provided the attachment to the Committee.]

Question. In recent years, several for-profit colleges have attempted to convert to not-for-profit status or have been acquired by public universities, such as the University of Arizona's acquisitions of Ashford University, Purdue University's acquisition of Kaplan University, and the University of Idaho's potential acquisition of the University of Phoenix. These for-profit colleges seek nonprofit status or acquisition by a public university in an effort to avoid the stigma associated with the predatory for-profit college industry and to avoid regulations meant to protect students and taxpayers.

Please provide a list of all for-profit conversions in the last 10 years, including those pending (with current status), previously approved, and denied or withdrawn.

Answer. An Excel file providing the requested information is enclosed. As of Jan. 1, 2013, there were 78 applications for a for-profit to nonprofit conversion that were pending, previously approved, denied, or withdrawn. Since our last report, two more applications were received from for-profit institutions requesting recognition as nonprofit institutions. None were removed due to aging.

[The Department provided the attachment to the Committee.]

Of those 78 applications, the Department has made final decisions on 40 conversion requests as of June 8, 2023. Of those 40 decisions, 37 conversion requests were approved.* The Department denied Argosy University's request for nonprofit recognition and denied Argosy's continued participation in the Title IV, HEA programs. The Department also denied Grand Canyon University's and the American Academy

*In August 2016, the four main locations operated by the Center for Excellence in Higher Education (CEHE) were originally denied their conversion request. Following the receipt of additional information and an updated valuation in October 2018, the Department determined that it would be appropriate to grant those institutions conditional approval to convert to nonprofit institutions and issued Provisional Program Participation Agreements in December 2018. The Department's December 2018 determination of CEHE's nonprofit status—based on the new information CEHE provided—also provided a basis to dismiss a longstanding lawsuit filed against the Department, because that was the relief sought in the lawsuit. In late July 2021, CEHE made the decision to close its remaining campuses effective Aug. 1, 2021. Additionally, one approved CIO transaction involving Kaplan University and Purdue University resulted in Kaplan University's conversion to a public institution status rather than to a nonprofit institution status.

of Art College's requests for nonprofit recognition when it approved their respective Change in Ownership applications, which allowed those institutions to continue to participate in the Title IV, HEA programs as proprietary institutions.

Regarding the remaining 38 applications that do not have an issued agency decision, 20 applications (including pre-acquisition review applications) did not require a final agency decision because the applicant institutions either closed or voluntarily withdrew their applications while the applications were under review. Consequently, there are 18 conversion applications pending a decision by the Department.

Your office may notice that the report does not include prospective transactions for the University of Phoenix (UoP). While UoP's prospective transactions with the University of Arkansas and the University of Idaho have been included in recent media coverage, UoP did not submit an application for its now-abandoned prospective transaction with the University of Arkansas, and UoP has not yet submitted an application regarding its prospective transaction involving the University of Idaho.

Question. How does the Department determine whether a school is able to move from for-profit status to nonprofit status?

Answer. The Department performs a rigorous case-specific substantive analysis for each for-profit institution that requests approval to be recognized as a nonprofit institution. The Department refers your office to the attached "Report to Congress on Proprietary Institution Conversions," dated May 27, 2021, which describes the process the Department uses to evaluate for-profit conversion requests. Copies of the report were provided to the Chairs and Ranking Members of the Department's authorizing committees and to the appropriations committees of the U.S. Senate and of the U.S. House of Representatives.

Report on Proprietary Institution Conversions

U.S. Department of Education

May 27, 2021

Introduction

In its Explanatory Statement for the Further Consolidated Appropriations Act, 2020, Congress directed the Department to issue a report outlining the process through which it approves or disapproves of a for-profit institution's conversion to not-for-profit status and a list of any staff involved in such decisions. Congress also directed the Department to include in the report all institutions of higher education that have changed their for-profit status in the past three fiscal years and any action the Department has made with respect to those institutions. This report was prepared in accordance with directions provided by Congress. We do note for awareness that this report refers to "nonprofit" status instead of "not-for-profit" status for consistency with the Higher Education Act of 1965 (the HEA) and the U.S. Department of Education's (the Department's) regulations. Likewise, the report refers to "proprietary" instead of "for-profit."

Background

The Department's Federal Student Aid office (FSA) administers the student financial assistance programs authorized by Title IV of the HEA, as amended (Title IV, HEA programs), and the Health Education Assistance Loan (HEAL) program transferred to the Department from the U.S. Department of Health and Human Services under Public Law 113-76.

FSA's Office of Partner Participation and Oversight (PPO) is responsible for activities that support and monitor FSA program participants and enforce compliance with laws and regulations governing student financial assistance programs. The activities within PPO cover the entire lifecycle of program participants. The Partner Eligibility and Oversight Services Directorate (PEOSD) within PPO is responsible for providing services and support related to the performance of the Title IV portfolio and administering a program of monitoring and oversight of the institutions (i.e., schools, guaranty agencies, lenders, and servicers) participating in the Department of Education's Federal Student Aid programs. The School Eligibility and Oversight Service Group (SEOSG) within PEOSD is the group responsible for administering a program of eligibility, certification, financial analysis, and oversight of schools participating in the Title IV, HEA programs. This compliance program, which also includes audit resolution, is administered in accordance with policies and procedures established by PPO's Performance Management Group (PMG) and utilizes the automated systems and facilities developed and maintained by PPO's Program Management and Support Services Directorate.

To accomplish this mission, SEOSG is divided into eight School Participation Divisions (SPDs) that specialize in the business processes necessary for managing accountability in campus administration of Title IV, HEA programs. There are seven SPDs for domestic schools and one SPD (the Multi-Regional and Foreign Schools Participation Division) that focuses on both domestic and foreign schools' responsibilities. The Multi-Regional and Foreign Schools

Participation Division (MRFSPD) is responsible for distinct functions of a group of staff responsible for the oversight and management of the evaluation and certification of publicly traded corporations and large school groups and foreign schools that apply to participate in the Title IV, HEA programs.

Each of the SPDs has responsibility for the oversight and management improvement services of a specific set of schools. Among the many responsibilities performed by SPDs are examining, analyzing, and making determinations on eligibility applications submitted by schools for participation in the Federal Student Aid programs.[1]

The Department's Review of Proprietary Institution Conversion Requests

Statutory and Regulatory Definitions

The HEA has long provided different definitions for an "institution of higher education," a "proprietary institution of higher education," and "nonprofit." The Department's regulations reflect the distinctions that the statute makes for these terms.

Statutory Definitions

"Institution of higher education" and "postsecondary vocational institution" mean, in pertinent part, an educational institution in any State that "is a public or other nonprofit institution." *See* 20 U.S.C. §§ 1001(a)(4); 1002(c)(1)(B).

"Nonprofit" means a school, agency, organization, or institution owned and operated by one or more nonprofit corporations or associations, no part of the net earnings of which inures, or may lawfully inure, to the benefit of any private shareholder or individual. *See* 20 U.S.C. § 1003(13).

The definition of a "proprietary institution of higher education" is an institution of higher education that is not a public or a nonprofit institution. *See* 20 U.S.C. § 1002(b).

The Department's Definitions and Regulations

"Institution of higher education," "proprietary institution of higher education," and "postsecondary vocational institution" are defined in the Department's regulations at 34 C.F.R. §§ 600.4, 600.5, and 600.6, respectively. The Department's definitions of an "institution of

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[1] *See* U.S. Department of Education Principal Office Functional Statements https://www2.ed.gov/about/offices/or/fs/fsa/intro.html and https://www2.ed.gov/about/offices/or/fs/fsa/partners.html

higher education" and a "postsecondary vocational institution" include a requirement for the institution to be a public or private nonprofit educational institution.

"Public," when applied to an institution, means that the institution is under the administrative supervision or control of a government other than the Federal Government. "Private" means that the institution is not under Federal or public supervision or control. *See* 34 C.F.R. § 77.1(b).

"Nonprofit institution," means, for a domestic institution, an institution that—

- Is owned and operated by one or more nonprofit corporations or associations, no part of the net earnings of which benefits any private shareholder or individual;
- Is legally authorized to operate as a nonprofit organization by each State in which it is physically located; and
- Is determined by the U.S. Internal Revenue Service to be an organization to which contributions are tax-deductible in accordance with section 501(c)(3) of the Internal Revenue Code (26 U.S.C. 501(c)(3)). *See* 34 C.F.R. § 600.2.

Overview of the Department's Proprietary Institution Conversion Review Process

Since 2016, we have significantly increased the rigor, thoroughness, and scope of our reviews. This includes requesting a wider range of documents and a much closer look at finances. We believe this results in a process that is more sophisticated, comprehensive, and better suited to identifying concerns that a surface-level review would not catch.

The Department's review of a proprietary institution's conversion request typically occurs in three phases: 1) a pre-acquisition review if requested by the school; 2) a post-closing review within the 60 days immediately following the closing of the transaction to ensure compliance with the regulatory requirements (34 C.F.R. § 600.20(g) and (h)) to continue participation while the change in ownership is under review; and 3) a final review and decision.[2] This is the same process followed for the review of all changes in control and ownership. Conversions to nonprofit status and most other changes of ownership are reviewed by the national change in ownership working group (CIO Working Group), which is described in more detail below.

An institution's request to convert from proprietary status to nonprofit status typically occurs through a transaction that transfers ownership or control of a proprietary institution either through a sale of assets, stock, or membership interests to a nonprofit entity, and results in a

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[2] This overview is discussed in terms of a proprietary institution's conversion to a private nonprofit institution type. A proprietary institution may also convert to a public institution type. The Department's review process for evaluating a proprietary institution's conversion to a public institution is like the process described here, with some analytical variations stemming from definitional differences between a nonprofit institution and a public institution. In other cases, a conversion may occur through a school of one ownership type acquiring a main or additional location of an institution of another ownership type.

change in ownership and change in control. For purposes of the Title IV, HEA programs, an institution that undergoes a change in ownership that results in a change in control ceases to qualify as an eligible institution upon the change in ownership and control. The Secretary may continue the institution's participation in the Title IV, HEA programs on a temporary, provisional basis if the institution submits a timely and materially complete application and otherwise qualifies for the extension.

The Department conducts both pre-acquisition and post-acquisition reviews of changes of ownership and requested conversions to nonprofit status. These review processes are outlined below. The Department has significantly enhanced both its pre- and post-acquisition review process for all changes of ownership, including requested conversions to nonprofit status since 2016. As part of those improvements, the Department currently requests approximately 30 categories of documents and information relating to a nonprofit conversion for both a comprehensive pre-acquisition review (described below) and a post-acquisition review. Responsive documentation is typically voluminous, and often involves follow-up requests for additional documents or information.

The Department's review of a requested conversion to nonprofit status focuses on whether following the transaction the institution would meet the statutory and regulatory definitions of a nonprofit institution. In addition to determining whether the institution meets the basic requirements of being owned by a nonprofit entity and having IRS 501(c)(3) tax-exempt status, the Department conducts its own independent analysis of the operational and financial terms of the transaction. To assess whether any part of the institution's net earnings benefits any private shareholder or individual, the Department focuses on whether any other party reaps financial benefits from the institution's operations. For example, the Department evaluates whether there will be ongoing servicing agreements or leases with the institution's for-profit former owner (or a related party) and the post-transaction institution, as well as the terms of any financing, including whether the prior owner is providing financing by way of a promissory note or some other method. The Department also examines whether common executive or board memberships exist between the former proprietary owner and the post transaction institution or its proposed new nonprofit owner, along with a review of the institution's and the nonprofit entity's governance structures, and other forms of control.

The Department reviews draft and final transaction agreements, proposed pre- and post-transaction ownership and governance structures, the identity of the officials of the institution, the sales price, any contracts or agreements that will be in place after the transaction is consummated (including, for example, leases and service contracts), financing for the transaction, valuations of the transaction or transferred assets, and financial statements of the nonprofit or public entity that may acquire the proprietary institution. When it needs additional information, the Department also conducts independent research on the parties to the transaction.

Pre-Acquisition Review: The Department's pre-acquisition review is a voluntary review requested by an institution prior to a change in control or ownership. The Department offers parties to a change of ownership transaction either a comprehensive pre-acquisition review or an abbreviated pre-acquisition review. Typically, when an institution requests a pre-acquisition review of a conversion to nonprofit status, it requests a comprehensive review to obtain the Department's preliminary determination as to whether the Department sees any impediment to the requested conversion to nonprofit status, to the extent any concerns can be identified from the available information. The review process also identifies potential additional requirements the Department may impose if the anticipated proprietary to nonprofit conversion transaction is executed, such as extended 90-10 compliance requirements or an irrevocable letter of credit. Given the complexity of proprietary to nonprofit conversion transactions, the Department may spend several months in its review. Sometimes after the Department has already begun its in-depth review, the Department receives additional or updated transaction documents, necessitating additional time for the review process. In addition, the Department's written response also recites standard requirements, such as the requirement for an institution to provide an audited same-day balance sheet, and State and accrediting agency approvals within specified timeframes following the date of the change in ownership and request for a proprietary to nonprofit conversion transaction.

Additionally, the Department offers institutions an abbreviated (and therefore expedited) pre-acquisition review of the proposed change in ownership. It is up to each institution whether to accept the Department's offer of such an abbreviated review. In those cases where an institution agrees to proceed with an abbreviated pre-acquisition review, the Department will provide an abbreviated pre-acquisition review response letter, which is limited to addressing whether the institution would be required to post an irrevocable letter of credit in lieu of the new owner providing two years of financial statements as is required for a materially complete application under the regulations (for example, if the new owner is a newly-created entity without the required two complete years of financial statements). Such response letters do not identify any other areas of concerns or obstacles. Nor do they involve the rigorous analysis the Department performs in a comprehensive pre-acquisition review relating to the request to convert to nonprofit status. The narrow scope of the abbreviated pre-acquisition review is made clear to institutions when such a review is offered.

Whenever the Department receives a pre-acquisition review application involving a proprietary institution's request for recognition as a nonprofit institution, or if the Department learns that such a transaction has closed without a pre-acquisition review, the Department notifies the institution that it may not identify itself as a "nonprofit institution" in any advertising, publications, or other notifications, unless and until the Department approves the institution's status as a nonprofit for HEA purposes. The Department's notice explains that the use of the term "nonprofit" may be potentially confusing to students and the public, who may interpret the use of "nonprofit" to mean that the Department has granted the institution nonprofit status under

its regulations. The Department does not take a position regarding statements that the institution's new owner may make about its status as a 501(c)(3) tax exempt organization(s) as designated by the Internal Revenue Service or its status as a nonprofit under state law.

Immediate Post-Transaction Review: An institution is required to report and seek approval of continued participation following a change in ownership (including a request to change status from proprietary to nonprofit) no later than 10 business days following the closing of the transaction. At this stage, the Department reviews the materials provided by the institution in response to the requirements set forth in 34 C.F.R. § 600.20(g) and (h) to determine whether the institution satisfies the conditions to receive a temporary provisional extension of its Program Participation Agreement. If the institution has not qualified for a temporary extension, the Department acts to implement the institution's loss of eligibility. If the institution qualifies for a temporary provisional extension of its participation, it continues to participate on a month-to-month status under the conditions of its pre-CIO proprietary status until a final decision has been rendered.

Final Review and Decision: Following the closing of the transaction, the Department analyzes the final transaction documents and other required submissions and determines whether the institution's request to convert to nonprofit status can be approved. Even if a pre-acquisition review was performed, the Department requires the submission of updated documents because the actual transaction may differ from the prospective transaction presented by the institution during the pre-acquisition review. If following the review of the post-acquisition documents the Department is satisfied that the institution meets all eligibility requirements as well as the statutory and regulatory definitions of a nonprofit institution, the Department approves the change in ownership with approval for conversion to nonprofit status. Alternatively, the Department may approve a change in ownership while disapproving the requested conversion to nonprofit status, thus allowing the institution to continue participation in HEA programs as a proprietary institution under new ownership. In some circumstances, if the Department has information from which to conclude that changes have occurred following the closing of the transaction (*e.g.,* significant restructuring or forgiveness of related party loans), it might approve the change of ownership and defer its decision on the requested conversion to nonprofit status until further updated information can be submitted and reviewed. Another possibility is that the Department may disapprove the change in ownership and act to end the institution's participation in the Title IV, HEA programs.

Post-Approval Monitoring: In response to a recent U.S. Government Accountability Office (GAO) recommendation, the Department agreed that additional monitoring procedures should be developed and implemented for staff to review the audited financial statements of all institutions

following the Department's approval of nonprofit status for the risk of improper benefit. The Department has begun developing and implementing modifications to existing decision letter templates to include additional reporting requirements for newly converted nonprofit institutions (e.g., reporting of any Internal Revenue Service (IRS) issues impacting the nonprofit status of the institution or IRS actions with related parties that involve the conversion, any changes in status with the institution's accrediting or state licensing agencies, and changes to existing agreements (e.g., loan and servicing), if any, between insiders and the institutions). Additionally, institutions will be required to report promptly any new or amended servicing or contracting agreements, and when another entity assumes any of the responsibilities associated with the functional components of the institutions (in addition to the regulations requiring an institution to report changes related to third-party servicers). As appropriate, the decision letters may also direct the schools to provide additional financial reporting, including projected cash flow statements, which include information about their current operations and future plans, as well as enrollment monitoring reporting. Requirements for additional reporting will also be included as a condition in the Provisional Program Participation Agreement for Department review during the provisional period. The Department anticipates the need for closely monitoring newly converted nonprofit institutions for the risk of improper benefit until the school receives its first recertification after the change of ownership with nonprofit conversion.

The Department will also develop new financial analysis procedures to ensure that all conversions are reviewed after the change in ownership by monitoring the additional reporting and subsequent financial statement submissions.

List of Staff Involved

As noted in Part 1, eight SPDs within FSA's SEOSG share responsibility for the oversight and management improvement services of specific schools assigned to them. The SPDs are responsible for processing institutional eligibility applications, including proprietary institution conversions, for institutions within their geographic region. The SPDs use a holistic case management approach (as prescribed by PMG procedures) in assessing an institution's Title IV, HEA program eligibility and compliance. SPD staff-involved in processing a proprietary to nonprofit conversion would typically include the SPD's Division Chief, a Branch Chief, an Eligibility Analyst, and a Financial Analyst, and in the case of the MRFSPD, the Case Manager for the institution.

National Change in Ownership Workgroup

Since 2016, the Department has enhanced its review of nonprofit conversions, as well as other changes in ownership. In September 2018, the Department organized a new national change in ownership workgroup (CIO Workgroup) which is comprised of both FSA and Office of the General Counsel (OGC) personnel.

The initial purpose of the CIO Workgroup was to develop expertise throughout the SPDs to ensure consistent, detail-driven review of change in ownership applications and requests to covert to nonprofit status, no matter which regional SPD receives the application. Due to the complexity of the conversion transactions, the review process has evolved over time, and recently the Department has given the CIO Workgroup primary responsibility for evaluating change in ownership transactions, including proprietary institution conversions to nonprofit status. The CIO Workgroup consists of staff and managers from throughout the country, as well as OGC attorneys from the Division of Postsecondary Education. The CIO Workgroup meets as a team for 90 minutes twice monthly, and as needed on individual cases. On most days, CIO Workgroup members have several hours of additional calls to work together on individual cases. Each conversion case involves a substantial and time-consuming review.

The CIO Workgroup has developed templates for the letters used by the CIO Workgroup and SPDs to communicate with the institutions. The letters are used to request documents as well as to notify the parties to the transactions of the determinations made by the Department regarding the change in ownership and conversion. As described above, the CIO Workgroup has a standard set of documents that it requests for nonprofit conversions (approximately 30 different categories), although the templates are customized to cover the specific aspects of each case. These templates were developed with substantial input from OGC and are regularly reviewed and updated. The CIO Workgroup assigns members of the group to review and analyze the application and documents in coordination with the SPD, and individual cases are regularly brought to the full CIO Working Group for discussion.

The following list identifies the composition of the CIO Workgroup as of April 20, 2021.

- Two Case Managers from the MRFSPD (one of whom is the chair of the CIO Workgroup)
- Division Chief, MRFSPD
- Branch Chief (Supervisory Accountant) from the Atlanta School Participation and Financial Analysis Division
- Three Senior Institutional Review Specialists
- Three Institutional Review Specialists
- One Case Specialist from the MRFSPD
- Two Financial Analysts
- One Specialist from the Administrative Appeals and Actions Service Group in FSA
- Two OGC Attorneys

Please note that the staff who are members of the CIO Workgroup are also assigned to other teams in FSA and in the Department, and they have other organizational roles and responsibilities. Very few staff are currently assigned to the CIO Workgroup to review change in ownership applications on a full-time basis. The Department is considering the need to allocate additional resources to the CIO Workgroup due to the increasing complexity of change in

ownership and proprietary conversion applications which require a high level of specialized analytical skills.

Decisions Made During the Three Most Recent Fiscal Years

The table on pages 10 through 13 lists all institutions of higher education that have changed their proprietary status in the past three fiscal years and any action the Department has made with respect to those institutions. The table identifies proprietary institution conversion requests that the Department has approved or disapproved during this time period.

OPE ID Number	Institution Name	Type of Conversion (proprietary to nonprofit, proprietary to public)	Department's Decision	Decision Date
00162800	American Academy of Art College	Proprietary to nonprofit institution	Approved continued Title IV participation after Change in Ownership (CIO) but denied nonprofit recognition. Institution has sought reconsideration, which is currently pending.	1/5/2021

OPE ID Number	Institution Name	Type of Conversion (proprietary to nonprofit, proprietary to public)	Department's Decision	Decision Date
00107400	Grand Canyon University	Proprietary to nonprofit institution	Approved CIO but denied conversion to nonprofit status. Denial affirmed 1/12/2021 following review of reconsideration request GCU has sued the Department over this decision	11/6/2019
02179900	Argosy University	Proprietary to nonprofit institution	Denied CIO and denied conversion to nonprofit recognition	2/27/2019
02110800	California College San Diego	Proprietary to nonprofit institution	Approved nonprofit recognition following initial denial (August 2016) and denial of reconsideration (December 2016). Approval granted as a result of changes to the relationship between the institution and its former proprietary owner (who was both lender and landlord)	12/17/2018

OPE ID Number	Institution Name	Type of Conversion (proprietary to nonprofit, proprietary to public)	Department's Decision	Decision Date
03120300	CollegeAmerica Arizona	Proprietary to nonprofit institution	Approved nonprofit recognition (same school group as California College San Diego)	12/17/2018
02594300	CollegeAmerica Denver	Proprietary to nonprofit institution	Approved nonprofit recognition (same school group as California College San Diego)	12/17/2018
00367400	Stevens-Henager College	Proprietary to nonprofit institution	Approved nonprofit recognition (same school group as California College San Diego)	12/17/2018
00170300	Kendall College	Proprietary to additional location of nonprofit institution	Approved as additional location of nonprofit institution (National Louis University)	9/20/2018
00458600	Kaplan University (now known as Purdue University Global)	Proprietary to affiliate of public institution	Approved as affiliate of public institution (Purdue University)	8/2/2018
04195600	Tribeca Flashpoint College	Proprietary to additional location of nonprofit institution	Approved as additional location of nonprofit institution (Columbia College Hollywood)	6/11/2018

OPE ID Number	Institution Name	Type of Conversion (proprietary to nonprofit, proprietary to public)	Department's Decision	Decision Date
00962100	Herzing University	Proprietary to nonprofit institution	Approved CIO and conversion to nonprofit recognition	2/1/2018
00743700	Pittsburgh Technical Institute	Proprietary to nonprofit institution	Approved CIO and conversion to nonprofit recognition	9/13/2017
02524000	Sunstate Academy – Clearwater	Proprietary to nonprofit institution	Approved CIO and conversion to nonprofit recognition	9/6/2017
02326900	Sunstate Academy - Ft. Myers	Proprietary to nonprofit institution	Approved CIO and conversion to nonprofit recognition	9/6/2017

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Starting September 15, 2022, the Department discontinued the Comprehensive Pre-Acquisition Review process described in the May 27, 2021, "Report to Congress on Proprietary Institution Conversions." Additional information regarding the change is described in the following Electronic Announcement:

https://fsapartners.ed.gov/knowledge-center/library/electronic-announcements/2022-09-15/updated-guidance-and-procedures-changes-ownership.

The Department has not always approved nonprofit recognition requests from institutions that have received a 501(c)(3) tax-exempt status from the Internal Revenue Service (IRS) or have received recognition as a nonprofit institution by other entities. The Department has so far successfully defended in Federal court its au-

thority to issue a nonprofit institution determination that is distinct from and may differ from determinations made by other entities, including an IRS decision to issue a 501(c)(3) tax-exempt designation.

The Department has a small team that invests a tremendous amount of time in analyzing highly complex proprietary conversion transactions.

For instance, when Grand Canyon University (GCU) requested recognition as a nonprofit institution, the Department performed a rigorous, case-specific substantive analysis of the transaction which supported an 18-page decision letter issued to GCU on November 6, 2019, denying its request for recognition as a nonprofit institution.

When GCU submitted to the Department potential modified terms and additional documentation for the transaction with its request for reconsideration of the November 2019 decision, the Department completed a new, rigorous case-specific analysis to examine the proposals. The second analysis led to the production of a 19-page reconsideration decision letter issued to GCU on January 12, 2021, indicating that GCU's potential modifications would not meet the Department's nonprofit institution definition.

Shortly thereafter, GCU filed suit to overturn the Department's decision in U.S. District Court. The U.S. District Court, ruling in the Department's favor on December 1, 2022, concluded "[t]he record and law reflect that the [Department] has authority to determine whether an institution qualifies as a nonprofit under Title IV."

Copies of the Department's November 6, 2019 letter to GCU, the Department's January 12, 2021 letter to GCU, and the U.S. District Court's December 1, 2022 decision are attached for your office's reference.

Further, last fall, the Department issued final regulations that created new accountability rules for colleges and universities undergoing changes in ownership.

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF ARIZONA

Grand Canyon University, Plaintiff, v. Miguel Cardona, et al., Defendants.	No. CV-21-00177-PHX-SRB **ORDER**

The Court now considers the Motion for Summary Judgment ("Motion") of Plaintiff Grand Canyon University ("GCU") and the Cross-Motion for Summary Judgment ("Cross-Motion") of Defendants Miguel Cardona ("the Secretary") and the United States Department of Education ("DOE") (collectively, "Defendants"). (Doc. 59, ("MSJ"); Doc. 74, Cross-MSJ ("X-MSJ").) For the following reasons, the Court grants Defendants' Cross-Motion and denies GCU's Motion.

I. BACKGROUND

The Higher Education Act of 1965 ("HEA") divides institutions of higher education into three categories: "public or other nonprofit institution[s]" as defined in § 1001 of the HEA; "proprietary institution[s]" defined in § 1002(b); and "postsecondary vocational institution[s]" defined in § 1002(c).[1] 20 U.S.C. §§ 1001(a)(4), 1002(b), 1002(c); *see Grand Canyon Univ. v. Cardona*, No. CV-21-00566-PHX-DLR, 2021 WL 5396090, at *1 (D.

[1] Congress reauthorized the HEA in 1992, at which point Congress adopted amendments to the HEA that "focused on proprietary schools." (Doc. 84, MSJ Reply at 5.) GCU represents that the DOE "informed Congress, at that time, that it intended to treat proprietary and nonprofit institutions differently." (*Id.*)

Ariz. Nov. 18, 2021). Through Title IV of the HEA, 20 U.S.C. § 1001 et seq., ("Title IV"), "Congress provides billions of dollars through loan and grant programs to help students pay tuition for their postsecondary education." *Ass'n of Priv. Sector Colls. & Univs. v. Duncan*, 681 F.3d 427, 433 (D.C. Cir. 2012). This case arises from GCU's attempt to convert to a nonprofit institution under Title IV and Defendants' allegedly unlawful denial of this conversion. (*See generally* Doc. 75, X-MSJ Statement of Facts ("X-MSJ SOF").)

GCU is a private, Christian university that has operated in Phoenix, Arizona since 1951. (Doc. 60, Plaintiff's Statement of Facts in Supp't of MSJ ("MSJ SOF") ¶ 1.) GCU functioned continuously as a nonprofit institution but began experiencing financial difficulties in the early 2000s. (*Id.* ¶¶ 2–3.) In 2004, GCU's Board of Trustees ("Board") sold GCU to the publicly traded company Grand Canyon Education ("GCE"), and GCU began participating in Title IV as a proprietary institution. (*See id.* ¶ 3; X-MSJ SOF ¶ 25.) In 2014, after GCU regained financial stability, the Board sought to convert GCU back to its nonprofit status. (MSJ SOF ¶¶ 4–5.)

The Board then began a protracted process to convert GCU to nonprofit status. A converting institution needs to meet three requirements to be recognized as a nonprofit under Title IV: (1) recognition as a 26 U.S.C. § 501(c)(3) tax-exempt organization; (2) recognition as a nonprofit from a state accreditor; and (3) recognition that it is operated by a nonprofit and none of its earnings benefit any private organization or individual. *See* 34 C.F.R. § 600.2. To meet these criteria, the Board created Gazelle University, a new entity, which contracted to purchase "the real property comprising the GCU campus as well as tangible and intangible academic-related assets (including the GCU name)" from GCE for approximately $853 million. (MSJ SOF ¶ 6; X-MSJ SOF ¶ 26; Doc. 1, Compl. ¶ 39.) GCE agreed to lend Gazelle the money necessary to purchase GCU. (*See* Doc. 59-2, 2019 Decision at 2.) The Board and GCE also negotiated a Master Services Agreement ("MSA") whereby GCE would provide "technological, marketing, promotional, financial aid, and other support services" to GCU once it had been sold to Gazelle. (*See* MSJ SOF ¶¶ 10–11, 15; Doc. 59-6, MSA at 2; Doc. 59-37, Req. for Preacquisition Review at 1–2.) GCE would

perform these services in exchange for a fixed 60% share of GCU's adjusted gross revenue. (X-MSJ SOF ¶ 27.) The MSA ran for an initial 15-year term and then provided for automatic five-year renewals. (*Id.* ¶ 38.) GCU could not terminate the MSA for at least seven years after its effective date, and if GCU chose to terminate the MSA after its initial term, the MSA obligated GCU to pay GCE a "non-renewal fee" equal to 50 percent of the previous year's services fee. (*See* AR-B-1295, AR-B-1322.)

GCE and Gazelle believed that outsourcing services to GCE under the MSA would not draw scrutiny under Title IV, as DOE regulation allows educational institutions to contract out "the administration of any aspect of the institution's participation in any Title IV, HEA program." (*See* MSJ at 22 (citing 34 C.F.R. § 668.25).) GCU represents, and Defendants do not dispute, that many nonprofit institutions maintain service agreements and revenue sharing agreements with for-profit companies. (MSJ at 21; *see* Doc. 75, X-MSJ Resp. to MSJ SOF ("X-MSJ RSOF") ¶¶ 12, 15.) Gazelle and the Board consulted other service agreements and revenue sharing contracts used by nonprofit institutions and for-profit service providers in drafting the MSA. (*See* MSJ at 20–21; MSJ SOF ¶¶ 77–78.) These service agreements included one in which Purdue University, a public institution based in Indiana, created a new entity, Purdue University Global ("Purdue Global"), to buy the "credential-issuing side" of Kaplan University ("Kaplan"), a for-profit institution ("Purdue-Kaplan transaction"). (Compl. ¶¶ 200, 203.) From GCU's account, Purdue Global and Kaplan executed a service agreement under which Kaplan continued to administer, *inter alia*, Purdue Global's marketing, financial aid, technology support, facilities management, and accounting. (*Id.* ¶ 204.) As compensation for these services, Purdue Global contracted to pay Kaplan for the costs of the "support services" plus 12.5 percent of Purdue Global's "consolidated revenues." (*Id.* ¶ 205.) In contrast to GCU's 15-year MSA term, Purdue Global and Kaplan contracted to a 30-year term with automatic five-year renewals, and Purdue Global's termination fee is 125 percent of the revenue earned over the year prior to termination. (*Id.* ¶¶ 207–09, 211.) Purdue Global participates

in Title IV as a public institution.[2] (Doc. 21, Ans. ¶ 315; X-MSJ SOF ¶ 36.)

The Board and GCE's Board of Directors, which are "fully independent" from each other, agreed that Brian Mueller, CEO of GCE, would be President of GCU after its sale. (MSJ SOF ¶¶ 75–76.) But the Board instituted several checks for Gazelle and GCU to retain independence from GCE. (*Id.* ¶ 76.) Per GCU's bylaws and the terms of the MSA, Mr. Mueller could not have any control over GCU's relationship with GCE. (*Id.*) The MSA further obligates GCE to "comply with all policies and standards of GCU," but imposes no reciprocal obligation on GCU. (MSJ at 25.) Under the MSA, GCU oversees the services executed by GCE and has the "unilateral ability to audit GCE at any time to ensure compliance with GCU's requirements." (*Id.* at 26 (citing AR-B-1292–94, 1324–38).) GCU also created an independent "MSA Committee" to "oversee" the relationship between service recipient and provider. (*Id.*)

A. Initial Conversion Review

On October 8, 2015, the Board applied to the Internal Revenue Service ("IRS") for Gazelle to be recognized as a § 501(c)(3) tax-exempt institution. (MSJ SOF ¶ 16.) In its application, the Board explained that Gazelle was "organized to . . . acquire, and thereafter own and operate [GCU]." (*Id.* ¶ 17.) The Board also provided the IRS "a substantially completed copy" of the MSA and "detailed the material terms of the MSA." (*Id.* ¶ 19.) The application to the IRS included the precise services GCE contracted to perform under the MSA, for which GCU would pay GCE fees "contemplated to be 55% of the University's Adjusted Gross Revenue." (*Id.* ¶¶ 20–21.) Additionally, the application disclosed that Mr. Mueller would serve as both President of the GCU and CEO of GCE following the sale. (*Id.* ¶ 22.) On November 20, 2015, the IRS approved the University's § 501(c)(3) tax-exempt status, concluding that GCU's gross income did not "inure to the benefit of a private shareholder or individual." (*Id.* ¶ 23; Doc. 59-31, IRS Decision); *see* 26 U.S.C. § 501(c)(3). The IRS affirmed its 2015 decision on August 31, 2018, though Defendants assert that the 2018 affirmation did not involve any substantive analysis of GCU's circumstances at that

[2] Because Purdue University is a public institution, its Title IV student loans are backed by the state of Indiana. (X-MSJ SOF ¶ 36 (citing AR-J-0006).)

time. (MSJ SOF ¶ 24; X-MSJ RSOF ¶ 89; *see* AR-F-0612.)

After receiving tax-exempt status, GCU's Board next sought approval for the sale from its accrediting agency, the Higher Learning Commission ("HLC"). (MSJ SOF ¶ 26.) The HLC initially denied the Board's request, as the HLC had not developed guidelines to review the kind of MSA at issue. (*Id.* ¶ 27.) In 2017, once the HLC had developed appropriate guidelines, the Board reapplied for accreditation and informed the HLC about GCU's conflict of interest policy, the checks on Mr. Mueller's power over GCU, and how the relationship between GCU and GCE had been structured to "ensure GCE had no ability to exercise authority over GCU and was subject to GCU's policies and control."[3] (*Id.* ¶¶ 27–28.) After reviewing the application and visiting GCU's campus, HLC staff issued a report approving GCU's change in control. (*Id.* ¶¶ 29–30.) The HLC specifically found that Mr. Mueller was excluded from any input regarding the relationship between GCE and GCU, the MSA was not subject to conflicts of interest with GCE, and the sale would not impose an excessive financial burden on Gazelle. (*Id.* ¶¶ 30–33.) On March 5, 2018, the HLC voted to approve GCU's change of control.[4] (*Id.* ¶ 34.)

B. Preacquisition Review & Sale of GCU

After obtaining § 501(c)(3) tax-exempt status and while the Board's application to the HLC was still pending, the Board set out to secure Title IV nonprofit status for GCU. (*Id.* ¶ 35.) When an institution that has been participating in Title IV programs undergoes "a change in ownership that results in a change in control," it automatically ceases to qualify as an eligible institution and must reapply to the Secretary to participate in Title IV programs. *See* 34 C.F.R. § 668.14(g)(1). Once an institution lodges an application for change in ownership, the institution can participate in Title IV programs on a provisional basis while its application is being evaluated. § 600.20(g)(1). If the institution applies to participate in Title IV as a nonprofit institution, "it must demonstrate that its new ownership

[3] At the time of the IRS and HLC review, Mr. Mueller also sat on Gazelle's Board. (MSJ at 26.) However, before the sale of GCU was complete, Mr. Mueller resigned from the Board. (*See id.*; AR-J-0076.)

[4] In April 2018, state regulator Arizona Board of Private Postsecondary Education also approved the sale. (MSJ SOF ¶ 52.)

structure satisfies the definition of a 'nonprofit institution' under the HEA and its implementing regulations." (X-MSJ SOF ¶ 17; X-MSJ at 5–6 (citing § 600.20(b)(2)(i))); § 600.20(b) ("[A]n . . . institution that participates in the Title IV, HEA programs must apply to the Secretary for a determination that the institution continues to meet the [three applicable] requirements . . . if the institution chooses to . . . reestablish eligibility and certification as a private nonprofit."). Defendants interpret these regulations to mean that the Secretary has "broad authority" to regulate programs administered by the DOE, which includes Title IV. (*See* X-MSJ SOF ¶4 (citing 20 U.S.C. § 1221e-3)); 34 C.F.R. § 600.20(b)(2)(B). The DOE asserts that it has more aggressively scrutinized such applications to convert to nonprofit status since 2016, and the DOE rejected an application for nonprofit conversion before GCU's sale.[5] (X-MSJ SOF ¶¶ 19–20; Doc. 85, GCU Resp. to X-MSJ SOF ¶ 20.)

The DOE reviews an application for Title IV participation after an institution has already undergone a change in control, but an institution anticipating a change in control may also request a "preacquisition review" from the DOE. (MSJ SOF ¶ 37.) This discretionary review allows an institution to receive feedback on how its prospective change in ownership will affect its Title IV participation. (*Id.* ¶¶ 37, 40.) On January 18, 2018, GCU submitted a request for preacquisition review, hoping "for guidance as to any regulatory limitations that the Department might impose on GCU following the closing of the Transaction." (*Id.* ¶ 43.) GCU contends that this request included "substantially the same information provided to the IRS and HLC, including the proposed MSA, asset purchase agreement, credit agreement, and proposed corporate structure." (*Id.* ¶ 45.) GCU filed its request for preacquisition review almost six months before the sale was due to close.[6] (*Id.* ¶¶ 47–48.) While GCU relied on prior successful nonprofit conversions to craft

[5] The Board acknowledged this recent denial, stating to the DOE that "[GCU] understand[s] the [DOE] makes an independent decision regarding an institution's status as a nonprofit institution for Title IV purposes." (X-MSJ SOF ¶¶ 21–23.)

[6] GCU suggests that this closing date was set after its March 2018 HLC approval, as the "HLC typically requires transactions to close within 30 days of its grant of approval, but [the] HLC agreed to extend the time for closing until the end of June 2018." (MSJ SOF ¶ 53.)

the material terms of the sale, GCU still hoped for the DOE's particularized input and provided the DOE with any updated information necessary for its review. (*Id.* ¶¶ 48–51, 54, 77–78.) The DOE had no published guidance regarding how a for-profit university could successfully convert to a nonprofit institution under Title IV. (*Id.* ¶ 80.) By late June 2018, GCU had not received any feedback from the DOE about how it would receive the sale, but Gazelle and GCE still decided to close the sale on July 1, 2018. (*See id.* ¶ 54.) Gazelle paid a purchase price of approximately $870 million by senior secured note to GCE.[7] (*Id.* ¶¶ 54, 58.)

GCU timely sent the DOE the "principal transaction documents" so that the DOE could conduct its mandatory review of GCU's change in control. (*See id.* ¶¶ 60–61; X-MSJ SOF ¶ 31.) These documents were (1) an Asset Purchase Agreement, identifying the particular assets GCU purchased from GCE; (2) the Credit Agreement outlining the terms of the senior secured note; and (3) the MSA detailing the specific services GCE would perform for GCU after the sale, subject to an initial 15-year term and automatic five-year renewals. (MSJ SOF ¶ 58.) In addition to the principal transaction documents, GCU also shared valuation reports of GCU's assets completed by financial experts at Deloitte and Barclays. (*See id.* ¶ 70.)

The DOE reviewed GCU's application for nonprofit conversion under its regulatory definition of a nonprofit institution. Specifically, the DOE evaluated whether, after the sale, GCU was:

> (i) owned and operated by a nonprofit corporation, with no shareholder or individual benefitting from the net earnings of the corporation;
> (ii) legally authorized to operate as a nonprofit organization in the state in which it is physically located; and
> (iii) determined by the [IRS] to be an organization to which contributions are tax-deductible in accordance with section 501(c)(3) of the Internal Revenue Code.

34 C.F.R. § 600.2. The DOE's regulation is derived from the HEA definition of a nonprofit, which is an institution "owned and operated by one or more nonprofit corporations or

[7] After Gazelle purchased GCU from GCE, Gazelle changed its name to Grand Canyon University. (Doc. 59-3, 2021 Decision at 1 n.1; AR-B-1421.) This Order refers to Gazelle and GCU as one and the same post-sale, as the entities are now indistinguishable for present purposes.

associations, no part of the net earnings of which inures, or may lawfully inure, to the benefit of any private shareholder or individual." (*See* X-MSJ SOF ¶ 7 (citing 20 U.S.C. § 1003(13)).) When evaluating GCU's application, the DOE considered the principal transaction documents; a chart of other service agreements which GCU provided to the DOE; valuation reports which GCU offered to support the conversion; and "relevant authority interpreting a similar standard from the Internal Revenue Code." (*Id.* ¶¶ 34–36.) During the review period, the DOE requested that GCU "identify any service providers . . . that are affiliates, owners, or former owners of the institution (including related persons and entities), and indicate whether any of the servicing agreements were entered into in conjunction with a change in ownership transaction [resulting in nonprofit conversion]." (*Id.* ¶ 35 (citing AR-J-0156–57).) GCU did not identify any such service agreements for the DOE, instead contending that "GCU believes that comparisons to the Kaplan transaction or any other example are not relevant . . . [r]ather, it believes that the Transaction stands on its own." (*Id.* (citing AR-J-0086).) Though the HEA and § 600.2 guide the DOE's nonprofit analysis, Defendants emphasize that the contours of change-in-control review may vary depending on the nature of the transaction at issue, leading to a "case-by-case" determination. (X-MSJ RSOF ¶ 138.)

C. 2019 DOE Decision

On November 6, 2019, the DOE issued a decision refusing to recognize GCU as a nonprofit institution under Title IV ("2019 Decision"). (MSJ SOF ¶ 83.) The DOE found that GCU met the second and third prongs of § 600.2 but concluded that GCU did not meet the first prong ("Subsection i") of the nonprofit definition. (*Id.* ¶ 85; 2019 Decision at 10.) In short, the DOE found some part of GCU's net earnings benefit a private party—GCE—in violation of Subsection i. (2019 Decision at 10–17.) Three factors determined the outcome of the DOE's analysis: (1) the terms of the MSA made GCU operate for the benefit of GCE; (2) Mr. Mueller's dual roles as President of GCU and CEO of GCE indicate that he may not have "undivided loyalty" to GCU; (3) and GCU was not actually operating the university, given the number of institution-specific functions performed by GCE under the

MSA. (MSJ SOF ¶¶ 92–94.) In the 2019 Decision, the DOE also forbade GCU from holding itself out to the public as a nonprofit under Title IV.[8] (*See* MSJ at 30.) Notwithstanding the 2019 Decision, GCU could still participate in Title IV programs as a proprietary institution, as the DOE otherwise approved its change in control.[9] (X-MSJ RSOF ¶ 8.)

The DOE also explained how it considered the two valuation reports submitted with GCU's application and why it discredited certain conclusions therein. (X-MSJ SOF ¶ 39.) Skeptical of the accuracy of the reports, the DOE noted that "opinions in key areas appear to have been based on information supplied by GCE management" and reasoned that Deloitte's report was "incomplete," rooted in "fundamentally flawed assumptions," and based on an outdated draft of the MSA. (*Id.* (citing 2019 Decision at 9); 2019 Decision at 7–8.) And from the DOE's observation, the Barclay's Report revealed that the cost to operate GCU would increase by $697 million purely as a result of the commitments in the MSA. (2019 Decision at 4–6.) "The increase is not because GCE will be providing new or additional services," the DOE wrote, "but solely because the MSA requires [GCU] to pay GCE the Services Fee." (*Id.* at 5.) The DOE also noted that GCE pocketed 60% of GCU's revenue despite performing only 28% of the services necessary for GCU to operate. Per the DOE's calculations, "[w]hen payments on the Senior Secured Note are included in the analysis, GCE will be receiving approximately 95% of Gazelle's revenue." (Doc. 91, X-MSJ Reply at 7 (citing 2019 Decision at 14); 2019 Decision at 6 n.11.)

In the remainder of the 2019 Decision, the DOE distinguished its review under

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[8] Between completing the sale and receiving the 2019 Decision, Mr. Mueller made public representations about GCU's Title IV status. For example, on December 20, 2018, Mr. Mueller stated in an interview: "[T]he University being not-for-profit is a tremendous advantage. That stigma is now gone. We can recruit in high schools that would not let us in the past . . . We're just 90 days into this, but we're experiencing, we believe, a tailwind already just because of how many students didn't pick up the phone [before] because we were for-profit." (X-MSJ SOF ¶ 32.) On February 20, 2019, Mr. Mueller shared in an earnings call that "new student online growth [following GCU's conversion] was more than we expected and I think it's evidence that being out there now a million times a day saying we're non-profit has had an impact." (*Id.* ¶ 33.)

[9] Proprietary institutions may still participate in some programs under Title IV, but they are not eligible for certain programs authorized by the HEA. (X-MSJ SOF ¶ 6; X-MSJ at 3.)

§ 600.2 from the IRS's decision to grant GCU § 501(c)(3) status. First, the DOE asserted that material terms of the transaction had changed in the time between the 2015 IRS approval and the 2018 sale of GCU. (X-MSJ SOF ¶ 44.) The DOE disputed that it reviewed the same information in the 2019 Decision that the IRS reviewed when it granted GCU § 501(c)(3) tax-exempt status. (X-MSJ RSOF ¶¶ 23, 45, 90.) Second, the DOE reasoned that its review was more thorough, in that "[u]nlike the IRS's initial grant of tax-exempt status, the Department's determination of nonprofit status considers the structure and planned operations of the institution when its owner(s) apply for that change of status." (X-MSJ SOF ¶ 45 (quoting AR-J-0077 n.3).) The DOE also raised that the IRS issued its § 501(c)(3) approval only 22 business days after Gazelle applied, whereas the DOE took more than a year to process GCU's application under Title IV. (X-MSJ at 19–20 (citing 2019 Decision at 15).) Relatedly, the IRS completes its analysis "based solely upon the facts, attestations, and representations" made by the entity seeking § 501(c)(3) status, whereas the DOE may conduct a "more in-depth" review. (*Id.* at 20.)

D. 2021 DOE Decision

GCU met with DOE officials on December 16, 2019 to discuss the nonprofit denial. (MSJ SOF ¶ 99.) At this meeting, the DOE affirmed that the issues raised in the 2019 Decision were the dispositive factors in the DOE's nonprofit denial. (*Id.* ¶ 100; *see* AR-B-2325.) In response to this meeting, GCU amended the MSA in an attempt to make the terms more favorable to GCU. (MSJ SOF ¶¶ 101–02, 104–06.) Specifically, the amended MSA ("AMSA") capped the fee for GCE's services at whichever was lower: 59% of GCU's total revenue or 66.8% of only GCU's tuition and fees. (*Id.* ¶ 104.) The AMSA also provided GCU more flexibility to terminate its relationship with GCE. (*Id.* ¶ 105.) Additionally, GCU took over certain responsibilities previously delegated to GCE, namely coordinating Curriculum Services and Faculty Operations. (2021 Decision at 17 n.23.) On January 8, 2020, GCU sent the AMSA to the DOE for consideration but explained that adoption of the AMSA was contingent on an updated transfer pricing study from Deloitte and the DOE's approval of GCU's nonprofit status. (MSJ SOF ¶ 107.) Later that month, the DOE

asked GCU to provide the updated transfer pricing study and requested GCU retain an independent expert to review the transfer pricing study to "ensure the [A]MSA was fair to GCU." (*Id.* ¶ 108.)

GCU set to work facilitating the DOE's review of the AMSA. GCU retained Deloitte to perform a transfer pricing study of the AMSA and retained BKD, LLP ("BKD") to review Deloitte's new study for fairness. (*Id.* ¶ 109.) BKD also performed valuations of GCU's investments as of July 1, 2018 and January 7, 2020. (*Id.* ¶ 110.) After reviewing Deloitte's transfer pricing study, BKD concluded that Gazelle paid below fair market value to purchase GCU from GCE. (*Id.* ¶¶ 114, 117.)

On January 12, 2021, the DOE once again denied GCU's application for nonprofit status, this time reviewing the AMSA and updated studies ("2021 Decision"). (X-MSJ SOF ¶ 49.) Though the DOE acknowledged the AMSA had altered certain problematic terms in the original MSA, it found the AMSA kept in place "the basic structure whereby a substantial portion of GCU's revenues benefits GCE."[10] (*Id.* ¶ 50 (citing 2021 Decision at 17).) The 2021 Decision explained that while the DOE considered Deloitte and BKD's valuations of GCU's assets, these valuations were not truly independent. (*See id.* ¶¶ 51–52; X-MSJ RSOF ¶¶ 13–14, 70.) The DOE also outlined how Deloitte and BKD found the AMSA was not comparable to any other service agreement in operation yet failed to consider the appropriate factors about this unique revenue-share agreement.[11] (2021 Decision at 10–12.) Further, the Barclays report commissioned by GCE indicated that "the costs to operate GCU following the change in ownership (with GCE providing services) would increase from $810 million to $1.496 billion for fiscal year 2019, solely as a result

[10] The DOE also considered the HLC's accreditation of GCU as a nonprofit institution, but found the HLC's review "neither binding nor persuasive." (X-MSJ SOF ¶ 46 (citing 2021 Decision at 17).)

[11] The DOE took issue with the use of the transfer pricing method in the analyses provided by GCU. (X-MSJ SOF ¶ 52.) According to the DOE, transfer pricing analysis "allow[s] for the establishment for the goods and services exchanged between a subsidiary, an affiliate, or commonly controlled companies that are part of the same larger enterprise [which] can lead to tax savings for corporations." (*Id.* (citing 2021 Decision at 7).) The DOE consequently did not condone transfer pricing analysis to evaluate "whether the service agreement is consistent with the behavior of what should be two financially independent entities." (*Id.*)

of fees paid to GCE," which suggested the sale was not in the university's financial interest. (X-MSJ RSOF ¶ 118 (citing AR-C-0041); 2021 Decision at 4 (noting that the AMSA did not substantially change the MSA revenue split).) The DOE explained that the AMSA ensured a "continuing revenue stream to [GCU's] former owner GCE, the primary purpose of which is to drive shareholder value for GCE." (X-MSJ SOF ¶ 51 (quoting 2021 Decision at 6).) The 2021 Decision recognized that GCU had taken more responsibility from GCE over the operations of the university, but the Decision also raised that GCE would receive almost the same revenue share under the AMSA as under the MSA, notwithstanding its reduced duties under the AMSA. (2021 Decision at 17 n.23.) The 2021 Decision also "reiterated [the DOE's] concerns about Mr. Mueller's dual roles as President of GCU and CEO of GCE," which had not changed under the AMSA. (*See* X-MSJ SOF ¶ 54.) The DOE clarified to Mr. Mueller that it "is not directing GCU to remove you as President of the University, [but] your multiple roles continue to be of concern to the Department. Of course, nothing would prevent you from severing ties with GCE if you (and the GCU Board) thought it was more important for you to stay with GCU instead of serving in two potentially conflicting positions." (2021 Decision at 18.)

E. Procedural History

On February 2, 2021, GCU filed its Complaint in this Court, alleging that the 2019 and 2021 Decisions (collectively, "the Decisions") violated the Administrative Procedure Act ("APA") and the First Amendment of the United States Constitution. (Compl.) Regarding Defendants' alleged APA violation, GCU argued that the Decisions are contrary to law because, *inter alia*, GCU should have been determined to be a nonprofit institution under both the HEA and § 600.2. (Compl. ¶¶ 338, 340, 346.) GCU also argued that the Decisions are arbitrary and capricious on several grounds. (*Id.* ¶ 339.) Separate from its APA claims, GCU alleged that the DOE's requirement that GCU refrain from calling itself a nonprofit under Title IV violates the First Amendment. (*Id.* ¶¶ 347–55.)

After litigating to establish the proper contents of the administrative record in this case, GCU filed its Motion on May 16, 2022. (MSJ; Doc. 55, 03/03/2022 Order (granting

in part GCU's Motion to Complete the Administrative Record).) On June 30, 2022, Defendants filed their Cross-Motion and Response to GCU's Motion, to which GCU filed its Response to the Cross-Motion and Reply to the DOE's Response on August 1, 2022. (X-MSJ; MSJ Reply.) On August 25, 2022, Defendants filed their Reply to GCU's Response. (X-MSJ Reply.) The Court held oral argument on the Motion and Cross-Motion on September 8, 2022. (Doc. 92, Min. Entry.)

II. LEGAL STANDARD

"[T]he standard set forth in Rule 56(c) does not apply [in reviewing cross-motions for summary judgment under the APA] because of the limited role of a court in reviewing the administrative record." *Gill v. Dep't of Justice*, 246 F. Supp. 3d 1264, 1268 (N.D. Cal. 2017) (quoting *Sierra Club v. Mainella*, 459 F. Supp. 2d 76, 89 (D.D.C. 2006)). "Under the APA, it is the role of the agency to resolve factual issues to arrive at a decision that is supported by the administrative record, whereas 'the function of the district court is to determine whether or not as a matter of law the evidence in the administrative record permitted the agency to make the decision it did.'" *Sierra Club*, 459 F. Supp. 2d at 90 (quoting *Occidental Eng'g Co. v. INS*, 753 F.2d 766, 769 (9th Cir. 1985)). "In other words, 'the district court acts like an appellate court, and the entire case is a question of law.'" *Gill*, 246 F. Supp. 3d at 1268 (quoting *Nat'l Law Ctr. on Homelessness v. U.S. Dep't of Veterans Affs.*, 842 F. Supp. 2d 127, 130 (D.D.C. 2012)).

III. ANALYSIS

GCU argues that the Decisions are a product of Defendants' overreach and error, violating the APA in several respects. (MSJ at 10–30.) GCU also argues that Defendants have placed an unjustified prior restraint on GCU's ability to represent itself as a nonprofit entity, violating the First Amendment. (*Id.* at 30–31.) The Court addresses each argument in turn.

A. APA Claims

GCU argues that Defendants violated the APA in multiple ways. First, GCU contends that Defendants acted contrary to law because (1) the Secretary does not have the

authority to determine nonprofit status under Title IV and (2) the Decisions constitute an amendment of previous DOE regulation without the requisite notice-and-comment rulemaking.[12] (*See* MSJ 10–16, 18.) Second, GCU asserts that even if Defendants have authority to determine nonprofit status under Title IV, the Decisions are arbitrary and capricious because (1) the DOE did not adequately explain its "reinterpretation" of § 600.2 and erred in determining that GCU's profits inure to GCE; (2) the DOE failed to consider factors relevant to the Decisions, namely GCU's § 501(c)(3) status and the HLC's grant of accreditation; (3) the DOE applied IRS tax law, which is outside the scope of the DOE's expertise and warrants no administrative deference; and (4) the DOE applied inconsistent, undefined standards to evaluate GCU's application for Title IV nonprofit status, damaging GCU's reliance interest in a uniformly-administered review process. (*Id.* at 18–27.)

1. Contrary to Law

a. The DOE's Statutory and Regulatory Authority

GCU argues that the "text, history, and structure" of the HEA and § 600.2 all indicate that nonprofit status under Title IV is a function of state approval and IRS § 501(c)(3) tax-exempt status. (MSJ Reply at 2.) GCU posits that the Secretary accordingly did not have independent authority to determine whether GCU is a nonprofit under Title IV. (MSJ at 10, 18.) Alternatively, GCU argues that if § 600.2 is ambiguous, the DOE's interpretation of the statute is unreasonable and unworthy of deference. (*See* MSJ Reply at 2.) For the following reasons, GCU does not persuade the Court.

i. Clear Interpretation

To interpret the meaning of a regulation, "a court must carefully consider the text, structure, history, and purpose of a regulation [before resorting to agency deference]. . . . If genuine ambiguity remains, [however], the agency's reading must still be reasonable."

[12] GCU briefly argues that even if Defendants have authority to determine GCU's nonprofit status, the Decisions are still contrary to law because they are wrong about GCU's nonprofit status. (*See* MSJ at 16–17.) As GCU asserts that the Decisions reached an incorrect conclusion because the DOE did not adequately explain its reasoning and misapplied IRS authority, this argument is more appropriately addressed alongside GCU's claims that the Decisions are arbitrary and capricious.

Kisor v. Wilkie, 139 S. Ct. 2400, 2415 (2019) (internal citations and quotation marks omitted). But "when the language [of a regulation] is clear . . . [courts] need not look to history or purpose of a regulation. Indeed, to do so sometimes amounts to an invitation for a freewheeling judicial inquiry, given the often amorphous or conflicting history or purpose of a regulation." *Mountain Cmtys. for Fire Safety v. Elliot*, 25 F.4th 667, 677 n.4 (9th Cir. 2022). GCU argues that the DOE's change-in-control regulations, as well as the most "natural reading of [§] 600.2, which the Department long endorsed," support the conclusion that Defendants have no independent authority to determine Title IV nonprofit status. (MSJ at 10–12.)

The DOE counters that the plain text of the HEA and § 600.2 both indicate that Defendants' review is independent from that of the IRS and the state accreditor. (X-MSJ at 10–13.) The Court agrees with Defendants. All subsections of § 600.2 are connected by the word "and," which reflects that the regulation requires all three subsections to apply in nonprofit evaluation. *See* § 600.2. Nothing in the surrounding regulation suggests that "and" should be read to mean "or," let alone that Subsection i is inoperative. *See Confederated Tribes and Bands of Yakima Nation v. Yakima Cnty.*, 963 F.3d 982, 990–91 (9th Cir. 2020) (quoting *Crooks v. Harrelson*, 282 U.S. 55, 58 (1930)) (explaining that while certain context-sensitive exceptions indicate that "and" means "or," "when 'and' is used to join two concepts, it is usually interpreted to require 'not one or the other, but both.'") Relatedly, the DOE persuasively raises that accepting GCU's interpretation of § 600.2 would render Subsection i mere surplusage. (*See* X-MSJ at 11; X-MSJ Reply at 4.) GCU asks the Court to functionally disregard Subsection i—asserting that the first subsection of a three-part regulation is an affirmation of the third section—but fails to rebut the presumption that every word in a statute or regulation is included for its specific meaning. (*See* MSJ Reply at 4); *c.f. Poder in Action v. City of Phoenix*, 481 F. Supp. 3d 962, 976 n.6 (D. Ariz. 2020) (citing *Duncan v. Walker*, 533 U.S. 167, 174 (2001)) ("[Courts] are . . . reluctant to treat statutory terms as surplusage in any setting.").

GCU also makes much of the contrast between § 501(c)(3) and the relevant

language in the HEA, but to no avail. (*See* MSJ Reply at 3.) Citing the HEA's definition of a nonprofit as an institution "no part of the net earnings of which inures, *or may lawfully inure*, to the benefit of any private shareholder or individual," GCU argues that "those institutions prohibited by law from engaging in private inurement qualify as nonprofit institutions for the Title IV programs." (*Id.* (citing 20 U.S.C. § 1003(13)) (emphasis in original).) The italicized text is the only difference between the HEA nonprofit definition and the § 501(c)(3) nonprofit definition. But this circular argument again fails to rebut the presumption against surplusage. If IRS approval were the only criterion for nonprofit status, both Subsections i and ii of § 600.2 would be meaningless. And GCU's narrow construction of "or" is not supported by the relevant law nor consistent with the statute itself. *See Hawaiian Airlines, Inc. v. Norris*, 512 U.S. 246, 253 (1994) (citing *McNally v. U.S.*, 483 U.S. 350, 358–59 (1987)) ("[The] second phrase in disjunctive [was] added simply to make the meaning of the first phrase 'unmistakable.'") Indeed, GCU's interpretation of "or may lawfully inure" does not comport with the HEA's purpose. One purpose of the HEA, and specifically of Title IV review, is undisputedly to guard the integrity of Title IV funds. (*See* MSJ Reply at 7–9 (acknowledging that Defendants are responsible for at least overseeing compliance with state accreditation and § 501(c)(3) nonprofit status); X-MSJ at 1.) If the Court adopted GCU's interpretation of § 1003(13), an institution would qualify as a nonprofit even its earnings in fact privately inured, so long as the institution had previously been determined to be a § 501(c)(3) nonprofit. The relevant law and record do not support this conclusion.

Defendants correctly note that because the text of § 600.2 is clear, the Court need not look to GCU's remaining arguments regarding the regulation's interpretation. (X-MSJ Reply at 4.) Even so, GCU's interpretation of the regulation still fails when accounting for the background of the regulation. GCU asserts that if the DOE intended to clarify that it independently reviewed nonprofit conversions, it would have done so during the 1992 reauthorization of the HEA, but there was a "conspicuous absence of such talk." (MSJ Reply at 5.) Firing back about the relevant "statutory and regulatory framework,"

Defendants persuasively recount that the DOE *did* state its intent to "independently scrutinize non-profit conversions in connection with" the HEA's 1992 amendments. (X-MSJ Reply at 5 (citing 59 Fed. Reg. 22,333 (Apr. 29, 1994)).) The DOE stated,

> The Secretary considers it reasonable to treat changes in business form [to a 501(c)(3)] as significant changes warranting the same scrutiny section 498(i) of the HEA dictates for other, perhaps far less consequential changes in governance by schools. . . . [A]lthough a corporation may affect the change in form from taxable to tax-exempt, nonprofit status with little formality . . . these consequences of the change make it a change cognizable under [the change-in-control requirements] of the HEA.

59 Fed. Reg. 22,333.

On this very note, GCU cites a written exchange between Congress and the Secretary that occurred after the 1992 HEA amendments. (MSJ Reply at 5–6.) Congress opens by asking the DOE how its "new approach" to differentiating between proprietary and nonprofit institutions will address regulatory abuses by nonprofit schools, particularly when "school[s] change [their] status from for-profit to non-profit and . . . simply plough through all of [their] profits into salary and expenses." (*Id.* at 5); Abuses in Fed. Student Grant Programs Proprietary School Abuses, S. Hr'g 104-477 at 222 (July 12, 1995) ("1995 Hearing"). It would make little sense that Congress inquired as to how the DOE would ensure regulatory compliance if Congress had not tasked the DOE with ensuring regulatory compliance. And in keeping with the conclusion that the DOE is empowered to police such compliance, the DOE responded that certain states allow schools to "easily switch" between for-profit and nonprofit status, but the DOE planned to "subject schools that do change from profit to non-profit" to certain standards to "ensure that schools do not evade certain regulatory requirements." (MSJ Reply at 6); 1995 Hearing. This exchange only confirms that the DOE may independently scrutinize conversions to ensure "the integrity of Title IV," even though the DOE must respect a state's independent determination of nonprofit status.[13] (*See* X-MSJ at 1, 17 (quoting 75 Fed. Reg. 66832-01).)

[13] GCU also fails to address why it modeled the MSA off of previous changes in control approved by Defendants, as well as why it repeatedly conceded the DOE reviews changes in control under all three factors in § 600.02, if § 501(c)(3) status and state law were and are the controlling authorities for Title IV nonprofit status. (*See also* X-MSJ at 11 n.5 (GCU stating that "[t]o our knowledge, the [DOE] has never published any [policy] on any other factors that [it] would consider in assessing whether an institution qualifies as a nonprofit

GCU also points to the DOE's definition of a foreign nonprofit educational institution, added after the HEA's most recent reauthorization in 2008, to show that IRS approval is dispositive for nonprofit designation. (*See* MSJ Reply at 6.) As of 2010, the DOE "automatically accept[s]" a foreign institution as a Title IV nonprofit if it has been designated as a nonprofit by its "relevant tax authority," on the condition that the tax authority applies the same criteria as the IRS. (*Id.*) But the DOE persuasively responds that this does not reflect that the DOE must defer to the IRS regarding domestic institutions. Foreign nonprofit institutions only receive Title IV funds for American students enrolled—the DOE need not allocate resources to monitor such a small output of funds. (*See* X-MSJ at 13 n.7.) Further, if the DOE clarified that § 501(c)(3) tax-exempt status controls nonprofit determination for foreign schools, it certainly could have done the same for domestic institutions. The absence of domestic institutions in this regulation, particularly given the existence of § 600.2's three-part definition, confirms that the DOE need not defer to IRS nonprofit determination for domestic schools. *See N.L.R.B. v. SW General, Inc.*, 137 S. Ct. 929, 940 (2017) (explaining that the interpretive canon *expressio unius est exclusio alterius* applies when "circumstances support a sensible inference that the term left out must have been meant to be excluded.") (internal citation and quotation marks omitted). Notwithstanding GCU's arguments to the contrary, the Court finds that reviewing change-in-control nonprofit conversions is clearly within the DOE's authority under the HEA and not contrary to law.

ii. Genuine Ambiguity

Defendants alternatively argue that even if § 600.2 is ambiguous, the DOE's interpretation of the statute is reasonable and entitled to deference. (X-MSJ at 13.) Courts presume that Congress intended an agency to have "the power authoritatively to interpret its own regulations [as] a component of the agency's delegated lawmaking powers . . . Congress usually intends to give [agencies] considerable latitude to interpret the ambiguous rules they issue." *Kisor*, 139 S. Ct. at 2412. "[T]he presumption that Congress intended

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entity for Title IV purposes beyond the three factors [of § 600.2].").)

[such] deference stems from the awareness that resolving genuine regulatory ambiguities often 'entail[s] the exercise of judgment grounded in policy concerns.'" *Id.* at 2413 (quoting *Thomas Jefferson Univ. v. Shalala*, 512 U.S. 504, 512 (1994)). But "the basis for deference ebbs when the subject matter of the dispute is distant from the agency's ordinary duties or falls within the scope of another agency's authority." *Id.* at 2417 (cleaned up). Further, "an agency's reading of a rule must reflect 'fair and considered judgment' to receive . . . deference [from courts]." *Id.* (quoting *Auer v. Robbins*, 519 U.S. 452, 462 (1997)).

The Court finds that if § 600.2 were ambiguous, the DOE's interpretation is reasonable and warrants judicial deference. GCU argues that the DOE's position is unreasonable, given that it "conflicts with its change-in-control regulations, deviates from its own prior interpretation, and takes the agency far outside its substantive expertise." (MSJ Reply at 2.) As addressed in the previous subsection, § 600.2 includes three separate criteria for Title IV nonprofit status, and the DOE's insistence that GCU meet each criterion does not contradict the regulation. Further, Defendants point out that while the DOE previously deferred in practice to the § 501(c)(3) determination of the IRS, there is no record that the DOE actually interpreted § 600.2 to leave nonprofit status to the IRS and the states, nor was any announcement made to suggest as much.[14] (Doc. 95, Not. of Hearing Trans. ("Hr'g Tr.") at 26:25–27:19.) And by GCU's own admission, Defendants have been

[14] GCU cites a passage from the regulatory history of the HEA in an attempt to argue that the DOE has publicly acknowledged that state and IRS approval are legally sufficient for Title IV nonprofit status. (*See* MSJ Reply at 7–8.) The passage in question reads, "[a]lthough changes in the form of incorporation from for-profit to nonprofit are governed by a variety of State laws, only those nonprofit organizations that meet the further restrictions of section 501(c)(3) of the Internal Revenue Code qualify to participate in the title IV, HEA programs as nonprofit institutions." 59 Fed. Reg. at 22,334. But GCU omits the sentence that immediately follows: "To so qualify, a corporation must not merely ensure that its net earnings do not benefit private individuals, but that, unlike a general corporation that may engage in any lawful business, this nonprofit institution must be organized and operated exclusively for educational or other qualifying purposes." Even in 1994, during the period when the DOE deferred to IRS determination of nonprofit status, Defendants detailed the criteria that an aspiring Title IV nonprofit needed to meet in order to survive *Departmental* scrutiny. As explained *infra*, it makes sense that certain Title IV nonprofit criteria are informed by IRS authority. But GCU's contention that the DOE has no role in determining nonprofit status, even in the context of this regulatory history, does not comport with the regulatory scheme or history.

tasked for decades with reviewing changes in control, so its argument that Defendants have insufficient expertise to determine nonprofit status falls flat. (*See* MSJ at 11–12.) Finally, regarding the agency's policy judgment, Defendants repeat that the DOE acts with the unique policy concern that Title IV funds are allotted to benefit the educational institutions which receive these funds, "serving [the HEA's] purpose of preventing program weaknesses and abuse among for-profit institutions." (X-MSJ at 13.) The Court agrees with Defendants that even if § 600.2 were ambiguous, the DOE's interpretation should stand.

b. Regulatory Rulemaking

Under the APA's "notice and comment" requirement, agencies must advise the public through a notice in the Federal Register of the substance of a proposed rule, allowing the public a period to comment. See 5 U.S.C. §§ 553(b), (c); *Auer*, 519 U.S. at 459. The notice and comment requirement does not apply to "interpretative rules, general statements of policy, or rules of agency organization, procedure, or practice." *Erringer v. Thompson*, 371 F.3d 625, 630 (9th Cir. 2004) (quoting 5 U.S.C. § 553(b)(3)(A)). In general, courts reviewing agency action under the APA must give "broad deference to agencies' interpretations of the statutes they are charged with implementing." *California by and through Becerra v. Azar*, 950 F.3d 1067, 1074 (9th Cir. 2020).

GCU argues that the Decisions were a departure from prior DOE practices, namely the practice of deferring to an IRS grant of § 501(c)(3) tax-exempt status when determining whether an institution qualified as a nonprofit under Title IV. (MSJ at 14–16.) It follows, GCU argues, that the DOE needed to go through the formal process of notice-and-comment rulemaking if it were going to apply a different process for change-in-control review under § 600.2. (*See id.*) Defendants repeatedly counter that the HEA empowers the DOE to ensure "the integrity of Title IV programs," meaning that Title IV funds are administered to benefit students rather than private companies. (X-MSJ at 17.) And "since at least 2016," two years before the sale of GCU, the DOE had been more closely analyzing applications for change-in-control and nonprofit conversion. (X-MSJ at 23.) Defendants contend that in denying GCU's application for nonprofit status, the DOE did nothing more than apply its

preexisting practice, in contrast to "actually chang[ing] [its] interpretation of the [controlling] regulation." (*Id.* (citing *Select Specialty Hosp.-Bloomington, Inc. v. Sibelius*, 774 F. Supp. 2d 332, 345 (D.D.C. 2011)).) The Court agrees with Defendants.

The record reflects that all parties understood that Defendants would independently review GCU's nonprofit status. As above explained, the DOE's authority to administer the HEA is distinct from the IRS's grant of § 501(c)(3) tax-exempt status. (*Supra* at Section II(A)(1)(a).) GCU accepted this conclusion throughout the change-in-control application and following review period, during which GCU repeatedly acknowledged that the DOE's review is discrete. (X-MSJ at 24; AR-J-0077–78 (letter to DOE stating, *inter alia*, "[GCU] recognize[s] the Department's position that it must make an independent determination as to [GCU's nonprofit status]."), 0081.) GCU also acknowledges that Defendants have previously taken other measures to ensure that institutions are not converting to nonprofit status in bad faith. (*See* MSJ Reply at 8–9 (explaining that the DOE can "ensure [an] institution had not converted to evade for-profit rules.").)[15] The relevant law and record reflects that the DOE has long monitored compliance with § 600.2 by applying different methods of scrutiny and control. Since 2016, the DOE has taken a more aggressive approach to monitoring compliance, but this is in keeping with the DOE's pattern of ensuring compliance within the scope of its delegated power.

Confirming the consistency of the DOE's process, the DOE gave GCU an opportunity to explain why other schools' service agreements were relevant to the DOE's analysis during the review period. (X-MSJ Reply at 7.) GCU declined to draw a parallel. (*Id.*) Specifically, the DOE asked GCU to review its proffered list of other schools' service agreements and "identify any service providers that are affiliates, owners, or former owners of the institution (including related persons and entities), and indicate whether any of the

[15] Attempting to minimize this history, GCU argues that the DOE's role is "not to determine whether the institution *is* a nonprofit for Title IV purposes; but, instead, to ensure the institution had not converted to evade for-profit rules." (MSJ Reply at 8–9.) This is a distinction without a difference. The DOE acknowledges that it previously deferred to the IRS evaluation of nonprofit status, yet the DOE still sought to at least ensure that nonprofits were not unlawfully acting as for-profit corporations after converting. In other words, the DOE wanted to make sure the nominally converted nonprofits were actually nonprofits.

servicing agreements were entered into in conjunction with a change in ownership transaction." (X-MSJ at 25 (citing AR-J-0156).) GCU responded that the sale of GCU "stands on its own." (*Id.* (citing AR-J-0086).) Consistent with the DOE's "case-by-case" review and GCU's assertion to the DOE that the sale should be evaluated individually, the DOE assessed the sale under its regulatory criteria and came to its reasoned Decisions. This is not regulatory rulemaking in violation of the APA.

2. Arbitrary & Capricious

The APA mandates that a reviewing court "shall . . . hold unlawful and set aside agency action, findings, and conclusions found to be arbitrary [or] capricious." 5 U.S.C. § 706(2)(A). "Under . . . this 'narrow' standard of review, [courts] insist that an agency 'examine the relevant data and articulate a satisfactory explanation for its action.'" *F.C.C. v. Fox Telev. Stations, Inc.*, 556 U.S. 502, 513 (2009) (quoting *Motor Vehicle Mfrs. Assn. of United States, Inc. v. State Farm Mut. Automobile Ins. Co.*, 463 U.S. 29, 43 (1983)). "[A] court is not to substitute its judgment for that of the agency . . . and should uphold a decision of less than ideal clarity if the agency's path may reasonably be discerned." *Id.* at 513–14 (internal quotations and citation omitted). This means that a reviewing court cannot "second-guess" the agency's "weighing of risks and benefits [or] penalize [the agency] for departing from [a different authority's] inferences and assumptions," nor may the court "ask whether [an agency] decision is the best one possible or even whether it is better than the alternatives." *Dep't of Commerce v. New York*, 139 S. Ct. 2551, 2571 (2019) (quoting *F.E.R.C. v. Elec. Power Supply Ass'n*, 136 S. Ct. 760, 782 (2016)).

But agencies must act within reasoned boundaries, and "[a]n agency may not . . . depart from a prior policy *sub silentio* or simply disregard rules that are still on the books." *Fox Telev. Stations*, 556 U.S. at 515 (*citing United States v. Nixon*, 418 U.S. 683, 696 (1974)). Agency action can be set aside "if the agency has relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the

product of agency expertise." *State Farm*, 463 U.S. at 43. Additionally, courts "may not supply a reasoned basis for the agency's action that the agency itself has not given." *Id.* (citing *SEC v. Chenery Corp.*, 332 U.S. 194, 196 (1947)).

GCU argues that the Decisions are arbitrary and capricious for multiple reasons. GCU asserts that the DOE did not adequately explain or justify its "reinterpretation" of § 600.2, particularly its analysis of why it determined that GCU's net revenue inures to the benefit of a private shareholder or individual. (MSJ at 18, MSJ Reply at 11–12, 16–20.) GCU argues that the DOE arbitrarily departed from the IRS's and the HLC's conclusions about GCU's nonprofit status and misapplied IRS authority in the Decisions. (MSJ Reply at 12–14, 20–23.) GCU relatedly argues that the DOE unlawfully ignored its own regulations and denied GCU fair notice of the outcome of the Decisions, damaging GCU's reliance interest. (*See id.* at 9–11.)

a. Private Inurement

The Decisions focused on Subsection i, the prohibition of private benefit from nonprofit earnings, in denying GCU nonprofit status. (2019 Decision at 10.) In the 2019 Decision, the DOE analyzed the MSA's revenue-sharing agreement using the Treasury's operational test, which prohibits both private benefit and private inurement. (*Id.* at 10–11 (citing 26 C.F.R. § 1.501(c)(3), (2), (1)).) The DOE explained that "unlike private inurement, private benefit does not necessarily involve the flow of funds from an exempt organization to a related private party, it can also include other benefits from the activities of the exempt organization to *an unrelated party*." (*Id.* at 11 (citing *P.L.R. 200914063*, 2009 WL 889714 (IRS PLR Apr. 3, 2009)) (emphasis in original).) The DOE went on to clarify that "[i]n looking at payments to a related for-profit enterprise, the focus is on whether 'the entire enterprise is carried on in such a manner that the for-profit organization benefits substantially from the operation of the [nonprofit entity].'" (*Id.* (citing *Church by Mail, Inc. v. C.I.R.*, 765 F.2d 1387, 1392 (9th Cir. 1985)).) Applying these authorities to the MSA, the DOE concluded that GCU's profits were benefitting GCE and its shareholders, violating Subsection i. (2019 Decision at 13.) The structure of the MSA,

including GCE's entitlement to an uncapped dollar amount in exchange for services, indicated to the DOE that "the revenues generated by GCU are transferred to and retained by GCE for the benefit of its shareholders." (*Id.* at 13–14.) After considering the AMSA, the DOE found "the basic structure whereby a substantial portion of GCU's revenues benefits GCE remains unchanged." (2021 Decision at 17.)

GCU argues that the DOE's private inurement analysis is arbitrary and capricious for multiple reasons. GCU first argues that the DOE has no "discernable standards" to determine private inurement. (MSJ Reply at 2.) Second, the DOE applied IRS tax authority in its private inurement analysis, which GCU contends is outside the scope of the DOE's expertise. (*See id.*) But GCU's more detailed analysis reaches a less subtle conclusion: the Decisions are simply incorrect, as GCU's revenues do not privately inure. (*Id.* at 17–20.) GCU asserts that because a nonprofit may incur "ordinary and necessary [operating] expenditures" without jeopardizing its nonprofit status, and because it is undisputed that GCU pays "fair market value" for GCE's services, any money GCU pays to GCE is "directly related to [GCU's] nonprofit mission." (*Id.* at 17–18.) Further, focusing on what GCU describes as the "well-established private inurement test," GCU argues that in order for GCU's revenue to be privately inuring to GCE, GCU's *insiders* would need to excessively benefit from GCU's revenues. (*Id.* at 17–19.) Citing the numerous conflict checks and corporate separation between GCU and GCE, GCU asserts that GCE is not an insider of GCU. (*Id.* at 19–20.) In sum, GCU argues that there is no private inurement as a matter of law. (*Id.* at 17.)

The Court finds the DOE's analysis of private benefit and inurement in the Decisions was not arbitrary and capricious. A reviewing court "must uphold a [decision] if the agency has examined the relevant considerations and articulated a satisfactory explanation for its action, including a rational connection between the facts found and the choice made." *F.E.R.C.*, 577 U.S. at 292. To justify the DOE's conclusion that GCU's operation creates excess private benefit for GCE, Defendants again turn to the structure of the MSA, whereby GCE receives 60% of GCU's revenue in exchange for providing only

28% of the services necessary to run GCU. (X-MSJ Reply at 8; Hr'g Tr. at 9:1–2, 35:2–4.) Defendants also point to the $870 million-dollar debt GCU owed GCE at the time of the Decisions, which only increased the percentage of revenue GCU paid to GCE. (X-MSJ Reply at 8.) Though GCU counters that GCE risks being undercompensated for its services that increase in value, the DOE points out that the opposite is also true, in that if GCU's revenues substantially increase, GCE will be paid a far greater amount of money for providing the same services. (*Id.*; Hr'g Tr. at 9:5–14.) Given the windfall to GCE once the cost of its services are subtracted from its revenue share, the DOE reasonably determined that an unacceptable percentage of GCU's revenue is enriching GCE, violating § 600.2's prohibition of private benefit.

To the extent that the DOE specifically addressed private inurement, the Court also finds it acted within the bounds of reasoned decision-making. "A [nonprofit] is not to siphon its earnings to its founder, or the members of its board . . . or anyone else fairly to be described as an insider, that is, as the equivalent of an owner or manager. The test is *functional*. It looks to the reality of control rather than to the insider's place in a formal table of organization." *United Cancer Council v. Commissioner*, 165 F.3d 1173, 1176 (7th Cir. 1999) (emphasis added). "[A]n organizational structure . . . entailing domination by the founder . . . raises concern about the potential for abuse unless allayed by other information in the record." *Fam. Trust of Mass., Inc. v. U.S.*, 892 F. Supp. 2d 149, 156 (D.D.C. 2012) (quoting *Church of the Visible Intel. that Governs the Universe v. U.S.*, 4 Cl. Ct. 55, 60 (1983)). "The [benefitting] insider could be a 'mere' employee—or even a nominal outsider, such as a physician with hospital privileges in a charitable hospital." *United Cancer*, 165 F.3d at 1176 (citing *Harding Hosp., Inc. v. U.S.*, 505 F.2d 1068, 1078 (6th Cir. 1974)).

At the time of the Decisions, GCE's only client was GCU.[16] (Hr'g Tr. at 22:6; 2019

[16] GCU raises that GCE has since expanded to providing services for additional institutions. (Hr'g Tr. at 34:11–18.) But given that this Court's review is limited to the Decisions and the information before the DOE at the time it issued the Decisions, GCE's subsequent business ventures are immaterial under the APA. *Dep't of Commerce*, 139 S. Ct. at 2573 ("[I]n reviewing agency action, a court is ordinarily limited to evaluating the agency's contemporaneous explanation in light of the existing administrative record.").

Decision at 13.) It is undisputed that the MSA caused the cost of operating GCU to increase,[17] though it is unclear whether GCU could have obtained a more favorable service agreement, as there is no record that GCU ever solicited offers from other service providers. (Hr'g Tr. at 23:4–8.) In addition to the disproportionate percentage of revenue awarded in compensation for GCE's services, the Decisions clarify the DOE's concern that Mr. Mueller's dual roles further commit GCU to operate for the financial benefit of GCE. (*See* X-MSJ 16–17.) As President, Mr. Mueller is an insider of GCU, yet he and the company he runs—GCE—stand to profit enormously from GCU's income. Mr. Mueller's entanglement between for-profit service provider and educational institution further explains the DOE's conclusion that GCU is a source of captive income for GCE. GCU touts that GCE is performing the services under the MSA for fair market value, but particularly given the incomparable nature of this conversion and service agreement, it is reasonable that the DOE's inquiry did not stop there. (*See* MSJ Reply at 21; X-MSJ Reply at 7 (DOE noting that the sale was "unlike any other prior nonprofit conversion").) The Court concludes that the DOE articulated its reasons for finding GCU does not meet Subsection i and connected those reasons to factors which the DOE is required to consider. *See Fox Telev. Stations., Inc.*, 556 U.S. at 513–14 ("[A] court is not to substitute its judgment for that of the agency . . . and should uphold a decision of less than ideal clarity if the agency's path may reasonably be discerned.").

GCU makes much of the DOE's particular scrutiny of the "economic profit split" transfer pricing method Deloitte and BKD used to analyze the fairness of the MSA and AMSA. (*See* MSJ Reply at 21–23; 2021 Decision at 13.) The DOE analyzed the transfer pricing study under 26 C.F.R. § 1.482-9, a Treasury regulation that speaks to applicability

[17] GCU asserts that Defendants' calculation of GCU's increased operating expense—$810 million to $1.496 billion as a consequence of the fees paid to GCE—was based on "mathematical errors." (MSJ at 23.) This purported error is rooted in the Barclays Report. (*See* 2019 Decision at 5; Doc. 59-10, Barclays Report at 33.) Yet the DOE did not make this conclusion about *GCU's* operating expenses. It instead opined that "under the planned separation . . . the costs to operate [GCU] increase from $810 million to $1.496 billion solely as a result of the Services Fee paid to GCE." (2019 Decision at 5; X-MSJ at 17 n.9.) It is undisputed that GCE and GCU are both contributing services to GCU. The DOE correctly observed that the Barclays Report showed a cost increase for both contributing parties, solely as a result of the MSA.

of different pricing methods for determining controlled transaction fairness.[18] (2021 Decision at 9.) Despite GCU's attacks, the Court finds the DOE adequately explained its objections to the transfer pricing analysis before it. The DOE explained not only that transfer pricing is not a preferred method of analyzing purportedly arm's length transactions, but also that transfer pricing analysis is normally applied to transactions between two parties under common control or ownership. (*See id.* at 7, 14.) The DOE noted that despite these indications that Deloitte and BKD did not use the appropriate evaluation method, "[n]either the Deloitte 2020 TPPR nor the BKD Review . . . explain why transfer pricing is an appropriate tool to evaluate a price being charged between two supposedly independent entities." (*Id.* at 8.) The DOE also reiterated its more generalized skepticism of GCU and GCE's incomplete separation, explaining that,

> [b]oth Deloitte and BKD[19] fail to acknowledge that the claimed lack of comparability [to other revenue-sharing agreements] is a creature of the unique structure of this transaction: taking a fully integrated proprietary institution and separating its academic and campus structure into a nonprofit entity, retaining the 'servicing' functions in the publicly-traded for-profit former owner for which the institution is the primary, if not only client, and providing services for a fee that is 59.9% of Tuition and Fee Revenue.

(2021 Decision at 10–11.) Even taking the analyses at face value, the DOE clearly explained its reasonable conclusion that the analyses commissioned by GCU indicated the MSA and AMSA were unique among service agreements, given the prior and ongoing

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[18] GCU also argues that the DOE improperly relied on a typo in the BKD report to condemn the transfer pricing study. (Doc. 63, Mot. to Supp. AR at 2; *see* MSJ at 27.) To support this contention, GCU moved to supplement the administrative record with a declaration from a BKD employee, in which the employee restates BKD's conclusions and discusses how the DOE erred in applying § 1.482-9. (Mot. to Supp. AR.) While true that the Decision appears to reference the misstatement in the BKD report, the DOE based its analysis on other portions of § 1.482-9, all of which are accurate reflections of the statute. *See* 26 C.F.R. §§ 1.482-9, 1.482-1 ("An arm's length result may be determined under any method without establishing the inapplicability of another method, but if another method subsequently is shown to produce a more reliable measure of an arm's length result, such other method must be used."); (2021 Decision at 9.) The Court therefore finds that supplementation would not aid the Court in understanding the complex issues at hand. *See Inland Empire Pub. Lands Council v. Glickman*, 88 F.3d 697, 703–04 (9th Cir. 1996) (courts only supplement with extra-record materials when "necessary to explain technical terms or complex subject matter.").

[19] Defendants also note that GCU's proffered expert opinions are not entitled to "controlling weight." (X-MSJ at 19 (quoting *Azar*, 950 F.3d at 1100).) The Court agrees. *See Azar*, 950 F.3d at 1096 n.28 ("'[T]he agency has discretion to rely on its own expertise 'even if, as an original matter, a court might find contrary views more persuasive.'")

relationship between GCU and GCE. (*Id.* at 15.) The above explanation is all that is required of the DOE under the APA.

b. IRS Review

Defendants also argue that the DOE's distinction from IRS review is not arbitrary and capricious. (X-MSJ 20–21.) GCU counters that the DOE had no proper basis to dismiss the conclusions of the IRS. (MSJ at 24.) GCU also argues that because Defendants merely applied IRS tax authority in the Decisions, the Decisions are not entitled to deference under the APA. (MSJ 23–24 (citing *Kisor*, 139 S. Ct. at 2417 ("[D]eference ebbs when the subject matter of a dispute is distant from the agency's ordinary duties or falls within the scope of another agency's authority.")).)

The Court finds that the DOE reasonably explained its discrete analysis. As outlined above, the DOE administers the nonprofit compliance provisions in the HEA, some of which are reflected in § 600.2, and ensuring compliance with these authorities is within the scope of the DOE's power and expertise. (*Supra* Section II(A)(1).) In delegating this power of review to Defendants, Congress did not mandate that Defendants promulgate authority completely distinct from that already applied by the IRS. (*See* Hr'g Tr. at 25:14–18 (explaining that the IRS approved GCU's § 501(c)(3) status but "does not have the expertise to understand what [MSA-provided] services are in the education context that the [DOE] has."); X-MSJ at 21.) It is undisputed that the DOE applied IRS regulations in the Decisions. But given that the DOE has no independent body of law under which to analyze changes in control, applying IRS authority to reach a coherently-explained conclusion about GCU's Title IV nonprofit status is a reasonable exercise of the DOE's unique power of review. (*See* X-MSJ Reply at 12 n.9, 21); *see Encino Motorcars, LLC v. Navarro*, 579 U.S. 211, 221 (2016) (the requirement of agency explanation "is satisfied when the agency's explanation is clear enough that its 'path may reasonably be discerned.'"); *c.f. Select Specialty Hosp.-Bloomington, Inc. v. Burwell*, 757 F.3d 308, 314 (D.C. Cir. 2014) (holding any "amorphous" decisional rule to be arbitrary and capricious).

c. HLC Accreditation

GCU also attacks Defendants' lack of deference to the HLC's determination as arbitrary and capricious. (MSJ at 25.) Specifically, GCU argues that Defendants "had no legitimate basis to dismiss" the HLC's conclusions, which included that "[GCU's] Board of Trustees has sufficient independence to ensure it is free from undue influence of the part of . . . GCE or its stockholders." (*Id.* at 25–26.) From GCU's perspective, the DOE disregarded the fact that GCU's "Executive Leadership team" and MSA Committee would be free from conflicts of interest after the sale closed and that GCU retained ultimate control over Mr. Mueller's employment as President. (*Id.* at 26.) Though the HLC found that GCU had dispelled any "apparent conflict of interest" by instituting these conflict checks, the Decisions outlined how the DOE reached a different conclusion. (*Id.*; 2019 Decision at 16 (observing that most of the Executive Leadership team remained employed by GCE after the sale closed and that GCE effectively operated GCU); 2021 Decision at 17 ("The Department makes its own determination regarding nonprofit status, and the fact that HLC may have reached a different conclusion is neither binding nor persuasive.").) GCU asserts that the DOE's conclusion regarding the HLC "fails the APA's requirement to fairly consider the relevant evidence before it." (MSJ at 27.)

Defendants contend that they considered the HLC's determination and explained why they reached a different conclusion, which suffices under APA review. (X-MSJ at 22); *see Fox Telev. Stations., Inc.*, 556 U.S. at 513. Neither the HEA nor the relevant regulations mandate that the DOE defer to the assessment of an accreditor. On the contrary, the HLC itself noted that it must defer to Defendants' assessment of whether GCU qualifies as a nonprofit under Title IV. (X-MSJ at 22 (citing AR-G-0048).) The Court finds that the DOE's disagreement with the HLC's conclusion does not render the Decisions arbitrary and capricious. *See Ass'n of Private Sector Colleges and Univs.*, 681 F.3d at 441 (under "fundamentally deferential" court review of agency decisions, an agency decision is arbitrary and capricious if it "offered an explanation of its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or a product of agency expertise.")

d. Fair Notice to GCU

Asserting that it relied on the DOE's prior practice of equating § 501(c)(3) status with Title IV nonprofit status, GCU argues that the DOE "failed to provide fair notice . . . about its standards governing nonprofit status." (MSJ Reply at 9; *see* MSJ at 18.) Defendants concede that they have raised their level of scrutiny in assessing applications for Title IV nonprofit status. (*See* Hr'g Tr. at 27:5–14; X-MSJ at 23.) "[T]he choice whether to proceed by rulemaking or adjudication is primarily one for the agency regardless of whether the decision may affect agency policy and have general prospective application . . . [although] there could be instances where reliance on adjudication rather than rulemaking would amount to an abuse of discretion." *Chisholm v. F.C.C.*, 538 F.2d 349, 365 (D.C. Cir. 1976) (citing *NLRB v. Bell Aerospace*, 416 U.S. 267, 291–95 (1974)). "Such [an abuse of discretion] may present itself where the new standard, adopted by adjudication, departs radically from the agency's previous interpretation of the law, where the public has relied substantially and in good faith on the previous interpretation, where fines or damages are involved, and where the new standard is very broad and general in scope and prospective in application." *Pfaff v. U.S. Dept. of Housing and Urban Dev.*, 88 F.3d 739, 748 (9th Cir. 1996).

The Decisions do not meet this standard. The Court already explained that this enhanced scrutiny is not a "radical" departure from prior interpretation of § 600.2, but instead is in keeping with the DOE's pattern of using various methods to ensure compliance with its regulations. In turn, GCU acknowledges that the DOE denied nonprofit status to an institution with § 501(c)(3) status in 2016, so GCU cannot persuasively argue that the Decisions present a completely new interpretation of § 600.2. (Hr'g Tr. at 12:21–24.) Lastly, GCU does not dispute that it is still able to participate in Title IV as a proprietary institution and certainly faces no fines or damages as a direct result of the Decisions.[20] (*Id.*

[20] Even though the DOE points out that its heightened scrutiny of nonprofit conversions has spanned multiple presidential administrations, "it is hardly improper for an agency head to come into office with policy preferences and ideas . . . and work with staff attorneys to substantiate the legal basis for a preferred policy." *Biden v. Texas*, 142 S. Ct. 2528, 2547 (2022) (quoting *Dep't of Commerce*, 139 S. Ct. at 2574); (Hr'g Tr. at 28:2–8.)

at 15:22–16:1, 18:7–12.) The Court finds that the Decisions comport with the standards for fair agency adjudication mandated by the APA.

GCU also raises that it asked the DOE if there were any "additional requirements" for nonprofit approval before closing the sale but received no response from the DOE. (MSJ at 18.) The DOE counters that GCU had the opportunity to gather information from the DOE about the status of its application through the preacquisition review process, but GCU chose to time the sale in such a way that it did not wait to receive the DOE's particularized guidance. (X-MSJ Reply at 8 n.3.) The Court agrees with the DOE. GCU does not and cannot assert that the DOE forced or incentivized GCU to seek out HLC approval in early 2018. Had GCU not sought HLC approval on its own timeline, it would not have needed to close the transaction on July 1, 2018. (*See* MSJ SOF ¶ 53.)

Related to its fair notice argument, GCU argues that the DOE "ignored" its own statutes, regulations, and guidance regarding changes in ownership. (MSJ Reply at 14.) The HEA forbids the DOE from exercising "direction, supervision, [and] control" over a nonprofit institution's "employment or administrative decisions." (*See* X-MSJ Reply at 13); 20 U.S.C. § 1232a; *Vitarelli v. Seaton*, 359 U.S. 535, 539–40 (1959) (an agency must follow its own regulations). GCU asserts that by repeatedly criticizing Mr. Mueller's dual roles as President of GCU and CEO of GCE, the Decisions attempted to interfere with GCU's employment decisions in violation of § 1232a.[21] (MSJ Reply at 14.) But the Decisions belie GCU's argument. In the 2021 Decision, the DOE noted GCU's preference for retaining Mr. Mueller as President of GCU and expressed concern over Mr. Mueller's potentially conflicting role *as CEO of GCE*. (2021 Decision at 18.) There is no record that

[21] GCU also argues that the Decisions interfere with GCU's ability to contract out services, in violation of DOE regulation which "expressly allow[s]" revenue-sharing agreements. (*See* MSJ Reply at 14 (citing 34 C.F.R. § 668.25(a)).) To support this argument and evidence that the DOE failed to consider the prevalence of colleges that use service agreements, GCU asks the Court to include a Government Accountability Office ("GAO") report regarding many service agreements used by various educational institutions. (Mot. to Supp. AR at 3.) While GCU now argues the DOE should have considered such data, this GAO report did not exist at the time of either Decision. Additionally, given the evidence already in the record, the Court does not doubt that many institutions used such service agreements at the time of the Decisions, nor does the GAO report independently clarify a complicated issue. The Court will not add the GAO report to the administrative record. *See Glickman*, 88 F.3d at 703–04.

the DOE "conditioned GCU's nonprofit status on removing its chosen President," but instead the Decisions suggest that GCU's application for Title IV status would have been stronger if Mr. Mueller were not the CEO of GCE. (*See* MSJ at 22.) GCU has pointed to no regulation, and the Court knows of none, indicating that the DOE may not speak to the employment decisions of a for-profit service provider associated with an institution seeking recognition as a Title IV nonprofit.

GCU's argument that existing nonprofits have similar revenue sharing agreements does not change the outcome of the Motion. (*See* MSJ at 20; MSJ Reply at 1.) Defendants are not expressly empowered by the HEA to "monitor service agreements of existing nonprofits," even though DOE regulations permit the Secretary to periodically review an institution's eligibility to participate in Title IV programs. (*See* MSJ at 20); 34 C.F.R. § 668.13(b) (enabling but not requiring the Secretary to periodically review and reauthorize an institution's eligibility for Title IV programs); *Fla. Coastal Sch. of Law v. Cardona*, No. 3:21-cv-721-MMH-JBT, 2021 WL 3493311, at *17–18 (M.D. Fla. Aug. 9, 2021) (discussing an institution's application for recertification under Title IV). Instead, the regulations at issue empower the DOE to review the eligibility of institutions undergoing a change in control for participation in programs under Title IV. (*See* X-MSJ at 24 (quoting AR-J-0329) ("The Department's decision to deny a conversion to nonprofit status '*depends on the structure and impact of the Transaction* in the context of the regulatory requirements for a nonprofit institution.'").) This Court's review is limited to whether the agency acted in accord with its own governing regulations in the instant Decisions. *See Dep't of Commerce*, 139 S. Ct. at 2569 ("[Courts] may not substitute [their] judgment for that of the Secretary . . . but instead must confine [them]selves to ensuring that he remained within the bounds of reasoned decisionmaking.") (internal citation and quotation marks omitted).

Lastly, GCU has consistently expressed that the DOE's "case-by-case" review of nonprofit conversions undermines fair notice to institutions like GCU and leads to inconsistent results. (MSJ at 20; *see* Hr'g Tr. at 41:21–25; MSJ Reply at 9–10.) Specifically citing the Purdue-Kaplan transaction, GCU asserts that there is no reasoned distinction

between the DOE's decision to grant Purdue Global nonprofit status and deny it to GCU. (*See* Hr'g Tr. at 40:18–41:6.) Defendants agree that there was no specific standard for service agreement structure at the time of the Decisions, but persuasively raise that GCU could have received case-specific guidance had it waited for the results of the DOE's preacquisition review. (*Id.* at 30:6–12.) Further, Defendants point to the fact that GCU received guidance through the 2019 Decision and chose not to substantially address many of DOE's concerns outlined in that Decision.[22] (*See id.* at 31:16–24.) Particularly where, as here, the agency provided ample case-specific feedback in the 2019 Decision and would have provided preacquisition feedback, the Court does not find its case-by-case adjudication process to be arbitrary and capricious.

B. First Amendment Claims

GCU argues that Defendants' licensing policy prohibiting GCU from holding itself out to the public as a nonprofit under Title IV is an unconstitutional prior restraint on speech. (MSJ at 30); *see* 34 C.F.R. § 668.71(b) (a Title IV participant may lose Title IV funding if it makes "substantial misrepresentations about the nature of its educational program, its financial charges, or the employability of its graduates."). The DOE does not restrict GCU from representing itself as a § 501(c)(3) tax-exempt entity or from openly disagreeing with the DOE's Title IV nonprofit determination, but GCU argues that there is no reason for the DOE's narrower ban. (*See* X-MSJ at 29; MSJ at 31.) According to GCU, any representation of nonprofit status by GCU is not misleading because GCU is a nonprofit. (MSJ at 30.) And regardless, GCU argues, "there is no evidence in the record that students place any importance on the [DOE]'s elusive nonprofit/for-profit distinction." (*Id.* at 30–31.) Defendants persuasively counter these claims.

As a threshold matter, "false or misleading commercial speech" is not protected under the First Amendment. (X-MSJ 26); *Hoffman v. Cap. Cities/ABC, Inc.*, 255 F.3d 1180,

[22] Defendants have repeatedly distinguished the Purdue-Kaplan transaction—after which the DOE recognized Purdue Global as a public institution—from GCU's sale. (*See* X-MSJ at 25, 25 n.16.) And again, GCU informed the DOE that the sale "stands on its own," which undermines its current claim that Defendants unfairly deviated from their decision regarding Purdue Global's Title IV status. (*See* X-MSJ at 25 (citing AR-J-0156).)

1184–85 (9th Cir. 2001) (citing *Florida Bar v. Went For It, Inc.*, 515 U.S. 618, 623–24 (1995)). The DOE argues that GCU "marketing itself as a nonprofit *school* suggests to students and the public that the [DOE] considers GCU a nonprofit under its regulations." (X-MSJ at 29.) GCU has an "economic motive" to present itself as a nonprofit institution, as evidenced by Mr. Mueller's comments that GCU recruiting has boomed since losing its for-profit stigma. (*See* X-MSJ SOF ¶ 32); *Am. Academy of Pain Mgmt. v. Joseph*, 353 F.3d 1099, 1106 (9th Cir. 2004) (citing *Bolger v. Youngs Drug Prods. Corp.*, 463 U.S. 60, 66–67 (1983)) (speech is commercial when "(1) the speech is admittedly advertising; (2) the speech references a specific product; and (3) the speaker has an economic motive for engaging in the speech."). GCU suggests that some of its speech inviting enrollment at GCU is advertising. (*See* MSJ at 30.) Any such misleading speech is not protected by the First Amendment.

Defendants also contend that the DOE's speech licensing provision is a "permissible condition on [GCU's] receipt of federal funds under Title IV." (X-MSJ at 26.) The Court agrees. "If speech is not 'purely commercial'—that is, if it does more than propose a commercial transaction—then it is entitled to full [protection]." *Mattel, Inc. v. MCA Records, Inc.*, 296 F.3d 894, 906 (9th Cir. 2002) (quoting *Hoffman*, 255 F.3d at 1185–86). But "if a party objects to a [speech-related] condition on the receipt of federal funding, its recourse is [usually] to decline the funds." *Agency for Intern. Dev. v. Alliance for Open Society Intern., Inc.*, 570 U.S. 205, 214 (2013). A speech-related condition on funding is only unconstitutional if "prohibits the recipient from engaging in the protected conduct outside the scope of the federally funded program." *Id.* at 217 (quoting *Rust v. Sullivan*, 500 U.S. 173, 197 (1991)). GCU is not forbidden from calling itself a § 501(c)(3) tax-exempt organization, nor is it forced to adopt the DOE's opinion about its Title IV nonprofit status—on the contrary, it may openly disagree with the DOE's determination and receive the same Title IV funding. *C.f. id.* at 218–19 (funding condition that forced recipients to "espouse [the Government's] belief as its own" violated the First Amendment). Defendants' speech condition only requires that GCU accurately represent the outcome of

the Decisions to the public. As such, the condition is a permissible restriction within the scope of Title IV. *Ass'n of Priv. Sector Colleges and Univs*, 681 F.3d at 435 ("[S]tudents are expected to repay their federal loans; their failure to do so shifts their tuition costs onto taxpayers. But schools receive the benefit of accepting tuition payments from students receiving federal financial aid, regardless of whether those students are ultimately able to repay their loans. Therefore, Congress codified statutory requirements in the HEA to ensure against abuse by schools.")

IV. CONCLUSION

The record and law reflect that the DOE has authority to determine whether an institution qualifies as a nonprofit under Title IV. Further, Defendants have shown that the Decisions were not arbitrary and capricious. The Court concludes that Defendants lawfully decided that GCU is not a nonprofit under Title IV, and therefore the DOE does not violate the First Amendment by placing corresponding restrictions on GCU's self-representation.

IT IS ORDERED denying Plaintiff Grand Canyon University's Motion for Summary Judgment (Doc. 59) and granting Defendants Department of Education and Miguel Cardona's Cross-Motion for Summary Judgment (Doc. 74).

IT IS FURTHER ORDERED denying Plaintiff Grand Canyon University's Motion to Supplement the Administrative Record and Take Judicial Notice (Doc. 63).

IT IS FURTHER ORDERED directing the Clerk to enter Judgment.

Dated this 1st day of December, 2022.

Susan R. Bolton
United States District Judge

January 12, 2021

Mr. Brian Mueller, President
Grand Canyon University
3300 West Camelback Road
Phoenix, AZ 85017-3030

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Sent via email to: brian.mueller@gcu.edu

Re: Reconsideration Review of the Change in Ownership and Conversion to Nonprofit Status of Grand Canyon University
OPE ID: 00107400

Dear Mr. Mueller:

At your request, the U.S. Department of Education ("Department"), Federal Student Aid has conducted a reconsideration review of the request of Grand Canyon University, OPE ID 00107400 ("Institution" or "GCU") to convert to nonprofit status.

Prior to July 1, 2018, GCU was owned and operated by Grand Canyon Education, Inc. ("GCE"), a Delaware publicly traded corporation. By way of an Asset Purchase Agreement ("APA"), dated July 1, 2018, GCE sold its School Assets (as set forth in APA at Recital B and as defined in APA §2.1) to Gazelle University ("Gazelle"), an Arizona nonprofit corporation ("the Transaction").

On November 6, 2019, the Department issued a letter setting forth its decision following its post-closing review of the change in ownership ("CIO") and requested a change of status from proprietary to nonprofit. ("Decision"). [1] The Department approved the CIO but denied GCU's request to convert to nonprofit status, finding that GCU did not satisfy the Department's requirements for a nonprofit institution.

The Decision provides details about the background of the Transaction, the Department's requirements for nonprofit status, and a discussion about relevant authority under the Internal Revenue Code. Those details are not repeated here. In summary, the Department determined

[1] After the Transaction closed, Gazelle changed its name to Grand Canyon University. In documents submitted to the Department, Gazelle has also been referred to as "GCU" and the "New GCU." To avoid confusion, the Decision referred to these parties as "Gazelle" and "GCE," based on the names used in the introductory paragraph of the APA: "Gazelle University" (the purchasing entity) and "Grand Canyon Education, Inc." (the selling entity). The sole member of Gazelle is Grand Canyon Foundation. This reconsideration letter continues the use of the names as they were used in the Decision.

that by virtue of the MSA[2] entered into between Gazelle and GCE at the time of the closing of the Transaction, GCE, not GCU/Gazelle, was the beneficiary of 60% of GCU's revenues. Accordingly, GCU did not qualify for nonprofit status for purposes of its participation in Title IV programs under the Higher Education Act.

Thereafter, GCU sought reconsideration of the Decision. On January 8, 2020, GCU provided the Department with potential revised terms for the MSA and asked the Department to confirm that the changes would meet the Department's requirements for GCU to be recognized as a nonprofit for purposes of its participation in the Title IV programs. On January 17, 2020, the Department requested that GCU provide additional documentation about the proposed revision. GCU provided some responsive materials on May 6, 2020 and the remaining materials on May 12, 2020. As it conducted its reconsideration review, the Department requested and received additional documents and information from GCU.

I. THE AMENDED AND RESTATED MASTER SERVICES AGREEMENT

The potential changes to the MSA are set forth in a draft Amended and Restated Master Services Agreement dated as of January 7, 2020 ("ARMSA"). Although the ARMSA generally tracks the MSA, there are some notable changes. As set forth in ARMSA Exhibit B, GCE will no longer provide Curriculum Services or Faculty Operations:

Services Provided (services marked with * are Exclusive Services[3])

Exhibit B	MSA	ARMSA
§ 1*	Marketing	Revision: §1.1.3 (alliances with other educational institutions) is deleted
§ 2*	Enrollment Services and Budget Consideration	No changes
§ 3*	Student Support Services Counseling	No changes
§ 4	Document Intake	No changes
§ 5	Student Records Management	No changes
§ 6	Curriculum Services	Deleted
§ 7	Accounting Services	No changes
§ 8	Financial Aid Services	No changes
§ 9	Procurement Services	No changes
§10	Audit Services	No changes
§11	Human Resources	No changes
§12*	Technology	No changes

[2] Words capitalized herein but not defined have the meaning set forth in the Decision, the APA and/or the MSA.

[3] In both the MSA and the ARMSA, GCE is the exclusive provider of certain services, identified in the MSA as "Exclusive Services," for which Gazelle agrees it will not contract with any third party absent GCE's approval (which is subject to GCE's sole discretion). MSA §3.1; ARMSA §3.1.

§13	Business Analytics Services	No changes
§14	Faculty Operations	Deleted
§15	Compliance Monitoring and Audits	No changes

The parties also agreed that GCE shall always provide at least three services in addition to Enrollment Services. MSA Exhibit B (introductory paragraph). This has not been changed in the ARMSA.

Pursuant to MSA §5.1, the Services Fee is determined and paid in accordance with MSA Exhibit D which provides that Gazelle is required to pay GCE a fee that is equal to 60% of Gazelle's Adjusted Gross Revenue (excluding charitable contributions or other gifts used for purposes other than payment of tuition and fees for students). MSA Exhibit D § 2. Adjusted Gross Revenue consists of all revenue (net of refunds and scholarships accounted for as a discount to tuition) received by Gazelle or its Affiliates from the following sources:

(a) Tuition (including tuition funded by third party sources and charitable contributions);
(b) Fee revenue from students for use of the online communications portal ("the Platform");
(c) Fee revenue from students and their related activities;
(d) Fee revenue from students for use of the Canyon Connect learning resources platform;
(e) Fee revenue from students for student housing;
(f) Fee revenue from students for meal plans and other food services; and
(g) Other revenue including revenue from: (i) sales of athletic tickets; (ii) the operation of the Grand Canyon University Hotel and Conference Center; (iii) the operation of the Maryvale Golf Course; (iv) the operation of the Grand Canyon University Arena; and (v) the operation of Canyon Enterprises (apparel sales and other businesses).

MSA Exhibit D §1.

In the Decision, the Department noted that the Services Fee under the MSA was imposed on revenue generated from sources for which GCE provided no services (*e.g.,* campus housing, food services, athletic tickets, etc.). Under the ARMSA, instead of a 60% Services Fee on all of the above listed items, the ARMSA provides for a "Monthly Services Fee" ("Monthly Fee") which is 66.8% of Tuition and Fee Revenue (items (a) through (d) above). ARMSA Exhibit D §3(a). However, for any calendar year in which 59% of Adjusted Gross Revenue (defined as all categories above) is less than the total of the Monthly Fees paid that year, GCU is entitled to a credit for that difference, which is deducted from the Monthly Fee(s) for the following year. ARMSA Exhibit D §3(b). The MSA did not provide any cap on the total amount of the Services Fee that must be paid to GCE in any year or cumulatively over the years. The ARMSA does not change that.

The Department also notes some additional items that have been revised in the ARMSA (these items are not intended to be an exhaustive list of changes):

- Revisions to the Non-renewal and Termination Provisions, including the elimination of the Non-renewal Fee and reduction of the Termination Fee from 100% to 50%, reduction of the time period for Early Termination of the Initial Term, and eliminating the

requirement that the Senior Secured Debt be paid in the event of Early Termination. ARMSA §§ 6.2 and 6.3[4]

- GCU has the right to hire a third party to perform Back Office Services Functions (not just assume them itself). ARMSA §6.9

II. THE ECONOMIC STUDIES

As discussed in detail in the Decision, in August 2018 (following the closing of the Transaction) GCU provided the Department with a report prepared by Barclays Capital Inc. ("Barclays Report") and a transfer pricing report from Deloitte Tax, LLP (hereinafter "Deloitte 2018 TPR"). Prior to issuance of the Decision, the Department also received a "follow-on" report from Barclays ("Barclays Update"). The Decision sets forth the Department's analysis of these reports. Of particular concern to the Department was the fact that, as detailed in the Barclay's Report, under the planned separation (and as effectuated on July 1, 2018) the costs to operate the separated GCU increase from $810 Million to $1.496 Billion for fiscal year 2019, solely as a result of the Service Fees paid to GCE. Barclays Report at 33.[5] As noted above, the revenue split set forth in the ARMSA is not appreciably different than the revenue split set forth in the MSA, providing for the lesser of 68.8% of Tuition and Fee Revenue, or 59% of Adjusted Gross Revenue (which includes Tuition and Fee Revenue).[6]

On May 6, 2020, GCU provided an updated transfer pricing report in support of its request for reconsideration, dated April 29, 2020 and entitled "Transfer Pricing Planning Report" ("Deloitte

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[4] The Initial Term of the MSA is 15 years, with automatic renewals thereafter for successive five years terms apparently in perpetuity. MSA §6.1. This remains the same in the ARMSA. ARMSA §6.1. The ARMSA has, however, eliminated the Non-Renewal fee. ARMSA §6.2. Gazelle has the right to terminate the ARMSA during the Initial Term, but it cannot elect do so before the fifth anniversary of the Effective Date (which is appears to be referring to the Effective Date of the MSA). ARMSA §6.3. If Gazelle exercises that right, it must pay GCE an Early Termination Fee (50% of the aggregate Services Fees paid or payable for the trailing twelve- month period just ended). ARMSA §6.3 and MSA Exhibit A at A-3. Thus, Gazelle is locked into the agreement for at least five years. The ARMSA eliminates the requirement that the Senior Secured note be paid in full as a condition precedent for early termination.

[5] Although the Barclays Report (dated April 26, 2018) assumed a 65%/35% revenue split on most items, and a different split on housing (20%/80%), meals (5%/95%) and Canyon Connect (5%/95%), the executed MSA provides for a straight 60%/40% split and included sources of revenue that are not included in the Barclays Report, including revenue from Gazelle Arena. As noted in the Decision, these differences would seem to only exacerbate Barclays' assessment that the separation of the servicing functions from GCI will (and has) resulted in a significant increased cost for the operation of the Institution, with those increased funds flowing to the benefit of its prior owner, GCE.

[6] The Services Fee under the MSA is 60% of Adjusted Gross Revenue. Adjusted Gross Revenue includes the same items in the ARMSA as are included in the MSA. As described above, the Monthly Fee under the ARMSA is 68.8% of Tuition and Fee Revenue. GCU's "largest primary component" of revenue is tuition, with online tuition accounting for "74% to 98% of total revenue." *See* "Valuation of the Invested Capital of Grand Canyon University," as of January 7, 2020, prepared by BKD CPAs and Advisors, at 7. "The second main revenue component is other revenue, which consists of fee income, room and board and other less meaningful sources." *Id.*

2020 TPPR").[7] The Deloitte 2020 TPPR includes another pricing transfer study as Appendix B, described as "FY 2017 EPS Analysis Grand Canyon University - TP Report August-19-2019 – Original Analysis" (hereinafter "Deloitte 2019 TPR").[8] the Deloitte 2020 TPPR refers to the Deloitte 2019 TPR as the "Original Analysis." The Department does not adopt the term "Original Analysis" because use of that term is confusing given the existence of the Deloitte 2018 TPR,[9] which is the report discussed in the Decision. The Deloitte 2018 TPR, the Deloitte 2019 TPR and the Deloitte 2020 TPPR are hereinafter collectively referred to as "the Deloitte Reports."

In its May 2020 submissions, GCU also provided three reports prepared by BKD CPAs & Advisors ("BKD"): a "Valuation of the Invested Capital of Grand Canyon University," as of July 1, 2018 ("BKD 2018 Valuation"); a "Valuation of the Invested Capital of Grand Canyon University," as of January 7, 2020 ("BKD 2020 Valuation")[10]; and a "Review of a Pricing Transfer Analysis Prepared By a Third Party with Respect to Provision of Education Services by Grand Canyon Education, Inc. on Behalf of Grand Canyon University as of December 31, 2018 and December 31, 2019" ("BKD Review"). The BKD Review is a review of the Deloitte 2020 TPPR, which is referred to in the BKD Review as the "Transfer Pricing Study."

The methodology used in the Deloitte Reports and reviewed by BKD is an "Economic Profit Split" ("EPS") analysis. *See* Decision at 6-9 for a discussion of the EPS analysis performed by Deloitte. As described in the Deloitte Reports, there are various steps required to perform an EPS analysis (*i.e.,* identifying the "assets and activities" of the enterprise that generate revenue, identifying risks associated with the revenue-generating activities and assets; calculating a consolidated contribution margin; estimating the share of total fixed costs for each entity; splitting the contribution margin based on the fixed cost share of each entity; recreating an accounting income statement and determining the revenue split between GCU and GCE). *See* Deloitte 2018 TPR at 32 and Deloitte 2020 TPPR at 39.

Although much of the verbiage in the three different Deloitte Reports is the same, the Deloitte 2020 TPPR contains a new discussion about the different methodologies for conducting transfer pricing studies. *See* Deloitte 2020 TPPR at 32-38. The EPS used by Deloitte is only one of several identified methods, as discussed more fully below.

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[7] Not surprisingly, GCU has not provided any further analysis from Barclays in support of its request for reconsideration.

[8] The Deloitte 2019 TPR (Appendix B to the Deloitte 2020 TPPR) was not provided by GCU when it submitted the Deloitte 2020 TPPR in May 2020. The Department requested and received the Deloitte 2019 TPR in November 2020.

[9] Although the Deloitte 2018 TPR and the Deloitte 2019 TPR are similar, they are not identical.

[10] Given the Decision's conclusion that the MSA prevented the Department from approving the requested conversion to nonprofit status, the Decision did not examine whether the purchase price was at fair value and was not based on a finding that the purchase price for the assets was not at fair value. *See* Decision at 6 n.11.

III. THE DEPARTMENT'S REVIEW OF THE DELOITTE TPPR AND THE BKD REVIEW

The Department has extensively reviewed both the Deloitte 2020 TPPR and the BKD Review.[11] Neither document changes the Department's conclusion, expressed in its November 6, 2019 letter to GCU, that "the primary purpose of the MSA, and by extension, the Transaction, was to drive shareholder value for GCE with GCU as its captive client – potentially in perpetuity." Decision at 12. Neither the Deloitte 2020 TPPR nor the BKD Review demonstrates that the Monthly Fee under the ARMSA (based on the lesser of 68.8% of Tuition and Fee Revenue or 59% of GCU's Adjusted Gross Revenue), potentially in perpetuity, constitutes anything other than a continuing revenue stream to its former owner GCE, the primary purpose of which is to drive shareholder value for GCE. [12]

Transfer Pricing in General

Transfer pricing assumes that a transaction is between related parties (referred to in the applicable regulations as "controlled taxpayers," as discussed below). GCU and GCE have repeatedly insisted that GCU/Gazelle and GCE are independent of each other. Neither the Deloitte 2020 TPPR nor the BKD Review acknowledge that GCU/Gazelle and GCE are ***not*** controlled parties and that this is ***not*** a controlled transaction. Furthermore, the EPS method selected by Deloitte assumes that both entities have profits. Gazelle, however, does not. It has 501(c)(3) status under federal regulations and was incorporated as a nonprofit corporation under state law. Neither Deloitte nor BKD even mention this fact. The analysis used by both assumes that GCU/Gazelle has profits to contribute to a joint enterprise, but that assumption is erroneous – there is no joint enterprise – or at least there should not be if GCU is truly independent.

Transfer pricing is an accounting and tax practice that is used to determine whether prices charged between controlled taxpayers or entities (*e.g.*, two divisions of one corporation or two subsidiaries of a parent) are fair and at arms-length for tax purposes. Indeed, the Deloitte 2020

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[11] This letter includes an extensive discussion of the transfer pricing methodologies used by Deloitte. The Department also notes the following qualifying language used by Deloitte – these are by way of example only:

- "Information and data provided by the Client, the completeness and accuracy of which we did not independently verify." Deloitte 2020 TPPR at 2.
- "[w]e have assumed all related party transactions involving the University and its subsidiaries are priced at arm's length." *Id.* (not clear to what "subsidiaries" Deloitte is referring).
- "For the fixed costs that generate OBSAs, based on the management confirmation, we rely on the estimates performed in the Original Analysis, for the lead time and useful lives of these costs to quantify the value of OBSAs and their amortization schedule." Deloitte 2020 TPPR at 4.

[12] The Department also notes the inconsistencies in the terminology used by Deloitte and the terminology used in the ARMSA. For example, the Deloitte 2020 TPPR bases the EPS on a percentage of GCU's net revenues. *See e.g.*, Deloitte 2020 TPPR at p. 4 (§1.3(3)(e); p. 10 (§4); p. 43 (§6.2.1.3, Table 7); p.45-46 (§6.3). BKD similarly states that "[b]ased on its analysis, Deloitte determined an arm's-length range for the share of revenue as a percentage of total net revenue . . .." BKD Review at 14 (emphasis added). In other places, the Deloitte 2020 TPPR refers to just "revenue." The ARMSA and Exhibit D thereto refer to "adjusted gross revenue," not "net revenue" or "consolidated net revenue." The ARMSA fee is based on a percentage of "Tuition and Fee Revenue" or "Adjusted Gross Revenue." ARMSA at Exhibit D, §3.

TPPR states at the beginning that the "analysis contained in this report ***is solely for tax purposes*** . . .." Deloitte 2020 TPPR at 1 (§ 1.1) (emphasis added). "Transfer pricing is an accounting practice that represents the price that one division in a company charges another division for goods and services provided. Transfer pricing allows for the establishment of prices for the goods and services exchanged between a subsidiary, an affiliate, or commonly controlled companies that are part of the same larger enterprise. Transfer pricing can lead to tax savings for corporations, though tax authorities may contest their claims." Shobhit Seth, Transfer Pricing, Corporate Finance & Accounting (Sept. 9, 2019) (available at https://www.investopedia.com/terms/t/transfer-pricing.asp). Transfer pricing is an "accounting and taxation practice that allows for pricing transactions internally within businesses and between subsidiaries that operate under common control or ownership. The transfer pricing practice extends to cross-border transactions as well as domestic ones." *Id.* Transfer pricing provides methods by which controlled taxpayers justify to the Internal Revenue Service (or other taxing authorities) how income and costs are being allocated amongst those taxpayers. Section 482 of the Treasury Regulations (26 C.F.R. § 482 *et seq.*) "places a controlled taxpayer on a tax parity with an uncontrolled taxpayer ***by determining the true taxable income of the controlled taxpayer***." Treas. Regs. § 1.482-1(a)(1) (emphasis added).

Here, the issue is not whether two controlled parties have properly allocated income and costs between themselves for tax and accounting purposes. Rather, the issue is whether requiring GCU to actually pay out to GCE, an independent entity, a substantial share of its revenues (*i.e.,* actual money out the door, not just a paper exercise of putting dollars in one column or another for accounting and tax purposes) for services under the MSA/ARMSA is the type of benefit that disqualifies GCU from being recognized by the Department as a nonprofit institution.

Treasury Regulations

The Internal Revenue Service has promulgated a complex set of regulations to determine for tax purposes whether the allocation of income, profit and expenses among related taxpayers is arms-length. The underlying premise of transfer pricing is that the entities involved are "controlled" entities. "The purpose of section 482 [Treasury's transfer pricing regulations] is to ensure that taxpayers clearly reflect income attributable to controlled transactions and to prevent the avoidance of taxes with respect to such transactions. Section 482 places a controlled taxpayer on a tax parity with an uncontrolled taxpayer by determining the true taxable income of the controlled taxpayer." Treas. Reg. 1.482-1. The following pertinent definitions apply:

- "Controlled" is defined by Treas. Reg. 1.482-1(i)(4) as "any kind of control, direct or indirect, whether legally enforceable or not, and however exercisable or exercised, including control resulting from the actions of two or more taxpayers acting in concert or with a common goal or purpose. It is the reality of the control that is decisive, not its form or the mode of its exercise. A presumption of control arises if income or deductions have been arbitrarily shifted."
- "Controlled group" is defined by Treas. Reg. 1.482-1(i)(6) means "the taxpayers owned or controlled directly or indirectly by the same interests."
- "Controlled taxpayer" is defined by Treas. Reg. 1.482-1(i)(5) as "any one of two or more taxpayers owned or controlled directly or indirectly by the same interests, and includes

the taxpayer that owns or controls the other taxpayers. Uncontrolled taxpayer means any one of two or more taxpayers not owned or controlled directly or indirectly by the same interests."

- "Controlled transaction or controlled transfer" is defined by Treas. Reg. 1.482-1(i)(8) defines as "any transaction or transfer between two or more members of the same group of controlled taxpayers. The term uncontrolled transaction means any transaction between two or more taxpayers that are not members of the same group of controlled taxpayers."

According to GCE's 2020 10-K, "GCU is a separate non-profit entity ***under the control of an independent board of trustees, none of whose members have ever served in a management or corporate board role at the Company. Accordingly, the Company's relationship with GCU, both pursuant to the Master Services Agreement and operationally, is no longer as owner and operator, but as a third-party service provider to an independent customer.***" Feb. 20, 2020 10-K at 23 (emphasis added). Taking this public pronouncement, as well as the parties' various representations to the Department as true, GCU/Gazelle does not control GCE and GCE does not control GCU/Gazelle.

Neither the Deloitte 2020 TPPR nor the BKD Review address these terms and definitions, much less explain why transfer pricing is an appropriate tool to evaluate a price being charged between two supposedly independent entities.

In addition to ignoring that these are not parties subject to common control, the BKD Review does not establish that the revenue-based pricing scheme is in fact arm's length nor does it establish that GCU could not purchase the same or better or more innovative service from other vendors at a better price. Nor does it address in any meaningful way the fact that given GCU's size and the revenue it generates, it would also seem that some of the services could be managed by GCU itself with the appropriate staff. This is exactly what it did before the two entities were separated in July 2018.

Nor does the BKD Review in any way address or challenge the conclusion set forth in the Decision that the revenue sharing arrangement between GCU and GCE precludes GCU from being recognized as a nonprofit institution for purposes of Title IV programs. While the Department considers the application of a transfer pricing analysis here to be questionable, it nevertheless wants to address the conclusions reached by Deloitte and BKD.

Transfer Pricing Methods

The main authorities for methods of transfer pricing used by U.S. companies are the Treasury Regulations 1.482-1 *et seq.* and the guidelines issued by the Organization for Economic Co-Operation and Development ("OECD"). OECD is an international organization that promulgates guidelines for evaluating transfer pricing in international transactions. The United States is a party to the OECD Convention and agrees to follow OECD policies/standards for *international* transactions. The Transaction at issue is ***not*** an international transaction. However, the transfer pricing method that Deloitte used in this case (the EPS) is a method that comes from OECD and is not recognized by the Treasury regulations for domestic transactions (and therefore

presumably would constitute an "unspecified method" under the Treasury regulations, as discussed below). [13]

Section 1.482-9 of the Treasury Regulations sets forth the following transfer pricing methods for determining taxable income in connection with a controlled services transaction: (1) services cost method; (2) the comparable uncontrolled services price method; (3) the gross services margin method; (4) the cost of services plus method; (5) the comparable profits method; (6) the profit split method; and (7) unspecified methods. *See* Treas. Reg. §1.482-9(a) (listing methods). By cross-reference to § 1.482-1(c), §1.482-9(a) of the regulations requires that the best method be used: "Best method rule—(1) In general. The arm's length result of a controlled transaction must be determined under the method that, under the facts and circumstances, ***provides the most reliable measure of an arm's length result***." Treas. Regs. 1.482-1(c) (emphasis added). Thus, the methods identified in §1.482-9(a) must be applied "in accordance with the provisions of §1.482-1, including the best method rule of §1.482-1(c), the comparability analysis of §1.482-1(d), and the arm's length range of §1.482-1(e), except as those provisions are modified in this section [§1.482-9]."

The BKD Review acknowledges that the taxpayer must demonstrate why the selected method was chosen and why the alternatives methods were rejected. Neither the Deloitte 2020 TPPR nor the BKD Review analytically demonstrate that the unspecified method chosen (EPS) is the most reliable methodology here, nor do they explain in anything more than a perfunctory way why the other methods were rejected. Notably, the Deloitte 2018 TPR fails to even mention any of the other methodologies, instead simply adopting the EPS method.

As noted above, the factual predicate for all the transfer pricing methods is that the entities and taxpayers are "controlled," a factor that does not exist here. Additionally, the Department notes that both the Deloitte 2020 TPPR and the BKD Review are, for the most part, superficial. Neither analyzes the applicable regulations (or the various examples contained therein), in any depth. Notwithstanding that these are not "controlled" parties and the Department therefore questions the appropriateness of using a transfer pricing study (especially an "unspecified" one under the Treasury regulations) to support a request to convert to nonprofit status, the following provides a summary of the Department's concerns about the conclusions reached by Deloitte and BKD as to the specific methodologies:

1. Services Cost Method ("SCM") - Treas. Reg. § 1.482-9(a)(1), (b)):
The SCM evaluates "whether the amount charged for certain services is arm's length by reference to the total services costs (as defined in paragraph (j) of this section [1.482-9(b)]) with no markup." Treas. Reg. § 1.482-9(b)(1). Deloitte's "analysis" and rejection of the SCM method consists of one sentence: "The Education Support Services provided by the GCE to GCU contribute significantly to the key competitive advantages of the *Company*. Under Treas. Reg. Section 1.482-9(b)(4)(vi) (research, development or experimentation type of service transactions) and Treas. Reg. Section 1.482-9(b)(4)(vii) (engineering or scientific type of service

[13] In fact, the Deloitte 2020 TPPR includes references to an "MNE" without any explanation. *See* Deloitte 2020 TPPR at 15-17. "MNE" means a "multinational enterprise … A group of associated companies with business establishments in two or more countries." OECD Guidelines (2017) at 28.

transactions) are ineligible for the SCM method and therefore, the SCM cannot be used as the best method/most reliable method." Deloitte 2020 TPPR at p.33, §6.1.1.2 (emphasis added). The BKD Review discusses this conclusion at pages 5 (§II.A.3(a)) and 9 (§II.B.1). Although the Deloitte 2020 TPPR does not define "Company," BKD substitutes "GCU" in place of "Company" in its Review. BKD Review at 9. However, the regulation discusses contributions to key competitive advantages of the "controlled group" (§1.482-9(b)(5)) which would have to include both GCU and GCE. As explained at the outset of this discussion, however, GCU and GCE are not controlled entities and therefore there is no "controlled group," which begs the question of whether the services do or do not "contribute significantly to the key advantages" of a controlled group. Moreover, the BKD Review states "[w]hile the Back Office Support component of the Education Support Services could potentially be eligible for SCM treatment, it is not a requirement that the taxpayer elect the SCM method (*i.e.*, it is a voluntary election)." While it may not be a *requirement* that a taxpayer elect the SCM method, the taxpayer is required to explain why SCM is rejected as an alternative method to evaluate services (like back office support) that are routine and do not contribute significantly to the success or failure of GCU. Neither Deloitte nor BKD have adequately done so here.

2. Comparable Uncontrolled Services Price Method ("CUSP") - Treas. Reg. § 1.482-9(a)(2),(c):
The CUSP method evaluates "whether the amount charged in a controlled services transaction is arm's length by reference to the amount charged in a comparable uncontrolled services transaction." Treas. Regs. § 1.482(c)(1). Deloitte rejected the CUSP method in part because "due to the specificity of the transaction and the industry, no external CUSP/CUP[14] method analyzing the transactions between two unrelated parties, is available." Deloitte 2020 TPPR at p. 33 (§6.1.2.2) (footnote added). BKD agreed. BKD Review at 9-10. However, neither the Deloitte 2020 TPPR nor the BKD Review identified which transactions they reviewed and on what basis those transactions were not similar. Although "similarity of services rendered, and of the intangible property (if any) used in performing the services, generally will have the greatest effects on comparability under this method," neither BKD nor Deloitte discussed whether or not "adjustments [could be made] to account for any differences." Treas. Regs. § 1.482-9(c)(2)(ii)(A).

3. Gross Services Margin Method ("GSMM")- Treas. Reg. § 1.482-9(a)(3), (d):
The GSMM "evaluates whether the amount charged in a controlled services transaction is arm's length by reference to the gross profit margin realized in comparable uncontrolled transactions." Treas. Regs. §1.482-9(d)(1). Similar to the brevity of its analysis and rejection of the SCM, Deloitte rejects the GSMM in two sentences: "Neither GCU [n]or GCE provide comparable services with third parties, and we are unaware of instances where two third parties jointly provide comparable services in a comparable market. Therefore, we reasonably concluded that the GSMM/RPM[15] method is not the best method/most reliable method to determine the arm's length nature of the Covered Transaction." Deloitte 2020 TPPR at 34 (§6.1.3.2) (footnote added). Both Deloitte and BKD fail to acknowledge that the claimed lack of comparability is a creature of the unique structure of this transaction: taking a fully integrated proprietary

[14] "CUP" refers to "comparable uncontrolled price" method which is a method used by OECD but not the Treasury Department for domestic transactions. The OECD methods are discussed further below.

[15] "RPM" refers to "resale price method" which is a method used by OECD but not the Treasury Department for domestic transactions.

institution and separating its academic and campus structure into a nonprofit entity, retaining the "servicing" functions in the publicly-traded for-profit former owner for which the institution is the primary, if not only client, and providing services for a fee that is 59.9% of Tuition and Fee Revenue.

4. Cost of Services Plus Method ("CSPM") - Treas. Reg. § 1.482-9(a)(4), (e):
The CSPM "evaluates whether the amount charged in a controlled services transaction is arm's length by reference to the gross services profit markup realized in comparable uncontrolled transactions." Treas. Regs. § 1.482-9(e)(1).[16] This method "is ordinarily used in cases where the controlled service renderer provides the same or similar services to both controlled and uncontrolled parties." Treas. Regs. § 1.482-9(e)(1). CSPM "measures an arm's length price by adding the appropriate gross services profit to the controlled taxpayer's comparable transactional costs." Treas. Regs. § 1.482-9(e)(2).

In determining that the CSPM was not applicable, Deloitte states, in part: "No internal CSP/Cost Plus transactions were identified for Covered Transaction. As stated above, GCE does not provide similar services to any other third-party entities. An external CSP/Cost Plus approach is also not available due to lack of sufficient information on similar service transactions involving third parties in the given industry." Deloitte 2020 TPPR at p. 34 (§6.1.4.2). Using those statements as support, BKD agreed with Deloitte. BKD Review at pp. 11-12. However, the regulations provide: "***If possible***, the appropriate gross services profit markup should be derived from comparable uncontrolled transactions of the same taxpayer participating in the controlled services transaction because similar characteristics are more likely to be found among services provided by the same service provider than among services provided by other service providers. ***In the absence of such services transactions, an appropriate gross services profit markup may be derived from comparable uncontrolled services transactions of other service providers.***" Treas. Regs. § 1.482-9(e)(3)(ii)(A) (emphasis added). Neither the Deloitte 2020 TPPR nor the BKD Review address this alternative approach. Nor, as described below, did Deloitte or BKD seem to make any attempt to identify any companies that provide individual components of the services provided under the ARMSA.

5. Comparable Profits Method ("CPM") – Treas. Regs. §1.482-9(a)(5), (f):
The CPM "evaluates whether the amount charged in a controlled transaction is arm's length, based on objective measures of profitability (profit level indicators) derived from uncontrolled taxpayers that engage in similar business activities under similar circumstances." Treas. Regs. § 1.482-9(f)(1). Deloitte concluded, and BKD agreed, that CPM is not the best transfer pricing method. Deloitte 2020 TPPR at 35-36 (§6.1.5.2);[17] BKD Review at 11.

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[16] Deloitte combines its discussion of the CSPM with a discussion of the Cost Plus Method which is an OECD method used in "circumstances where semi-finished goods are sold between related parties, where related parties have concluded joint facility agreements or long-term buy-and-supply arrangements." Deloitte 2020 TPPR at p. 34 (§6.1.4.1). It is unclear why Deloitte included the discussion of the Cost Plus Method. Not only is the Cost Plus Method not included in the Treasury Regulations, the ARMSA does not involve the sale of goods.

[17] Deloitte also analyzed the OECD's transactional net margin method ("TNMM"). TNMM is not a method recognized by the Treasury Department for domestic transactions.

In agreeing with Deloitte's conclusion, BKD points to the "highly integrated nature of GCE and GCU and the non-routine nature of the services being provided by GCE." BKD Review at 11. "Routine" and "non-routine" are not terms that are used in the regulatory discussion of the CPM. BKD defines "routine" service providers as entities that do not hold valuable intangible assets. BKD Review at p. 11. Although § 1.482-9(f) does not itself refer to valuable intangible assets, §1.482-5, which it cross-references does: "Consequently, ***in most cases*** the tested party will be the least complex of the controlled taxpayers and will not own valuable intangible property or unique assets that distinguish it from potential uncontrolled comparables." Treas. Regs. § 1.482-5(b)(2)(i)(emphasis added). Thus, contrary to what BKD suggests, holding valuable intangible property is not disqualifying, it just may not occur "in most cases." Moreover, as to vertical integration, the Deloitte 2020 TPPR explains that vertical integration is something that happens "within the same organization." Deloitte 2020 TPPR at 13 (§4.1.3) (quoting Joskow, Paul. Vertical integration, Handbook of New Institutional Economics, Kluwer, 2003). Clearly, GCE and GCU are not within the same organization. Yet, neither the Deloitte 2020 TPPR nor BKD Review acknowledges this fact and do not explain why they are discussing a vertically integrated organization when that is not the pattern here. Moreover, neither Deloitte nor BKD apparently made any effort to analyze the component parts of the ARMSA (or the MSA) to determine whether other companies (for which data is available) provide services that can be compared to the various components of the ARMSA. By way of example only -- companies that provide institutions with financial aid servicing, or companies that provide marketing or student support services.

6. Profit Split Method ("PSM") – Treas. Regs. §1.482-9(a)(6), (g):
The PSM "evaluates whether the allocation of the combined operating profit or loss attributable to one or more controlled transactions is arm's length by reference to the relative value of each controlled taxpayer's contribution to that combined operating profit or loss." Treas. Regs. §1.482-9(g)(1). There are two types of profit splits – comparable and residual. Treas. Regs. §1.482-9(g)(1); *see also* §1.482-6(c). Deloitte rejected the comparable split method because "it did not identify publicly available information on uncontrolled companies, the transactions and activities of which are sufficiently comparable to the Covered Transaction. Further, it is highly unlikely that an arrangement sufficiently comparable to the Covered Transaction can be found." the Deloitte 2020 TPPR at p. 36 (§ 6.1.6.3). Again, as noted above, this "lack of comparables" results from the way this Transaction was structured (separating the academic and servicing functions) to maintain the continued revenue stream to GCE from GCU's operations.

BKD's review of Deloitte's rejection of PSM consists of block quotes from the Deloitte 2020 TPPR and then just one sentence of "analysis": "The Preparer rejected both forms of the PSM, the comparable PSM and the RPSM. Given the lack of comparable profit split transaction information, Deloitte's rejection of the comparable PSM is appropriate." BKD Review at 12. This is hardly an analysis, and demonstrates the lack of any consideration of whether the component parts of the services could be examined.

7. Unspecified Method – Treas. Regs. § 1.482-9(a)(7), (h):
Treasury Regulations § 1.482-9(h) provides that "[m]ethods not specified in paragraphs (b) through (g) of this section [§ 1.482-9] may be used to evaluate whether the amount charged in a controlled services transaction is arm's length. Any method used under this paragraph (h) must

be applied in accordance with the provisions of §1.482-1." The regulation cautions however that "an unspecified method will not be applied unless it provides the most reliable measure of an arm's length result under the principles of the best method rule." Treas. Regs. § 1.482-9(h) (citing § 1.482-1(c)).

Deloitte determined that the economic profit split ("EPS"), an unspecified method, was the most reliable transfer pricing method. Deloitte's analysis of the EPS is based on the OECD's guidance because OECD has identified EPS as a transfer pricing method; the Treasury Regulations have not. Indeed, the Treasury Regulations specifically provide that "the allocation of profit or loss under the profit split method must be made in accordance with one of the following allocation methods – (i) the comparable profit split … ; or (ii) the residual profit split … ." As described immediately above, Deloitte rejected both of these methods for another "profit split" method – the EPS.

The EPS method (also referred to as the Transactional Profit Split Method):

> . . . first identifies the profits to be split from the controlled transactions—the relevant profits—and then splits them between the associated enterprises on an economically valid basis that approximates the division of profits that would have been agreed at arm's length. As is the case with all transfer pricing methods, the aim is to ensure that profits of the associated enterprises are aligned with the value of their contributions and the compensation which would have been agreed in comparable transactions between independent enterprises for those contributions. The transactional profit split method is particularly useful when the compensation to the associated enterprises can be more reliably valued by reference to the relative *shares* of their contributions to the profits arising in relation to the transaction(s) than by a more direct estimation of the value of those contributions.

C.1. ¶2.114, OECD Guidelines (2018) (emphasis in original).[18] The OECD explains further:

> The main strength of the transactional profit split method is that it can offer a solution for cases where both parties to a transaction make unique and valuable contributions (e.g. contribute unique and valuable intangibles) to the transaction. *In such a case, independent parties might effectively price the transaction in proportion to their respective contributions, making a two-sided method more appropriate.*

[18] OECD issued comprehensive guidelines in 2017 (referred to herein as "OECD Guidelines (2017)"). In June 2018 OECD issued "Revised Guidance on the Application of the Transactional Profit Split Method" (referred to herein as ("OECD (2018)").

C.2.1. ¶2.119, OECD Guidelines (2018) (emphasis added). Yet Deloitte and BKD have failed to establish that any of the services provided by GCE are truly unique or valuable[19] or to examine what price independent parties would have put on the services provided here.

Further, Deloitte and BKD fail to explain why EPS is the most reliable method for evaluating the revenue sharing fee structure in the ARMSA when (1) there is no controlled transaction because GCU and GCE are not controlled taxpayers; (2) there are no profits to split because under Internal Revenue Service ("IRS") and state authority Gazelle is a nonprofit entity; and (3) GCU/Gazelle and GCE are not "associated enterprises." The MSA is a revenue sharing agreement between two uncontrolled (*i.e.*, supposedly independent) parties; it is not a profit splitting allocation between two related entities. The proposed revised terms for the arrangement, as set forth in the ARMSA, do not change the fact that most of the revenue being generated by Gazelle/GCU is going out the door to another entity – GCE – for the benefit of its shareholders. The Department located no authority, nor have either Deloitte or BKD cited any sources, that support a profit-splitting transfer pricing method as the correct methodology to evaluate a transaction in which one of the parties is organized as a nonprofit entity under state law.

EPS is, according to Deloitte, appropriate when, among other factors, the "business operations are highly integrated such that the contributions of the parties cannot be reliably evaluated in isolation from each other[.]" Deloitte 2020 TPPR at 16 (§4.1.7). Similarly, Deloitte describes GCU and GCE as entities "in a corporate group." Deloitte 2020 TPPR at 38 (§ 6.2). As noted *supra*, however, GCU and GCE are represented to the Department as separate, independent entities – they do not constitute, and are not part of, a "highly integrated" taxpayer and they are not entities in a "corporate group."[20] Even more significant is the fact that the EPS is a method that allocates profits from a controlled transaction to each entity based on their relative contribution. Deloitte 2020 TPPR at 17-18 (§ 4.1.8). According to Deloitte, GCU and GCE "should share the profits in a manner proportional to each entity's relative value contribution." Deloitte 2020 TPPR at 38 (§6.1.7). Deloitte "selected the EPS method to recommend an

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[19] Functions performed or assets used are "'unique and valuable' in cases where (i) they are not comparable to contributions made by uncontrolled parties in comparable circumstances, and (ii) they represent a key source of actual or potential economic benefits in the business operations." OECD (2018) at 15 ("The Glossary of the Transfer Pricing Guidelines will be amended to add a definition of 'Unique and valuable contributions'"). The Department views the services provided by GCE as garden variety services in higher education. Either typically performed in-house, or by one or more services providers. Indeed, Deloitte explains that GCE relies on four third parties to provide the IT platforms, although those platforms are apparently enhanced by GCE ("GCE subscribes or pays for third-party platforms because it is more efficient for the third-party providers to maintain the systems"). *See* Deloitte 2020 TPPR at 23. Deloitte notes that GCE employs "roughly 14" people to support one of the platforms. There is absolutely no examination of why these functions cannot be performed by GCU employees, as they certainly were before the July 1, 2018 CIO which resulted in two entities – Gazelle and GCU.

[20] Although both Deloitte and BKD use the term "corporate group" in their respective documents, neither document defines the term. The term does not appear in either the relevant Treasury regulations or OECD's guidelines. The Department assumes that Deloitte means a group of entities that are either within a parent/subsidiary or brother/sister corporate chain. GCU and GCE do not share such an organizational relationship and the Department does not consider them part of a "corporate group."

appropriate range with respect to the allocation of overall profits between GCU and GCE," and explains that the steps in the EPS method are intended "to arrive at an eventual allocation of profits to each entity in the corporate group based on their relative contribution." Deloitte 2020 TPPR at 38 (§§6.1.8, 6.2).[21] The Deloitte 2020 TPPR does not explain why it is appropriate to "allocate profits" between two independent, unrelated, uncontrolled taxpayers, one of which is for-profit and the other of which is organized as a nonprofit.

Indeed, Deloitte notes that "at arm's length, each party to a transaction optimize their own value." Deloitte 2020 TPPR at 14. That is what should govern the relationship between GCU and GCE. Contrary to how parties work at arm's length, Deloitte explains that "companies by definition optimize value of the group as a whole." *Id.* There is no singular "company here" nor is there a "corporate group." GCE and GCU are not controlled taxpayers; there is no controlled transaction; and there are no profits to split – GCU is a tax-exempt entity and is organized as a nonprofit entity under state law. Neither the Deloitte 2020 TPPR nor the BKD Review address these factors. In fact, in agreeing with Deloitte's selection of the EPS method, BKD simply block-quoted from the Deloitte 2020 TPPR and then concluded, "[g]iven that both GCU and GCE make significant contributions to the creation of intangible assets and the lack of comparable transactions/comparable companies, a profit split-based method appears to be reasonable in this instance." BKD Review at 13.[22] With respect to the profit factor, if GCU wants to stand by Deloitte's and BKD's characterization of it as earning profits that can be "split," then it seems to be acknowledging that it operates as a for-profit.

The common thread running through both the Deloitte 2020 TPPR and the BKD Review transfer pricing analysis is that "no comparables" exist. Yet the OECD defines47 transactions as "comparable if none of the differences between the transactions could materially affect the factor being examined in the methodology (e.g., price or margin), or if reasonably accurate adjustments can be made to eliminate the material effects of any such differences." OECD Guidelines (2017) at 24. OECD's revised guidance on the transactional profit split method further explains:

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[21] The "steps" identified by Deloitte principally focus on the risk of fixed costs, defined as costs that do not vary with the quantity of services provided. Deloitte 2018 TPR at 1, 33-35; Deloitte 2020 TPPR at 1, 39-44. Deloitte claims that the party assuming fixed costs assumes greater risk justifying a greater share of profits. Deloitte 2018 TPR at 5; Deloitte 2020 TPPR at 10-11. Deloitte apparently determined which costs associated with the seven revenue-generating activities were fixed costs and what share of fixed costs Gazelle and GCE were contractually obligated to pay. Deloitte 2018 TPR at 33; Deloitte 2020 TPPR at 44 (and Appendix C at 11 and Appendix D at 11). The Deloitte 2020 TPPR (as did the Deloitte 2018 TPR) also appears to give significant weight in its determination of fixed costs to its consideration of off-balance sheet assets ("OBSA"). Deloitte states that it considered historic trial balance sheet financial data to "capture any fixed costs incurred in the past accounting period that are tied to the revenue generated in FY 2018 and FY 2019. These are the costs that contribute to the generation of OBSAs." Deloitte 2020 TPPS at 39; *see also* Deloitte 2018 TPR at 32. As noted previously in the Decision, because all of those earlier costs were incurred during the years prior to the separation, Deloitte's calculation of fixed costs gives GCE – and not GCU – the benefit of those historical costs that were incurred before the services function was separated on July 1, 2018. Indeed, Deloitte divides the OBSAs into three categories: marketing; technology development; and executive strategy and explains: "further refinement of these OBSAs is not as reliable due to the interrelated nature of GCE's business model." Deloitte 2020 TPPR at 39-40.

[22] Although BKD more thoroughly recounted ***how*** Deloitte applied each step of the method (*e.g.,* how it identified economic risks), it failed to analyze the appropriateness of selecting the EPS method in the first place.

> In general, it will tend to be the case that the presence of factors indicating that a transactional profit split is the most appropriate method will correspond to an absence of factors indicating that an alternative transfer pricing method—one which relies entirely on comparables—is the most appropriate method, determined in accordance with paragraph 2.2 of these Guidelines. ***Put another way, if information on reliable comparable uncontrolled transactions is available to price the transaction in its entirety, it is less likely that the transactional profit split method will be the most appropriate method. However, a lack of comparables alone is insufficient to warrant the use of a transactional profit split.*** See paragraph 2.128.

C.2.3 ¶2.143, OECD Guidelines (2018) (emphasis added). Paragraph 2.128 states:

> A lack of closely comparable, uncontrolled transactions which would otherwise be used to benchmark an arm's length return for the party performing the less complex functions should not *per se* lead to a conclusion that the transactional profit split is the most appropriate method. Depending on the facts of the case, ***an appropriate method using uncontrolled transactions that are sufficiently comparable, but not identical to the controlled transaction is likely to be more reliable than an inappropriate use of the transactional profit split method***. …

C.2.2. ¶2.128, OECD Guidelines (2018) (emphasis added). Paragraph 2.129 cautions: "if independent parties engaged in comparable transactions are found to make use of other pricing methods, this should also be taken into account in determining the most appropriate transfer pricing method." C.2.2. ¶2.129, OECD Guidelines (2018). None of these additional provisions of the OECD Guidelines were discussed by either Deloitte or BKD.

BKD states that it reviewed 24 agreements between service providers and higher educational institutions and that of those, ten agreements used a revenue-sharing fee structure. According to BKD, the percentage of revenues used in those agreements ranged from 12.5% to 80%, with an interquartile range of 45.9% to 62.4%, with a median of 50.0%. BKD Review at16. BKD then states:

> We note that the Preparer's concluded TY 2018 range of revenue split in the Transfer Pricing Study of 60.22% to 60.71% falls within the interquartile range of the ten agreements. Further, we note that the Preparer's concluded TY 2019 range of revenue split to the renderer of the services in the Transfer Pricing Study of 59.32% to 59.72% also falls within the interquartile range of the agreements. Accordingly, the Preparer's concluded results for TY 2018 and TY 2019 in the Transfer Pricing Study do not appear unreasonable.

BKD Review at 16. BKD's analysis is striking for what it does ***not*** address. For example, what is the relationship between the institution and the service provider – were they formerly one and the same? Why is it reasonable to charge GCU a fee equal to 59.9% - 68.8% of revenues (as described in ARMSA Exhibit D §3) when the range of the

ten agreements BKD cites included a low of 12%?[23] Why is it reasonable to charge GCU that fee when the median of the ten agreements reviewed is 50%? Does the increase over the low of 12% or the median of 50% indicate the purpose of the ARMSA is to benefit GCE stockholders?

And what are the fee structures in the remaining 14 agreements? Why were those fee structures not analyzed as alternatives to the revenue sharing fee used in the ARMSA? The failure to do so is especially concerning, given that GCE has very recently advised its shareholders and the public that "[i]n recent years, an alternative unbundled fee-for-service model has emerged, in which the companies offer the same services, or some subset of services, ***for the market price of those services***." 8/28/20 GCE 8-K at 9 (emphasis added). Neither the Deloitte 2020 TPPR nor the BKD Review reflect any examination of such alternative models – nor did they appear to analyze unbundled services to compare them to the components of the services provided under the ARMSA.

IV. THE DEPARTMENT'S RECONSIDERATION DETERMINATION

In both its initial request for nonprofit status and in its request for reconsideration of the Decision, GCU has pointed to the fact that Gazelle is an Arizona nonprofit corporation, the IRS granted Gazelle tax-exempt status and GCU's accreditor (the Higher Learning Commission ("HLC")) has approved nonprofit status. However, unlike the IRS's initial grant of tax-exempt status and state organization as a nonprofit, the Department's determination of nonprofit status considers the structure and planned operations of the institution when its owner(s) apply for that change of status, and seeks to ensure that a nonprofit institution's revenues – a good portion of which are generated from Title IV funds – are primarily devoted to the mission of the school and not to other parties, including (as here) the prior owner and its shareholders. The Department makes its own determination regarding nonprofit status, and the fact that HLC may have reached a different conclusion is neither binding nor persuasive.

Although the revenue sharing percentages have changed somewhat under the ARMSA, the basic structure whereby a substantial portion of GCU's revenues benefits GCE remains unchanged. Based on the tax authority cited in the Decision, the Department has determined that, under the ARMSA, GCU will still not meet the requirement that both the primary activities of the organization and its stream of revenue benefit the nonprofit itself. The Deloitte 2020 TPPR and the BKD Review have not convinced the Department otherwise.

GCU has repeatedly tried to convince the Department that it should be granted nonprofit status because of GCU's positive accomplishments on campus and in the community. Although those

[23] Deloitte recognizes that curriculum is "the heart of any learning institution." (Deloitte 2018 TPR at 26, Deloitte 2020 TPPR at 27). However, as noted above, Curriculum Services and Faculty Operations services have been eliminated from the ARMSA, and therefore, the risks related to curriculum and faculty are primarily borne by GCU. Deloitte 2020 TPPR at 27. Presumably, both a strong curriculum and talented faculty – the risks and costs of which are borne by GCU -- are primary drivers of enrollment, and thereby, GCU's revenue. Yet, the Monthly Fee payable to GCE under the ARMSA is 68.8% of Tuition and Fee Revenue (or 59% of Adjusted Gross Revenue). Deloitte and BKD do not discuss why the revenue sharing percentages were not significantly reduced given this change in risk and responsibility.

activities are worthwhile and commendable, they are not remarkable for an institution of higher education – whether proprietary, nonprofit, or public. And they do not change the Department's conclusion that the arrangement between GCU and GCE under the ARMSA precludes approval of GCU's request to convert to nonprofit status.

Beyond the continuing revenue stream to GCE, the Decision also noted your (Brian Mueller's) dual roles as a concerning factor. You remain the President of GCU and the Chief Executive Officer of GCE. You are also Chairman of GCE's board. In a Memorandum to the Board of Directors of GCE from the Board of Directors of GCU (updated as of January 7, 2020), GCU's Board stated, "[g]iven President Mueller's critical importance to the ongoing operations of the University, we are not willing to concede this point and we intend to reiterate our insistence to the Department that President Mueller retain his position as President of the University." Although the Department is not directing GCU to remove you as President of the University, your multiple roles continue to be of concern to the Department. Of course, nothing would prevent you from severing ties with GCE if you (and the GCU Board) thought it was more important for you to stay with GCU instead of serving in two potentially conflicting positions. As the Decision explained regarding your dual role of running both GCU and GCE (and as one of GCE's shareholders):

> [A]s the CEO of GCE, [Mr. Mueller] is the key executive responsible for providing the services under the MSA, with duties of loyalty to shareholders of GCE. Yet, as the Institution's President he will have responsibility to manage matters large and small with its primary service provider, notwithstanding the appointment of a Designee and the independent trustees who comprise the MSA Committee. Given those obviously conflicting loyalties, and the breadth of the services provided under the MSA, the Department is not satisfied that these structures are sufficient to ensure that Mr. Mueller's undivided loyalty is to the Institution.

Decision at 15. The Decision also noted the Department's skepticism that any nonprofit could outsource the number and type of institutional functions that Gazelle has and still be deemed to operate the Institution. Curriculum Services and Faculty Operations have now been transferred to GCU. Given the Department's conclusion in this reconsideration determination that the continued revenue stream under the ARMSA (if executed) would prevent the Department from approving GCU's requested conversion to nonprofit status, there is no need for the Department to re-examine this issue.[24]

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[24] Given the Department's conclusion that the continuing revenue stream to GCE (whether under the MSA or the ARMSA) prevents the Department from approving the requested conversion to nonprofit status, this reconsideration determination is not based on an examination of the purchase price valuation. The BKD 2018 Valuation and the BKD 2020 Valuation conclude that the range of value for the purchased assets was between $1,100,000,000 to $1,400,000,000 which exceeded the purchase price of $877,459,000. However, as noted in the Decision, at a GCE board meeting immediately prior to the closing of the Transaction, Mr. Bachus (GCE Chief Financial Officer) explained that "[w]hile the purchase price for the assets will be at book value, which approximates fair value based on the appraisals received … it was expected that Gazelle would seek a new appraisal post-closing on certain assets including the land being sold. To the extent the new appraisal showed a higher fair value for those assets, [GCE] would not get the benefit from that." GCE June 28, 2018 Board Minutes at 1. However, Mr. Bachus further explained that "a higher fair value, and a resulting margin between fair value and book value, benefitted Gazelle in

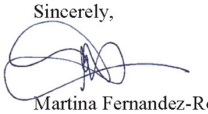
V. CONCLUSION

For the reasons discussed above, GCU does not satisfy the Department's definition of a nonprofit. Accordingly, the Department rejects GCU's request to reconsider the Department's decision denying GCU's request to convert to nonprofit status.

As explained in the Decision, GCU's status as a proprietary institution is for purposes of its participation in the Title IV, HEA programs. The Department does not take a position with respect to Gazelle's non-profit 501(c)(3) status with the Internal Revenue Service. However, GCU/Gazelle must not engage in any advertising or other communications that refer to GCU as a "nonprofit." Such statements are confusing to students and the public, who may interpret such statements to mean that the Department has approved GCU as a nonprofit under its regulations. The Department does not take a position regarding statements that GCU or Gazelle may make about Gazelle's status as a 501(c)(3) tax exempt organization.

The PPPA under which the Institution has been operating since November 14, 2019 continued the prior approval for GCU to participate under a proprietary status. The proprietary status for GCU's continued participation is therefore unchanged. GCU is reminded that it must meet the Title IV, HEA programs reporting and program eligibility requirements applicable to for-profit institutions, including the 90/10 eligibility requirements described in 34 C.F.R. §668.28.

Sincerely,



Martina Fernandez-Rosario, Director
School Eligibility and Oversight Service Group

cc: The Higher Learning Commission (*email: Barbara Gellman-Danley, President - president@hlcommission.org, Anthea Sweeney, VP for Legal and Governmental Affairs - asweeney@hlcommission.org*)
AZ State Board for Private Postsecondary Education (*email:* Kevin.LaMountain@azppse.gov)
New Mexico Higher Education Department (*email: exec.admin@state.nm.us*)
IRS
Attn: EO Classification
MC 4910 DAL
1100 Commerce Street
Dallas, TX 75242
eoclass@IRS.gov

connection with its composite score." *Id.* Although no details are provided, Mr. Bachus apparently further explained "why a good composite score for Gazelle ultimately benefited the Company [*i.e.*, GCE]." *Id.* at 1-2.

November 6, 2019

UPS Tracking #
1ZA879640294525311

Mr. Brian Mueller
President
Grand Canyon University
3300 West Camelback Road
Phoenix, AZ 85017

Re: Review of the Change in Ownership and Conversion to Nonprofit Status of Grand Canyon University (OPE ID 00107400)

Dear Mr. Mueller:

At your request, the U.S. Department of Education ("Department"), Federal Student Aid has conducted a review of the change in ownership application for Grand Canyon University, OPEID 00107400 ("Institution" or "GCU").

Prior to July 1, 2018, GCU was owned and operated by Grand Canyon Education, Inc. ("GCE"), a Delaware publicly traded corporation. By way of a July 1, 2018 Asset Purchase Agreement ("APA"), GCE sold its School Assets (as set forth in APA at Recital B and as defined in APA §2.1) to Gazelle University ("Gazelle"), an Arizona nonprofit corporation ("the Transaction"). Gazelle and GCE are hereinafter collectively referred to as the "APA Parties."[1] Prior to the Transaction, Gazelle was granted tax-exempt status by the Internal Revenue Service. GCU seeks approval of its change in ownership and request to convert to nonprofit status for purposes of its participation in Title IV, HEA programs. Although the parties had requested the Department to conduct a pre-acquisition review, the Transaction closed on or about July 1, 2018, prior to completion of the Department's pre-acquisition review. This letter constitutes the Department's post-closing decision on the change in ownership ("CIO") and requested change of status from proprietary to nonprofit.

Following the closing of the Transaction, GCU timely submitted a materially complete application and other documentation to satisfy the regulatory requirements set forth at 34 C.F.R. § 600.20(g) and (h). GCU has also submitted additional documentation and information as

[1] After the Transaction, Gazelle changed its name to Grand Canyon University. In documents submitted to the Department, Gazelle has also been referred to as "GCU" and the "New GCU." To avoid confusion, the Department will refer to the APA Parties as "Gazelle" and "GCE," based on the names used in the introductory paragraph of the APA: "Gazelle University" (the purchasing entity) and "Grand Canyon Education, Inc." (the selling entity). The sole member of Gazelle is Grand Canyon Foundation.

requested by the Department during its review.[2] A temporary provisional program participation agreement ("TPPPA") was issued to GCU on August 20, 2018, and GCU has been participating on a month to month basis since September 1, 2018.

I. BACKGROUND ON THE TRANSACTION

A. Overview of the APA

Pursuant to the APA, Gazelle purchased the School Assets,[3] which included Campus Property, certain Personal Property, Assumed Contracts, Course Materials and intellectual property embodied in the Course Materials and other identified intellectual property, and other assets, as listed in APA §2.1. Under APA §2.2, Services Assets remained the property of GCE, and include assets not listed in APA §2.1 or the related schedules, Retained Property (including GCE's headquarters building at 2600 West Camelback Road), and other assets (including cash and cash equivalents) as further described in APA §2.2.

APA §2.3 identifies the liabilities assumed by Gazelle ("Assumed Liabilities") and APA §2.4 identifies the liabilities that are not assumed by Gazelle ("Excluded Liabilities"). Significantly, the APA purports to insulate Gazelle from assuming Liabilities arising under Educational Laws.

The Purchase Price for the Transaction includes the assumption of the Assumed Liabilities, and payment of the Base Purchase Price ($853,068,386.00 "plus []$1.00") and the Invested Amount.[4] APA §3.1. The Base Purchase Price was paid by Gazelle's delivery of the Senior Secured Note and Credit Agreement ("CA"). APA §3.2. Notably, the lender for the Transaction is GCE. The loan is secured by a first lien on all of Gazelle's property and the property of all of Gazelle's subsidiaries, which are also guarantors of the loan. CA § 7.12, CA § 7.13. GCE also provides funding for Gazelle's operations under the Credit Agreement. CA § 2.01.

B. Overview of the Master Services Agreement

As part of the Transaction, the APA Parties also entered into a Master Services Agreement ("MSA") pursuant to which GCE provides Services to Gazelle/GCU and Gazelle/GCU pays a part of its revenues to GCE. Exhibit B to the MSA describes the Services that GCE provides to Gazelle. Gazelle further agreed that GCE is the exclusive provider (during the Term of the MSA) of certain services, identified in the MSA as "Exclusive Services," for which Gazelle agrees it will not contract with any third party absent GCE's approval (which is subject to GCE's sole discretion). MSA §3.1. The Exclusive Services are the following: Marketing (MSA Exh. B

[2] Some information in this letter is shaded in grey as a result of the APA Parties' designation of that information as confidential, consistent with the Department's directions when it requested documents from the APA Parties.

[3] Words capitalized herein but not defined have the meaning set forth in the APA and/or the Master Services Agreement entered into as part of the Transaction.

[4] At closing, Gazelle paid an additional $17 million, rounded, representing amounts contributed to, or paid by, GCE in connection with GCU in the two months prior to the closing of the Transaction. *See* Purchase Price Adjustment Certificate.

§1); Enrollment Services and Budget Consultations (MSA Exh. B §2); Student Support Services Counseling (MSA Exh. B §3); and Technology (MSA Exh. B §12). The non-exclusive services are the following: Document Intake (MSA Exh. B §4); Student Records Management (MSA Exh. B §5); Curriculum Services (MSA Exh. B §6); Accounting Services (MSA Exh. B §7); Financial Aid Services (MSA Exh. B §8); Procurement Services (MSA Exh. B §9); Audit Services (MSA Exh. B §10); Human Resources (MSA Exh. B §11); Business Analytics Services (MSA Exh. B §13); Faculty Operations (MSA Exh. B §14); and Compliance Monitoring and Audits (MSA Exh. B §15). The MSA provides that GCE shall at all times provide at least three services in addition to Enrollment Services. MSA Exh. B (introductory paragraph). However, even if services are provided by a third party, Gazelle is still obligated to pay GCE its Services Fees described in MSA §5. *See* MSA §3.1. GCE also has the right to subcontract any of the services, as described in MSA §3.2.

Pursuant to MSA §5.1, the Services Fee is determined and paid in accordance with MSA Exhibit D which provides that Gazelle is required to pay GCE a fee that is equal to 60% of Gazelle's Adjusted Gross Revenue (excluding charitable contributions or other gifts used for purposes other than payment of tuition and fees for students).[5] Adjusted Gross Revenue consists of all revenue (net of refunds and scholarships accounted for as a discount to tuition) received by Gazelle or its Affiliates from the following sources:

(a) Tuition (including tuition funded by third party sources and charitable contributions;
(b) Fee revenue from students for use of the online communications portal ("the Platform");
(c) Fee revenue from students and their related activities
(d) Fee revenue from students for use of the Canyon Connect learning resources platform;
(e) Fee revenue from students for student housing;
(f) Fee revenue from students for meal plans and other food services; and
(g) Other revenue including revenue from: (i) sales of athletic tickets; (ii)the operation of the Grand Canyon University Hotel and Conference Center; (iii) the operation of the Maryvale Golf Course; (iv) the operation of the Grand Canyon University Arena; and (v) the operation of Canyon Enterprises (apparel sales and other businesses).

MSA Exh. D §1. The MSA does not provide any cap on the total amount of the Services Fee that must be paid to GCE in any year or cumulatively over the years.

Although the Services Fee is subject to review and adjustment pursuant to Exh. D §2(b), the first Optional Adjustment Date does not occur until the tenth anniversary of the Effective Date, and thereafter occurs on the first date of each Renewal Term (*i.e.,* at five-year increments thereafter). Exh. D at 2(b) and (c), and MSA §6.1. The Initial Term of the MSA is 15 years, with automatic renewals thereafter for successive five years terms ("Renewal Term") apparently in perpetuity. MSA §6.1. Either party can elect not to renew at the end of the Initial Term or any Renewal Term, but if Gazelle exercises that right, on the last day of such term it must pay GCE a Non-Renewal Fee equal to 50% of the aggregate Services Fees paid or payable for the trailing twelve month period ended as of the end of the immediately preceding month. MSA §6.2 and MSA

[5] The Services Fee is exclusive of all Tax, such that Gazelle must "pay and be liable for any and all Tax imposed on, sustained, incurred, levied and measured by the cost, value or price of the Services" provided under the MSA. MSA §7.1.

Exh. A at A-5 (definition of Non-Renewal Fee). Although Gazelle has the right to terminate the MSA during the Initial Term, it must give notice 18 months in advance, and cannot elect do so before July 1, 2025 (seventh anniversary) or the date by which the Senior Secured Note is paid in full – whichever is later. MSA §6.3. If Gazelle exercises that right, on the effective date of termination it must pay GCE an Early Termination Fee equal to 50% of the aggregate Services Fees paid or payable for the trailing twelve-month period ended as of the end of the immediately preceding month. MSA §6.3 and MSA Exh. A at A-3 (definition of Early Termination Fee). The MSA may be terminated as a result of a Performance Failure (subject to notice and cure) only if the breach in performance has a materially adverse effect on the Non-Defaulting Party or its business. MSA §6.4.[6]

The MSA provides Gazelle with the right to assume Back Office Services (defined in MSA Exh. A at A-2 as Accounting Services, Financial Aid Services, Human Resources and Technology[7]), and if it does, Gazelle and GCE agree to negotiate an adjustment to the Services Fee to account for any transfer of costs. MSA §6.9. But the MSA requires Gazelle to assume those Back Office Services directly, so that it cannot retain any other service provider to perform the Back Office Services. MSA §6.9. By way of example only, this would preclude Gazelle from retaining an outside payroll provider if it assumed Accounting Services, despite the fact that GCE performs payroll services through a third-party payroll provider. *See* MSA Exhibit B §7.1.

II. REPORTS

The Department has also been provided with several reports and valuations that were commissioned to support the Transaction, including reports from Barclays Capital Inc. ("Barclays") and Deloitte Tax, LLP ("Deloitte).

A. Barclays

The report from Barclays ("the Barclays Report") is dated April 26, 2018 and entitled "Project Gazelle." It is marked "Preliminary/Subject to further review, diligence and revision." The Barclays Report describes the contents of the report as containing "material that was provided to the Board of Directors … of Gazelle [identified as 'the Company']."[8] On August 29, 2019,

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[6] The MSA limits GCE's liability for any claim (other than one related to Confidentiality or Intellectual Property Rights, or based on GCE's gross negligence or willful misconduct) to the amount paid by Gazelle to GCE in the most recently completed three month period, and Gazelle "releases and waives any claim against GCE in excess of such amount, to the extent permitted by Applicable Law." MSA §11.

[7] "Technology" is designated as both a Back Office Service (MSA Exhibit A at A-2) and one of several Exclusive Services (MSA Exhibit B §12, identified with an *).

[8] While the Barclays Report states that it was prepared for/ provided to the Board of Directors of Gazelle (cover and at 1), Barclays was engaged by GCE and provided its analysis to the GCE Board as set forth in various places in GCE's board minutes. For example, both the November 21, 2017 and December 6, 2017 board minutes note the engagement of Barclays as GCE's "financial advisor." On February 21, 2018 the GCE Board and representatives of Barclays discussed how Barclays could best help the Board, and the potential merits and risks of the Transaction or "remaining as a for profit education company." *See*

Jonathon Glass, (counsel for GCU) provided the Department with a "follow-on" report from Barclays which was provided to the board of GCE "to confirm certain information in the final days before the transaction closed ("Barclays Update")."[9]

The Barclays Report reviews the strategic options available to GCE, including separation of the Institution and GCE, with GCE as the services provider as an alternative to the status quo. One of the considerations Barclays notes in regard to separation is "significant concentration of revenue for GCE and reduced influence over University." Barclays Report at 14. The Barclays Report provides a side-by-side comparison of the Institution's operating costs in 2019 based on two different assumptions – (1) GCE continues to own the Institution and incurs the costs to operate the Institution or (2) the Transaction closes, and Gazelle is required to hire GCE to perform some of the operational activities. *See* Barclays Report at 33. The comparison shows that under the planned separation (and as effectuated on July 1, 2018) the costs to operate the separated Institution increase from $810 Million to $1.496 Billion for fiscal year 2019, solely as a result of the Service Fees paid to GCE. Barclays Report at 33. The increase is not because GCE will be providing new or additional services, but solely because the MSA requires Gazelle to pay GCE the Services Fee.[10]

Although the Barclays Report (dated April 26, 2018) assumes a 65%/35% revenue split on most items, and a different split on housing (20%/80%), meals (5%/95%) and Canyon Connect (5%/95%), the executed MSA provides for a straight 60%/40% split and includes sources of revenue that are not included in the Barclays Report, including revenue from Gazelle Arena. These differences would seem to only exacerbate Barclays' assessment that the separation of the servicing functions from the Institution will result in a significant increased cost for the operation of the Institution, with those increased funds flowing to the benefit of its prior owner, GCE. Under the assumptions in the Barclays Report, the Services Fees under the MSA (estimated at $697 million for fiscal year 2019), *see* Barclays Report at 33, are a 67% markup on GCE's $416 million costs of performance. No evidence has been presented to the Department that would suggest that the services provided post-Transaction would be markedly different or more

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February 21, 2018 GCE Board Minutes at 2. The Barclays Report was provided to the GCE Board and discussed at the meeting held on April 26, 2018. *See* April 25-26, 2018 Minutes at 3. This is consistent with references in the Barclays Report to the Company's "shareholders." By contrast, the Gazelle board minutes do not reflect any discussion of the Barclays Report, and it is not clear whether the Barclays Report was provided to the Gazelle board prior to the approval of the Transaction.

[9] In his August 29th e-mail transmitting the Barclays Update, Mr. Glass explained that the Gazelle/GCU board "did not see or receive the [Barclays Update] until following up with GCE re [the Department's August 26, 2019] request." The Barclays Update was discussed with the GCE Board at its June 20, 2018 meeting. *See* June 20, 2018 GCE Board Minutes at 3-4.

[10] The cost for GCE's services is particularly high considering that GCE is not even performing the entirety of the operational activities that were previously performed at a cost of $810 million. Some services are performed by Gazelle.

expensive to provide.[11] Once the Services Fees are added, GCE will incur 28% of total expenses ($416,000,000 of $1,496,000,000) and Gazelle will incur 72% of total expenses ($1,080,000,000 of $1,496,000,000), as can be extrapolated from the information contained in the report:

OPERATING EXPENSE SPLIT POST-TRANSACTION			
Expenses in Millions $	**Total**	**GCE Share under MSA**	**Gazelle Share as Owner under MSA**
Instructional	476	105	371
Marketing & Promotional	125	125	0
Admissions Advisory	149	149	0
General & Administrative	49	37	12
Subtotal	**799**	**416**	**383**
Share %	**100%**	**52%**	**48%**
Gazelle Fees under MSA Agreement	697	0	697
Total	1496	416	1080
Share %	**100%**	**28%**	**72%**

See Barclays Report at 33 (source of information for the above chart).

B. Deloitte

Perhaps trying to circumvent the somewhat obvious conclusion that under the MSA the Institution costs an additional $697 Million to operate in the first fiscal year, the parties have also provided the Department with a Transfer Pricing Report for the Fiscal year ending December 31, 2018, which was prepared by Deloitte ("Deloitte Report"). Deloitte performed an "Economic Profit Split" ("EPS") analysis in connection with the services provided by GCE to Gazelle during the 15 year period "beginning with fiscal year ending December 31, 2018," and the transfer of certain intangible assets and license of the technology platform from GCE to Gazelle during FY 2018. Deloitte Report at 1. An EPS is an analysis of what each party to a common economic enterprise contributes to revenue-generating activities. Deloitte Report at 1. The Department was provided with two Deloitte Reports, one clearly marked "Draft" and a virtually identical version. Neither version is signed, identifies the person(s) responsible for the report's conclusions, nor provides an affirmation from an appropriate person that the report has been prepared according to the applicable standards. However, the Department has confirmed with counsel for GCU that the version of the Deloitte Report that is not marked as a draft is the final version of the report.

[11] For purposes of this analysis, the Department assumes that the payments owed to GCE under the Credit Agreement are fair value. When those payments are included in the analysis, GCE receives 95% of Gazelle's revenue.

The first step in Deloitte's EPS analysis was to identify the "assets and activities" of the enterprise that generate revenue. *Id.* at 1. Based "on fact finding discussions with key management personnel" – which at the time would have consisted solely of GCE's management – Deloitte found that the Institution generates revenue from seven activities.[12] Deloitte concluded that virtually all of the Institution's revenue-generating activities are those that will be wholly or partially performed by GCE under the MSA. *Id.* at 19-30. Because Deloitte was working from a prior draft of the MSA, its conclusion in this regard is not accurate. *See* discussion below regarding revenue from the arena, athletic tickets, etc.

Significantly, Deloitte did not identify the Institution's physical campus as revenue-generating, which is at odds with statements made by GCE to its shareholders. Notwithstanding the campus facilities' undeniable contribution to revenue, Deloitte did not consider it as a revenue-generating asset. According to GCE's 2017 Annual Report to shareholders, one of the competitive factors in the post-secondary education market is "the quality of the ground campus facilities." GCE 2017 Annual Report at 15. In fact, GCE told its shareholders that one of the primary factors for its revenue increase in 2017 was due to "ancillary revenues resulting from the increased traditional student enrollment (e.g. housing, food, etc.)" and that a higher percentage of its students were residing on campus. *Id.* at 48. GCE noted that its campus was also valuable to "provide our online students, faculty, and staff with a sense of connection to a traditional university." *Id.* at 14. To continue increasing revenues, GCE planned to enhance the reputation of the ground campus by expanding campus infrastructure. *Id.* at 14. According to the figures provided in the Barclays Report, over 27% of the Institution's tuition revenue is from on-campus students. *See* Barclays Report at 33.

According to Deloitte, the next step in the EPS analysis was to identify risks associated with the revenue-generating activities and assets and determine which party: contractually assumes the risk; encounters upside or downside consequences of the risk; controls the risk; mitigates the risk; and has the financial capacity to assume the risk. Deloitte Report at 5-6. Deloitte identified several risks associated with the seven revenue-generating activities it considered. Those risks include negative perception of marketing campaigns, failure to develop course content that will prepare students to complete the course work, failure to attract prospective students, software bugs, inability to recruit and hire effective faculty, and workplace injuries, among others. *Id.* at 26-30. In each instance, the Deloitte Report simply notes that the fixed costs are borne by both GCE and the Institution, and that both face risks related to the various functions. However, the Deloitte Report wholly fails to assess which party assumes these risks, encounters upside or downside consequences of these risks, controls these risks, mitigates these risks, or has the financial capacity to assume these risks. As the Deloitte Report states, this failure renders Deloitte's EPS analysis "incomplete." *Id.* at 5.

The principal focus of the Deloitte Report is the risk of fixed costs, defined as costs that do not vary with the quantity of services provided. *Id.* at 1, 33-35. Deloitte claims that the party assuming fixed costs assumes greater risk justifying a greater share of profits. *Id.* at 5. Although this information is not detailed in the report, Deloitte apparently determined which costs

[12] Based on discussion with "key management personnel," Deloitte concluded that the following functions constituted the "key value creating drivers": marketing; curriculum development; admissions advisory; IT and technology; back-office support; faculty services; and Executive Leadership. Deloitte Report at 19.

associated with the seven revenue-generating activities were fixed costs and what share of fixed costs Gazelle and GCE were contractually obligated to pay. *Id.* at 33. Nowhere does the Deloitte Report identify the specific costs Deloitte deemed fixed, let alone provide any analysis supporting the conclusion as to which party is responsible for paying such costs. Instead, the Deloitte Report simply states that GCE is responsible for paying approximately $270 million in fixed costs for the seven revenue-generating activities and that Gazelle is responsible for paying approximately $164 million. Deloitte Report at 36. The Deloitte Report is wholly devoid of any information that would allow the Department to assess the accuracy or reasonableness of this conclusion.

The Deloitte Report also appears to give significant weight in its determination of fixed costs to its consideration of off-balance sheet assets ("OBSA"). Deloitte apparently considered historic trial balance sheet financial data (from FY 2013 through FY 2017) to "capture any fixed costs incurred in the past accounting period that are tied to the revenue generated in FY 2017. These are the costs that generate OBSAs." Deloitte Report at 32. Presumably, because all of those earlier costs were incurred during the years prior to the separation, Deloitte's calculation of fixed costs gives GCE – and not Gazelle – the benefit of those historical costs that were incurred before the services function was separated on July 1, 2018.

GCE has recognized that an important competitive factor in the post-secondary education market is "qualified and experienced faculty." 2017 Annual Report at 15. As GCE described it, the high quality of the Institution's faculty contributed to student retention and was "critical" to the Institution's success. *Id.* at 6, 9. Although Deloitte included "faculty services" as one of the seven "key value driving factors," it is unclear how it evaluated the faculty's contribution to revenue generation or risks related thereto, given that Gazelle is responsible for most of the costs of "Instructional Cost and Services" (i.e.,. $371 Million for Gazelle and $105 Million for GCE). *See* Barclays Report at 33. The Deloitte Report does not include any discussion of whether or not Gazelle was responsible for fixed-cost risk in connection with the Institution's faculty.

In addition, because the Deloitte Report failed to identify the Institution's campus as a revenue-generating asset, it failed to consider the fact that Gazelle is incurring significant fixed-cost risk in connection with the campus. Gazelle owes a lump sum payment to GCE on July 1, 2025 of $853,068,386, which represents the purchase price for the campus. CA §1.01 (defining "Term Loan Commitment" and "Maturity Date") and §2.07(c). Gazelle also owes GCE a monthly interest payment of approximately $4.2 million. *Id.* §1.01 (defining "Applicable Rate" and "Interest Payment Date") and §§2.08 (a) and (f) (interest is payable at the Applicable Rate on each Interest Payment Date).

Despite the fact that the purpose of the Deloitte Report was to determine a reasonable range of remuneration by Gazelle to GCE as a percentage of Gazelle's Adjusted Gross Revenue, the Deloitte Report was premised on the inaccurate assumption that Adjusted Gross Revenue for calculating the Services Fees excluded sales of athletic tickets, operations of Gazelle's hotel and conference center, the operation of the Maryvale golf course, and the operation of Grand Canyon University Arena. *See* Deloitte Report at 3, and at n.4, and at 6. Apparently without considering these sources of revenue and the risks/costs related thereto, Deloitte concluded that the reasonable split is 62%/38% or 63%/37%. Under the executed MSA, all of those sources of revenue are included in calculating the 60% Services Fees. MSA at Exhibit D. In short, the

revenue sources Deloitte uses to calculate each parties' percentage contribution to the seven revenue-generating activities identified is based on fundamentally flawed assumptions.

It also bears mentioning that the main opinions in the Deloitte Report do not appear to be based on information that Deloitte independently tested and analyzed on behalf of Gazelle. Rather, those opinions in key areas appear to have been based on information supplied by GCE management.[13] For example, Deloitte states that it identified revenue-generating activities based on "fact finding discussions with key management personnel," that the classification of fixed costs was made "in conjunction with GCE management," and that the calculation of the share of fixed costs Gazelle and GSA would each pay under the MSA was determined by "Deloitte Tax and GCE." *See, e.g.,* Deloitte Report at 19, 33.

III. THE DEPARTMENT'S REQUIREMENTS FOR NONPROFIT STATUS

The Department regulations identify certain covered transactions for an instituton that constitute a change in ownership which require the institution to apply for and obtain approval from the Department to continue participating in Title IV, HEA programs. These include instances where an institution is sold, is merged with one or more eligible institutions, experiences a change in the ownership of the controlling stock, has a transfer of assets that comprise a substantial portion of the education business of the institution, or has a change in status as a for-profit, nonprofit, or public institution. 34 C.F.R. § 600.31(d).

To establish eligibility and to continue participation in Title IV, HEA programs, an institution must demonstrate to the Department that, after the change, the institution qualifies to be certified to participate under 34 C.F.R. Part 668, Subpart B pursuant to 34 C.F.R. § 600.31(a)(3)(ii). *See also* 34 C.F.R. § 600.20(g) and (h) (requirements for temporary provisional certification following a change in ownership which results in a change of control).

Because Gazelle seeks to participate in Title IV, HEA programs as a nonprofit institution, it must meet the Department's requirements for that status. The Higher Education Act ("HEA") defines an institution of higher education as "a public or other nonprofit institution." HEA §101(a)(4), 20 U.S.C. §1001(a)(4); HEA §102(a)(1), 20 U.S.C. §1002(a)(1). The Department regulations define a nonprofit institution as an institution that:

(i) Is owned and operated by one or more nonprofit corporations or associations, no part of the net earnings of which benefits any private shareholder or individual; and

(ii) Is legally authorized to operate as a nonprofit organization by each State in which it is physically located; and

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[13] Although the Deloitte Report indicates at p. 19 that it conducted interviews with "University personnel," it appears to be referring to "management" which it describes as "GCE management."

(iii) Is determined by the Internal Revenue Service to be an organization to which contributions are tax deductible under 26 U.S.C. §501(c)(3) of the Internal Revenue Code (26 U.S.C. § 501(c)(3)).

34 C.F.R. §600.2. [14]

Gazelle, an Arizona nonprofit corporation, now owns GCU, satisfying the "owned by one or more nonprofit" entity requirement of the Department's definition of a nonprofit. Gazelle is also legally authorized to operate a private postsecondary degree-granting institution in Arizona, the only location where GCU is located. Arizona law does not require separate approval to operate as a nonprofit, so GCU meets the requirement of legal authority to operate under subsection (ii) of the Department's definition. *See* April 27, 2018 Letter from the Arizona State Board for Private Postsecondary Education and Arizona Secretary of State Website on Veteran's Charity Organizations (explaining that only Veteran's Charities are required to register). Gazelle has been granted 501(c)(3) status by the IRS, meeting the requirement of subsection (iii) of the definition. *See* November 9, 2015 IRS Letter 947 for EIN 47-2507725.

The remaining issue (*i.e*, whether GCU is operated by a nonprofit and whether its net earnings benefit any private shareholder or individual) requires a review of relevant authority under the Internal Revenue Code and an analysis of the impact of the MSA on the regulatory requirements.

IV. AUTHORITY UNDER THE INTERNAL REVENUE CODE

The Department's definition of a nonprofit institution mirrors the statutory language for tax exempt organizations found in 26 U.S.C. § 501(c)(3). Under Treasury regulations, the taxpayer has the burden to demonstrate that it is entitled to tax-exempt status pursuant to section 501(c)(3).[15] This includes the requirement for tax exempt entities to meet both an organizational test and an operational test. 26 C.F.R. § 1.501(c)(3)-1(a)(1).

The organizational test requires a nonprofit organization to be organized exclusively for one or more exempt purposes and its articles of organization must: "(a) Limit the purposes of such organization to one or more exempt purposes; and (b) Do not expressly empower the organization to engage, otherwise than as an insubstantial part of its activities, in activities which in themselves are not in furtherance of one or more exempt purposes." 26 C.F.R. § 1.501(c)(3)-1(b). Gazelle's First Amended and Restated Articles of Incorporation are consistent with these limitations.

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[14] Similarly, the HEA defines a nonprofit entity as having "no part of the net earnings of which inures, or may lawfully inure, to the benefit of any private shareholder or individual." HEA § 103(13), 20 U.S.C.A. § 1003(13) (West).

[15] 501(c)(3). Rule 142(a)(1), *Tax Court Rules of Practice and Procedure*; *Bubbling Well Church of Universal Love, Inc. v. Commissioner*, 670 F.2d 104, 106 (9th Cir.1981).

The focus of the operational test is on the prohibition against private benefit and private inurement, and the related Treasury regulations examine both the primary activities of the organization and its distribution of earnings.[16] *See* 26 C.F.R. § 1.501(c)(3)-1(c)(1)(primary activities) and 26 C.F.R. § 1.501(c)(3)-1(c)(2)(distribution of earnings). Although there is significant overlap in the analysis of prohibited substantial private benefit under the primary activities test and private inurement under the distribution of earnings test,[17] the prohibition on private benefit encompasses a greater range of activities. *See Am. Campaign Acad. v. C.I.R.,* 92 T.C. 1053, 1068–69 (Tax 1989)("while the private inurement prohibition may arguably be subsumed within the private benefit analysis of the operational test, the reverse is not true. Accordingly, when the Court concludes that no prohibited inurement of earnings exists, it cannot stop there but must inquire further and determine whether a prohibited private benefit is conferred"). Unlike private inurement, private benefit does not necessarily involve the flow of funds from an exempt organization to a related private party, it can also include other benefits from the activities of the exempt organization *to an unrelated party. See P.L.R. 200914063*, 2009 WL 889714 (IRS PLR Apr. 3, 2009) (citing Rev. Rul. 76-206, 1976-1 C.B. 154 which found that an organization formed to promote broadcasting and classical music in the community created a substantial financial benefit to an unrelated for-profit radio station); see also *Capital Gymnastics Booster Club, Inc. v. C.I.R.,* 106 T.C.M. (CCH) 154 (Tax 2013) ("Impermissible benefit to 'private interests' thus encompasses not only benefit to insiders but also benefits that an organization may confer on unrelated or even disinterested persons, *i.e.,* outsiders").

Under the primary activities test, the existence of even one non-exempt purpose, such as creating a private benefit, if substantial in nature, will destroy the organization's exempt status. *See Intl. Postgraduate Med. Foundation v. C.I.R.*, 56 T.C.M. (CCH) 1140, 1989 WL 3808 (Tax 1989)(the existence of a "single noneducational purpose, if substantial in nature, will destroy the exemption regardless of the number or importance of truly educational purposes") (*citing Better Business Bureau of Washington D.C., Inc. v. United States*, 326 U.S. 279 (1945); *Nat. Assn. of American Churches v. Commissioner*, 82 T.C. 18, 28-29 (1984)). As the United States Tax Court stated in *Intl. Postgraduate Foundation,* "[w]hen a for-profit organization benefits substantially from the manner in which the activities of a related organization are carried on, the latter organization is not operated exclusively for exempt purposes within the meaning of section 501(c)(3), even if it furthers other exempt purposes." *Id.* In concluding that the IRS had properly revoked the petitioner's exempt status, one of the significant findings of the Tax Court was that the owner of the for-profit business "formed the [nonprofit entity] to obtain customers for his tour business."

In looking at payments to a related for-profit enterprise, the focus is on whether "the entire enterprise is carried on in such a manner that the for-profit organization benefits substantially from the operation of the [nonprofit entity]." *Church By Mail, Inc. v. C.I.R.*, 765 F.2d 1387, 1392 (9th Cir. 1985)(citing *Est of Hawaii v. Commr. of Internal Revenue*, 71 T.C. 1067, 1080-81 (Tax

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[16] The final element prohibits the organization from being involved in political or lobbying activities. 26 C.F.R. § 1.501(c)(3)-1(c)(3).

[17] *See Canada v. Commr. of Internal Revenue*, 82 T.C. 973, 981 (Tax 1984) ("In determining whether these conditions are satisfied, the 'operated exclusively for exempt purposes' and the 'private inurement' requirements often substantially overlap").

1979)). Thus, "the purpose and objective to which the income of the [nonprofit entity] is devoted is the ultimate test in determining whether it is operated exclusively for an exempt purpose." *Church By Mail*, 765 F.2d at 1392. In *Church by Mail,* the Ninth Circuit found that the tax court did not err in determining that the church was operated "for a substantial non-exempt purpose of providing a market" for the printing and mailing services provided by the for-profit entity, where the employees of the for-profit spent a considerable portion of their time working on services provided to the church, and where the majority of the church's income was paid to the for-profit for payments on loan principal, interest, and commissions. 765 F.2d 1391-92.

Percentage of revenue contractual arrangements can lead to prohibited private benefit, and the scrutiny is heightened in arrangements where the compensation is based on an uncapped percentage of revenue. *See* P.L.R. 201235021, 2012 WL 3764677 (IRS PLR Aug. 31, 2012) ("This lack of cap limit entails that [the for profit company] can receive unlimited income that will more than compensate [the for profit company] for the services [it] renders to you. Thus, rather than devoting substantially all your income towards a purpose tax-exempt under § 501(c)(3), your income will be inuring to the benefit of [the for profit company]"). An uncapped percentage as low as 5% of donation receipts has been held to be a prohibited inurement to private shareholders and individuals. *Id.*; *see Spokane Motorcycle Club v. U.S., 222 F. Supp.* 151, 153-54 (E.D. Wash. 1963)(even a de minimis amount can be an impermissible private inurement).

V. THE DEPARTMENT'S DETERMINATION ON THE REQUESTED CHANGE TO NONPROFIT STATUS

A. The Impact of the MSA

Having reviewed voluminous materials provided to it, the Department has concluded that the primary purpose of the MSA, and by extension, the Transaction, was to drive shareholder value for GCE with GCU as its captive client – potentially in perpetuity. Notably, the Executive Summary of the Barclays Report includes the following:

- The Company's strong balance sheet and track record of performance position it to consider a broad range of strategic alternatives to continue to drive share price performance
    - However, perceived and tangible limitations on the Company's ability to aggressively pursue select alternatives as a for profit postsecondary provider must be considered
- Project Gazelle provides an attractive alternative for the Company ***and its shareholders*** to position the Company to:
    - Continue to provide an attractive (and enhanced), competitive offering, and therefore, grow its student population
    - Mitigate the potential risk (perceived or real) posed by its for profit status

- Pursue additional growth vectors to ***drive incremental value for shareholders***

Barclays Report at 2 (emphasis added).

The Barclays Update, provided to the GCE board days prior to the July 1, 2018 closing on the Transaction contains similar language in an updated Executive Summary:

- Investors recognize the Company's pursuit of Project Gazelle, and have continued to show support and interest in the stock, reflecting a positive expected outlook for the Company

- Project Gazelle provides an attractive alternative for the Company ***and its shareholders*** to position the Company to: .... Pursue additional growth vectors ***to drive incremental value for shareholders***

Barclays Update at 1 (emphasis added). The Barclays Update also includes a "Preliminary Discounted Cash Flow Analysis -Implied Value Transfer" analysis which notes that following the Transaction, "current shareholders ***retain ownership*** of GCE cash flows." Barclays Update at 7 (emphasis added). Of course, the primary (if not sole) source of those cash flows is revenue generated from Gazelle/GCU pursuant to the MSA. As explained in the Barclays Update, "following the transaction GCE, Inc. will have a single client, and as a result, a highly concentrated source of revenues," and further, "GCE, Inc.'s performance will be closely tied to that of Gazelle University – should Gazelle University's performance (or regulatory standing) be impacted in any way by (or following) the transaction, GCE, Inc. could also be negatively impacted." *See* Barclays Update at 9.

Similarly, the November 21, 2017 GCE board minutes reflect that the Board engaged in an extensive discussion about "Project Gazelle" including "the benefit to [GCE] and its stockholders." Board Minutes at 1. And at a GCE board meeting immediately prior to the closing of the Transaction, Mr. Bachus (GCE Chief Financial Officer) explained that a post-closing appraisal might result in a higher fair value for the assets transferred, and although GCE would not benefit from that, the higher valuation would benefit GCU in connection with its composite score, and he further explained why a good composite score for GCU "ultimately benefited the Company," meaning GCE. GCE June 28, 2018 Board Minutes at 2-3.

Not only was the Transaction structured so that the revenues generated by GCU are transferred to and retained by GCE for the benefit of its shareholders, the implementation of operations under the MSA results in an additional $697 Million to operate in the first fiscal year, solely resulting from the Services Fee paid to GCE. *See* Barclays Report at 33.

As described above the Services Fee is paid on a variety of revenue generating items:

- tuition
- student use of the online platform
- "students and their related activities"
- Canyon Connect

- student housing
- meal plans and other food services
- athletic tickets
- Grand Canyon University Hotel and Conference Center
- Maryvale Golf Course
- Grand Canyon University Arena
- Canyon Enterprises (apparel sales and other businesses)

MSA Exh. D §1. Although GCE receives 60% of the revenue from all of these revenue generating operations, it does not appear that GCE actually provides services for a significant part of many of these operations – e.g., student housing, food services, operation of the hotel, conference center, golf course, arena or Canyon Enterprises.

Despite GCE only taking on the responsibilities of 28% of the operating costs, 60% of the gross adjusted revenue from the Institution will be paid to GCE under the MSA. When payments on the Senior Secured Note are included in the analysis, GCE will be receiving approximately 95% of Gazelle's revenue. It is also worth noting that if revenue increases at a rate faster than operating costs, GCE has the potential to be paid even significantly higher amounts over the costs of the services it provides. Therefore, instead of the increased revenue being used for GCU's exempt purpose of providing education, the additional revenues would primarily benefit the shareholders of GCE.

It is equally concerning that GCU is essentially a captive client. As described above, the Initial Term of the MSA is 15 years, with automatic renewals thereafter for successive five years terms apparently in perpetuity. MSA §6.1. Although either party can elect not to renew at the end of the Initial Term or any Renewal Term, if Gazelle exercises that right, it has to pay GCE a Non-Renewal Fee (50% of the aggregate Services Fees paid or payable for the trailing twelve month period just ended). MSA §6.2 and MSA Exh. A at A-5. Gazelle has the right to terminate the MSA during the Initial Term, but it cannot elect do so before July 1, 2025 (seventh anniversary) or the date by which the Senior Secured Note is paid in full – whichever is later. MSA §6.3. If Gazelle exercises that right, it must pay GCE an Early Termination Fee (50% of the aggregate Services Fees paid or payable for the trailing twelve-month period just ended). MSA §6.3 and MSA Exh. A at A-3. Thus, Gazelle is locked into the agreement for at least seven years. And even if Gazelle wanted to terminate the MSA after July 1, 2025 because it found a more competitive service provider, the required payment of the Senior Secured note is an arguably prohibitive termination fee.

On October 1, 2018, Mr. Glass (counsel for GCU) wrote to the Department, providing various documents and responding to a September 10, 2018 letter from the Department seeking further information on GCU's request to convert to nonprofit status. ("October 1 Letter"). In part, the October 1 Letter described the approvals from the Higher Learning Commission ("HLC"), the IRS, the State of Arizona and other bodies, including the National Collegiate Athletic Association. As described above however, the Department makes its own determination of nonprofit status for a school's participation in Title IV. Although state and IRS approvals are required for nonprofit status under the Department's regulations, those approvals are not the sole determining factors, nor does the Department need to defer to those determinations. In regard to

the IRS designation of tax-exempt status, and as noted by the October 1 Letter, the IRS approval was issued three years prior to the Transaction. Even if the "basic structure" of the Transaction and a prior draft of the MSA were provided to the IRS at that time, there is no evidence that the IRS conducted a comprehensive review of the MSA or any of the studies that were later performed to support the MSA. Unlike the IRS's initial grant of tax-exempt status, the Department's determination of nonprofit status considers the structure and planned operations of the institution when its owner(s) apply for that change of status, and seeks to ensure that a nonprofit institution's revenues – a good portion of which are generated from Title IV funds – are primarily devoted to the mission of the school and not to other parties, including (as here) the shareholders of the prior owner.

Based on the tax authority cited above, the Department has determined that GCU does not meet the operational test's requirement that both the primary activities of the organization and its stream of revenue benefit the nonprofit itself. Rather, the materials that the Department has reviewed demonstrate that GCE and its shareholders – rather than Gazelle/GCU -- are the primary beneficiaries of the operation of GCU under the terms of the MSA. This violates the most basic tenet of nonprofit status – that the nonprofit be primarily operated for a tax-exempt purpose and not substantially for the benefit of any other person or entity.

B. Other Factors

The Department has identified other factors related to the MSA that provide additional support for the Department's determination that granting nonprofit status to GCU is not warranted.

1. Mr. Mueller's Dual Roles

The October 1 Letter explains that the GCE and Gazelle boards have adopted independent structures, and that the boards of GCE and Gazelle made independent decisions to retain Mr. Mueller in his positions as President of GCU and Chief Executive Officer of GCE. The October 1 Letter further notes that the terms of the MSA and Gazelle's bylaws "limit Mr. Mueller's direct involvement in the day to day oversight of the relationship with GCE" because direct oversight is vested in a Designee (*see* MSA §3.11), and because from Gazelle's side, management oversight is vested in a standing committee of the independent members of the board of trustees ("MSA Committee"). But not only is Mr. Mueller the President of GCU and the CEO of GCE, he is also a shareholder of GCE (even if he holds a de minimis percentage of stock). Thus, he is in the dual role of running both the Institution and its managed services provider – the major recipient of the Institution's revenues – and one of its shareholders. GCE's only client is GCU. Thus, as the CEO of GCE, he is the key executive responsible for providing the services under the MSA, with duties of loyalty to shareholders of GCE. Yet, as the Institution's President he will have responsibility to manage matters large and small with its primary service provider, notwithstanding the appointment of a Designee and the independent trustees who comprise the MSA Committee. Given those obviously conflicting loyalties, and the breadth of the services provided under the MSA, the Department is not satisfied that these structures are sufficient to ensure that Mr. Mueller's undivided loyalty is to the Institution.

2. GCE's "Management and Oversight" of GCU

According to GCE's statements to Deloitte, GCE's 44-person "Executive Leadership is responsible for managing and overseeing the University." Deloitte Report at 26 ("the majority of their time relate [sic] to strategic activities that generate future benefits for the University"). Relying on the titles used in the Deloitte Report, the Department has determined that the Executive Leadership team (as of the date the Transaction closed) had 58 members, not 44 members, assuming that the CEO is also included in the team.[18] Upon closing of the Transaction, a significant number of these executives remained employed by GCE – they did not transition to become Gazelle/GCU employees. *See* APA Disclosure Schedules at Schedule 6.3(a)-2. Of the 58 executives, only seventeen transferred to Gazelle: the General Counsel, the Chief Academic Officer, eight academic deans of the various colleges, three senior vice presidents and four vice presidents. Brian Mueller, the CEO of GCE and the President of GCU, is identified in Schedule 6.3(a)-3 as the sole "Joint Employee." This means that nearly 75% of the executive team members responsible for managing and overseeing GCU and developing its strategic vision are employed by its service provider. As employees of GCE, these executive leaders have a primary fiduciary responsibility to the shareholders of GCE[19], a for-profit publicly traded corporation, while at the same time providing significant management and oversight of the Institution. This is particularly so given the scope of the activities GCE is performing under the MSA, including: marketing, enrollment services and budget consultations, student support services counseling, document intake, student records management, curriculum services, accounting services (payroll, accounts payable, general ledger, etc.), financial aid services, procurement services, audit services, human resources, technology, business analytics services, faculty operations, and compliance monitoring and audits. MSA at Ex. B §§1-15.

The Department is skeptical that any nonprofit could outsource the number and type of institutional functions that Gazelle has and still be deemed to operate the Institution. Given the enormous leverage GCE now has over Gazelle by virtue of the MSA and the fact that most of the Institution's key management personnel work for GCE, not Gazelle/GCU, the Department concludes that, as a practical matter, Gazelle is not the entity *actually operating* the Institution as is required under the Department's regulations. *See* 34 C.F.R. § 600.2 (definition of nonprofit at (1)(i)).

VI. CONCLUSION

For the reasons discussed above, the Institution does not satisfy the Department's definition of a nonprofit. The Department approves the change in ownership application of the Institution from GCE to Gazelle (now known as Grand Canyon University) and approves the Institution as a for-

[18] While the Deloitte Report does not identify the Executive Leadership Team members by name, it states that the Team consists of those with the title of CFO, CIO, COO, CTO, Chief Academic Officer, General Counsel, EVP, SVP, VP, Director, and Dean. In regard to the designation of "Director," the Department only counted personnel with the title of "Executive Director," not all personnel with the designation "Director" in their titles.

[19] And at least some of these executives are GCE shareholders themselves.

profit institution for purposes of its continued participation in the Title IV, HEA Programs. The Department denies the request for recognition of the Institution as a nonprofit.

The for-profit status of the Institution is for purposes of its participation in the Title IV, HEA programs. The Department does not take a position with respect to Gazelle's non-profit 501(c)(3) status with the Internal Revenue Service. However, GCU must cease any advertising or notices that refer to its "nonprofit status." Such statements are confusing to students and the public, who may interpret such statements to mean that the Department considers GCU a nonprofit under its regulations. The Department does not take a position regarding statements that GCU may make about its IRS status as a 501(c)(3) tax exempt organization.

The TPPPA under which the Institution has been operating since the CIO continued the prior approval for the Institution to participate under a for-profit status. The for-profit status for the continued participation of the Institution is therefore unchanged. The Institution is reminded that the Institution must meet the Title IV, HEA programs reporting and program eligibility requirements applicable to for-profit institutions, including the 90/10 eligibility requirements described in 34 C.F.R. §668.28 and any applicable gainful employment program requirements set out in 34 C.F.R. Subpart Q.

Under APA § 2.4, Gazelle does not assume any liabilities arising under Educational Laws related to or based on the conduct of the Institution prior to closing. The Department's approval of the CIO does not include the exclusion of liabilities arising under the Title IV, HEA programs, and the approval of the CIO is expressly conditioned on Gazelle/GCU's responsibility for both pre-closing and post-closing liabilities arising under Title IV. Notwithstanding this condition, GCE also retains responsibility for pre-closing liabilities arising under Title IV. The parties are not foreclosed from requiring GCE to indemnify Gazelle/GCU for any losses resulting from pre-closing Title IV liabilities.

The TPPPA will expire at the end of this month. The Department has included with this letter the provisional program participation agreement ("PPPA") for the Institution. The PPPA includes the approval of the new programs requested by GCU. If the Institution wants to continue to participate in Title IV programs without interruption, the PPPA should be signed and returned to the Department no later than November 25, 2019 (given the Thanksgiving holiday) for countersignature.

The APA Parties also previously inquired (through counsel) about whether GCE is considered an "unaffiliated third party" for purposes of the March 17, 2011 Dear Colleague Letter (GEN-11-05) that addressed the implementation of the program integrity regulations and the incentive compensation ban. That question is currently under review, and the Department will provide the parties with a separate response on that issue.

If the Institution has additional factual information or documents that it believes the Department should consider relating to the decisions set forth in this letter, GCU should submit a request for reconsideration. That request should be submitted to Jane Eldred (Jane.Eldred@ED.Gov) within 10 calendar days of the date of this letter. Please note that a request for reconsideration will not stay the expiration of the TPPPA which expires on November 30, 2019.

Sincerely,

Michael J. Frola
Director,
Multi-Regional and Foreign Schools Participation Division

cc: The Higher Learning Commission (*email: Barbara Gellman-Danley, President - president@hlcommission.org, Anthea Sweeney, VP for Legal and Governmental Affairs - asweeney@hlcommission.org*)

AZ State Board for Private Postsecondary Education (*email: Terr Stanfill, Executive Director - teri.stanfill@azppse.gov*)

New Mexico Higher Education Department (*email: exec.admin@state.nm.us*)

IRS
Attn: EO Classification
MC 4910 DAL
1100 Commerce Street
Dallas, TX 75242
eoclass@IRS.gov

Question. How will the new gainful employment rule apply to for-profit colleges that have successfully converted for nonprofit institutions or were acquired by public universities?

Answer. The Department's proposed regulations, published May 19, 2023, would reinstate the Gainful Employment (GE) requirements for GE programs, which include practically all programs at for-profit colleges and non-degree programs that lead to a recognized credential at all colleges. These requirements would establish a debt-to- earnings metric and an earnings premium metric and would end the eligibility of GE programs that fail one of those rates for two out of three consecutive years.

The proposed regulations would also establish Financial Transparency requirements to calculate the same metrics for non-GE programs—generally degree programs at public and non-profit institutions—which would then be provided to the public and current and prospective students to apprise them of those outcomes along with better information about program price. Non-GE programs would not be subject to loss of program eligibility if they fail either metric.

The same proposed regulations would also adjust the treatment of a for-profit institution that converts to nonprofit status. We propose that such an institution would still be subject to the 90/10 and gainful requirements until the Department has received and reviewed two audits that cover two complete and consecutive fiscal years under the new ownership or until the conversion is approved, whichever is later.

Question. During the Obama Administration, former Secretary Arne Duncan created a Federal interagency task force to coordinate oversight and enforcement efforts related to for-profit colleges. The task force was based on a bill that I introduced called the Proprietary Interagency Education Oversight Coordination Improvement Act (S. 5155, 117th Congress). The task force was successful in coordinating Federal action in response to misconduct by several for-profit colleges—including a $100 million DeVry settlement with the Federal Trade Commission. The Department has expressed deep interest in strengthening oversight and accountability for higher education institutions, including for-profit colleges.

Would the Department consider recreating an interagency task force?

Answer. Strengthening school oversight and accountability continues to be a focus at the Department. This important work is most effectively accomplished by working closely with other key parties that investigate institutions. The Department has continued to strengthen relationships both with other Federal agencies, as well as with state attorneys general. For example, we reinvigorated the Principles of Excellence work in which the Departments of Education, Defense, and Veterans Affairs, and the Consumer Financial Protection Bureau collaborate on issues affecting veteran and military students. In addition, through the work of FSA's reestablished Enforcement Office, we have strengthened relationships with other state and Federal partners to identify and take action against schools that fail to put their students' interests first. We will keep this recommendation in mind as we continue to explore opportunities to support more effective collaboration across the Federal government on these important issues.

Question. What resources would the Department need to implement this taskforce?

Answer. As noted above, the Department will continue to consider such a task force, as well as the resources that may be necessary to implement it.

Question. The Fiscal Year (FY) 2024 President's Budget Request includes $500M for free community college for students enrolled in programs that lead to four-year degrees or "good-paying jobs." I have been supportive of making higher education more affordable and accessible. At the same time, it is important that the Federal government uses taxpayer dollars responsibly by investing in high-quality programs.

What is the Department's plan to ensure that the institutions of higher education are high-quality?

Answer. There are many dimensions of what constitutes quality in postsecondary education. The Department's focus is on ensuring that students get a reasonable financial return on their investments from the Federal student aid programs. For example, we have proposed new regulations that would require career training programs to show that they meet a minimum standard of debt relative to earnings and also have earnings that exceed those of a with only a high school diploma in the same state. We have also proposed requiring students to acknowledge key information on program outcomes and costs before receiving aid to attend a program with a high debt-to-earnings ratio. Finally, the Department has announced it will separately identify the programs that provide the least- financial value and ask institutions offering those programs to submit a plan to improve their outcomes. The Department would seek to incorporate best practices learned from these efforts in developing quality measures in the Accelerated Success: Free Community College program and we look forward to working with Congress to further refine the details of this proposal.

Question. What metrics will the Department use to determine whether a community college leads to a four-year degree or a good-paying job?

Answer. As noted in the answer to (a), the Department's focus is on ensuring reasonable financial returns to postsecondary programs, and we will continue to support community college success.

Question. Over the last five fiscal years, this Subcommittee—with the support of Chair Baldwin and Ranking Member Capito—has provided $47 million for an Open Textbook Pilot to expand the use of open textbooks on college campuses and achieve savings for students. While this program may be small, it has energized students and faculty across the country who see open textbooks—free, high-quality alternatives to costly traditional textbooks—as key to reducing student debt and improving learning outcomes. Many students do not purchase required course materials because they are too costly, which affects student outcomes. The College Board estimates that the average student budget at a four-year public institution of higher education for books and supplies was $1,240 during the 2022–2023 academic year. These costs disproportionately affect low-income, first-generation, and students of color. In 2023, the Department made two new awards with its FY 2022 appropriation. Using FY 2022 funds, the Department also fully funded the nine additional FY 2021 awardees. Research shows that projects supported by the grant program are estimated to save students $250 million.

Given the initial success of the pilot program, will the Department consider requesting funding for the Open Textbook Pilot in the FY 2025 President's Budget Request?

Answer. The Open Textbooks Pilot (OTP) program received $12 million in the Consolidated Appropriations Act, 2023, an increase of $1 million over the prior year. The Department has already made one new FY 2023 award from the FY 2022 grant slate and anticipates making five additional awards through an FY 2023 competition. From FY 2018 to FY 2022, the Department has made grant awards to 18 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 and develop the FY 2025 President's Budget Request, the Department will continue to support efforts to increase affordable and equitable access to quality open educational resources for all students.

Question. What other activities is the Department undertaking to promote the use of open textbooks and open educational resources to save students money?

Answer. The Infrastructure Investment and Jobs Act that President Biden signed into law in November 2021 codified a definition of digital equity and digital inclusion. Digital inclusion includes access to connectivity and devices, instructional materials, and digital literacy. The Department's Office of Educational Technology adopted digital inclusion as one of their office priorities with these three elements as focal areas in which open educational resources are included as part of access to instructional materials. (https://tech.ed.gov/priorities/).

The Department believes that high-quality educational opportunities should be available to all learners. Creating an open education ecosystem involves making learning materials, data, and educational opportunities available without restrictions imposed by copyright laws, access barriers, or exclusive proprietary systems that lack interoperability and limit the free exchange of information. In support of promoting the use of open educational resources, the Department's Open Licensing Requirement (2 C.F.R. 3474.20) went into effect on May 27, 2017, and was fully implemented in fiscal year 2018. The requirement requires grantees of the Department's competitive grant programs, with certain exceptions, to openly license copyrightable grant deliverables created with grant funds and to publicly disseminate the products developed with grant funds. This requirement significantly enhances dissemination of valuable educational resources, including online courses and modular digital textbooks, and provides stakeholders with greater access to use, reuse, and modify these deliverables, making it easier for education stakeholders such as SEAs, LEAs, IHEs, teachers, and students, to benefit from Department-funded learning materials while reducing out-of-pocket costs for students.

The Office of Educational Technology is providing technical assistance to all Department offices and program officers to build their knowledge of open education and open licensing and ensure the Open Licensing Requirement is met by all grantees.

As part of guidance on HEERF use issued in January 2022, the Department made clear that colleges could use these emergency funds to support OER programs. We offered an example of Chippewa Valley Technical College, an Open Textbook Pilot grantee, who used HEERF to expand their offerings of free textbooks and supplemental materials for nursing students.

On top of these policies, senior officials have also discussed open textbooks in their travels. In 2022, Under Secretary James Kvaal visited Rice University's OpenStax, a leading publisher of open textbooks and Open Textbook Pilot grantee. In 2023, Secretary Miguel Cardona met with the Massachusetts Department of Higher Education's Student Advisory Council to discuss student basic needs and their advocacy to promote open textbook on their campuses.

Question. The National Student Legal Defense Network recently released an analysis identifying a potential loophole in Federal regulations that makes it harder for students to take advantage of cost-saving alternatives like used books and open educational resources. What is the Department doing to look into this potential loophole and ensure that students are protected from being overcharged for their textbooks?

Answer. In April 2023, the Department announced public listening sessions and a public comment period on potential issues for future rulemaking sessions. One of the topics suggested by the Department for consideration was the issue of cash management to address disbursement of student funds. We are reviewing the public comments.

Question. I applaud the Department's recent efforts to provide student loan debt relief to borrowers who were defrauded by predatory for-profit colleges, including the Department's enforcement action to revoke Title IV funds from Florida Career Colleges (FCC), a for-profit college with a history of poor student outcomes. The Department's plan to impose conditions on FCC through a Provisional Program Participation Agreement (PPA), including a prohibition on enrolling new students under the Title IV program, are welcome. A critical next step is to continue to use the PPA to end this predatory behavior by terminating fraudulent schools from Title IV student aid. Colleges that meet Title IV standards enter into a PPA. The Department can terminate a school's participation in Title IV when it applies for recertification or when a school is out of compliance with its PPA. If a school falls short of the Department's eligibility requirements, but the Department determines the school is capable of coming into compliance within a short period, the Department may grant the school a Provisional PPA. Provisional PPAs can be revoked by the Department when an institution is unwilling or unable to correct deficiencies and fully meet requirements. Additionally, Temporary Provisional PPAs allow schools that have expired PPAs or are experiencing a change in ownership and control and who have submitted recertification applications to receive month-to- month access to Title IV funds while the Department considers the school's renewal application. Hundreds of schools currently are languishing in this limbo status, including schools with a history of misconduct. The Department has been reluctant to revoke provisional PPAs—and in some cases has even renewed provisional PPAs for schools that have failed to show improvements—for troubled schools or to use its authority to impose and enforce conditions on schools with compliance issues. The Department also has permitted schools to continue to receive Title IV funds for months or even years while in expired status.

What actions does the Department plan to take to hold schools that are in expired or Temporary Provisional PPA certification status accountable and stop them from receiving Title IV Federal student aid?

Answer. The Department welcomes the opportunity to clarify the eligibility and certification status of institutions that continue to participate in the Title IV, HEA programs under expired Program Participation Agreements (PPAs) or under Temporary Provisional PPAs (TPPPAs). Institutions that continue to participate under expired PPAs or TPPPAs have been certified to participate in the Title IV, HEA programs and timely submitted new applications for renewed certification. These new applications may be pending with the Department for any number of possible reasons. While the participating institution's application for renewal is pending, its prior eligibility and certification status remains intact until the Department finalizes its review of and determination on the new application. Consequently, an institution that continues to participate under an expired PPA or TPPPA remains authorized to award and disburse Title IV, HEA program funds to its otherwise eligible students in accordance with the Department's longstanding regulations (described below). These regulations help to ensure that a participating school's students do not experience any unnecessary financial hardships or disruptions in their educational journeys that would arise if the school could not disburse Title IV, HEA program funds to its otherwise eligible students while the Department finalizes a review of the institution's pending renewal application.

The Department's regulations at 34 C.F.R. § 668.13(b) provide that if an institution has submitted an application for a renewal of certification that is materially complete at least 90 days prior to the expiration of its current period of participation, its existing certification will be extended on a month to month basis following

the expiration of the institution's period of participation until the end of the month in which the Secretary issues a decision on the application for recertification.

In the case of a change in ownership resulting in a change in control, the Department's regulations at 34 C.F.R. § 600.20(g) provide that an institution may apply for a provisional extension of certification following the change in ownership, while 34 C.F.R. § 600.20(h) defines the conditions under which such an institution's participation may be extended through a TPPPA.

Once the Department completes its evaluation of the application for a school, it may be fully or provisionally certified, or the application may be denied. If an institution's application is denied, the Department's regulation state that the institution loses eligibility to participate in the Title IV programs at the end of the month in which the Department issues its decision to the school. A school has an opportunity to submit a reconsideration request in response to a denial.

Please also see our response to question (f), which discusses how the Department's recently proposed regulations would address many of these issues.

Question. Please provide a list of institutions with PPAs that were terminated within the last 5 years, either during the term of the PPAs or at recertification:

Answer. An Excel spreadsheet providing the requested data for 14b-e and 14h is enclosed.

[The Department provided the attachment to the Committee.]

Question. Please provide a list of institutions with Provisional PPAs or Temporary Provisional PPAs that were terminated or revoked within the last 5 years.

Answer. Please see Excel spreadsheet referenced in 14b.

[The Department provided the attachment to the Committee.]

Question. Please provide a list of institutions that have received Title IV funds while in expired or Temporary Provisional PPA certification status within the last 5 years. For each institution, please indicate how long the institution received Title IV funds while in expired or Temporary Provisional PPA certification status.

Answer. Please see Excel spreadsheet referenced in 14b.

[The Department provided the attachment to the Committee.]

Question. Please provide a list of schools that have had Provisional PPAs renewed multiple times within the last 5 years. For each institution, please indicate how long the institution has remained in provisional certification status and the compliance problem that led to its provisional status.

Answer. Please see Excel spreadsheet referenced in 14b.

[The Department provided the attachment to the Committee.]

Question. Please describe the Department's procedures for evaluating eligibility for certification and recertification, including whether such review involves the following: review of consumer complaints or reports from whistleblowers; identification and review of adverse actions by regulators, including investigations or enforcement actions by state attorney generals' offices, other state agencies, or Federal agencies; identification and review of adverse actions by accreditors; identification and review of consumer class actions alleging violations of consumer protection laws; review of marketing or advertising materials, including third-party materials; and training for reviewers in what constitutes a misrepresentation.

Answer. The Department's certification procedures are governed by the Department's regulations at 34 C.F.R. § 668.13. The Secretary certifies an institution to participate in the Title IV, HEA programs if the institution qualifies as an eligible institution under 34 CFR Part 600, if it meets the standards of this subpart and 34 CFR Part 668, Subpart L, and if it satisfies other relevant requirements.

The Department recently released a packages of proposed regulations titled "Financial Value Transparency and Gainful Employment (GE), Financial Responsibility, Administrative Capability, Certification Procedures, Ability to Benefit (ATB)." See 88 Fed. Reg. 32,300–32,511 (May 19, 2023). The draft rules propose to expand the Department's authority to address many of the issues raised in your question.

These proposed rules would allow the Department to impose additional PPA requirements and conditions on provisional PPAs to mitigate many of the risks identified in your question. As an example, the Department is proposing to amend the PPA regulations at 34 C.F.R. § 668.14 to enable the Department to require a provisionally certified institution to hire a monitor and to submit marketing and other recruiting materials (e.g., call scripts) for the review and approval by the Secretary if an institution is alleged or found to have: engaged in misrepresentations to students, engaged in aggressive recruiting practices, or violated incentive compensation rules. The draft rules also propose to amend the PPA regulations to ensure that a school complies with all State consumer protection laws related to closure, recruitment, and misrepresentations, including both generally applicable State laws and those specific to educational institutions. Additionally, the draft rules propose to amend the PPA regulations to require that a school authorize the Secretary to share

information with an expanded set of oversight partners —including additional Federal agencies and State attorneys general. This includes information pertaining to the institution's eligibility for or participation in the Title IV, HEA programs, as well as any information related to fraud, abuse, or other violations of law.

The Department has also proposed rules that would specify that an institution will not be considered administratively capable under 34 C.F.R. §668.16 if the school engages in misrepresentations or if it uses aggressive and deceptive recruitment tactics or conduct. Likewise, a school would not be considered administratively capable if it has been subject to a significant negative action or a finding by a state or Federal agency, a court, or an accrediting agency where the basis of the action is repeated or unresolved, such as non- compliance with a prior enforcement order or supervisory directive. Similarly, an institution that has lost eligibility to participate in another Federal educational assistance program due to an administrative action against the institution would not be considered administratively capable.

Additionally, the Department is proposing to amend financial responsibility requirements to add new triggering events and link triggering events more closely to requirements proposed to be included the Department's certification procedures regulations. For instance, the Department is proposing rules that would require a school's certification to become provisional upon a notification from the Secretary if the school experiences a mandatory or discretionary financial responsibility triggering event and, as a result, the Secretary requires the school to post financial protection. For example, the Department has proposed establishing a triggering event that would be triggered when a school's accrediting agency or a Federal, state, local or tribal authority places a school on probation or issues a show-cause order or places the institution in a comparable status that poses an equivalent or greater risk to its accreditation, authorization, or eligibility. Another proposed triggering event would occur when an institution loses eligibility to participate in another Federal educational assistance program due to an administrative action against the school. In these cases, the school's certification would become "provisional" if the institution was participating under an unrestricted PPA.

The Department is currently reviewing public comments.

Question. Please describe the Department's procedures for monitoring institutions' compliance with conditions in PPAs and Provisional PPAs.

Answer. By entering into a PPA, an institution agrees that it will comply with all statutory provisions of or applicable to Title IV of the HEA, all applicable regulatory provisions prescribed under that statutory authority, and all applicable special arrangements, agreements, and limitations entered into under the authority of statutes applicable to Title IV of the HEA, including the requirement that the institution will use funds it receives under any Title IV, HEA program and any interest or other earnings thereon, solely for the purposes specified in and in accordance with that program. See 34 C.F.R. §668.14(b)(1). The Department therefore relies upon an expansive set of monitoring tools including Title IV compliance audit reviews and resolutions, institution financial health ratio analyses, Title IV program reviews, periodic financial reporting reviews, and policy and procedures reviews to ensure school compliance with the expansive set of PPA requirements.

Question. Please provide a list of institutions that were identified as out of compliance with a condition of their PPA or Provisional PPA within the last 5 years. For each institution, please describe the actions taken by the Department, if any, to address the noncompliance issue.

Answer. Please see Excel spreadsheet referenced in 14b.

Question. Does the Federal Student Aid Office of Enforcement coordinate and share information with the offices at the Department that handle Title IV certification and program review?

Answer. Yes, FSA's Office of Enforcement provides information of which it is aware about schools to other offices that handle Title IV certification and program reviews, both within FSA and the Department.

Question. Last October, I and other Members of Congress wrote to the Department, urging it use its authority under 20 U.S.C. 1009c(e) to hold owners and executives of predatory for-profit colleges personally, financially accountable for scamming students. The Department came out with guidance in March addressing the Secretary's authority to hold owners and executives personally liable, stating that the Secretary cannot use the personal liability authority retroactively if the owner or executive did not sign the PPA.

Since the Secretary's authority to invoke personal liability is only forward looking, the Department cannot hold FCC's owners and executives personally liable per their previous PPA; however, since the Department is granting FCC a conditional PPA on a month-to-month basis, is the Department asking FCC owners and executives to sign the conditional PPA so that they could potentially be held personally liable?

If not, can the Department please provide the reasoning not to ask FCC owners and executives sign the conditional PPA?

Answer. As noted above, the Department's regulations at 34 C.F.R. § 668.13(b) provide that if an institution has submitted an application for a renewal of certification that is materially complete at least 90 days prior to the expiration of its current period of participation, its existing certification will be extended on a month to month basis following the expiration of the institution's period of participation until the end of the month in which the Secretary issues a decision on the application for recertification. Florida Career College (FCC) submitted a materially complete application for renewal of certification more than 90 days prior to the expiration of its PPA on September 30, 2022. FCC therefore continued its participation on a month to month basis in accordance with the Department's regulations until the Department issued its decision on the recertification application.

On April 11, 2023, the Department denied FCC's recertification application. Please be aware that FCC has requested the Department's reconsideration of this decision, and submitted a lengthy reconsideration request on or about May 25, 2023. The Department is currently reviewing that request.

The Department appreciates the opportunity to clarify for your office that FCC was not granted a conditional PPA. On April 19, 2023, the Department entered into an "Agreement for Limited Continuation of Program Participation" negotiated by Federal Student Aid's Office of Enforcement on behalf of the Department, which provides that the Department will defer the effective date of the denial of recertification to a date no later than January 31, 2024. The "Agreement for Limited Continuation of Program Participation" contains protections for the Title IV program, including a requirement that the school continue on HCM2 so that the Department may review each claim for payment, as well as a financial protection in the form of a Letter of Credit or cash escrow in the amount of $6,015,824. In offering that Agreement, the Department focused on maximizing options and choices for FCC's current students. Although the Department did not require the owners or executives to personally sign the agreement, the Department required authorized representatives of FCC's corporate owners, IEC US Holdings, Inc., and IEC Corporation, to cosign the agreement. A copy of the "Agreement for Limited Continuation of Program Participation" is attached.

FCC Agreement for Limited Continuation of Program Participation 2023.4.19 (003).pdf

Question. Please outline the circumstances or criteria the Department will use to determine whether owners and executives should sign a PPA that could provide authority in the future to hold them personally liable.

Answer. On March 1, 2023, the Department issued guidance that clarified how it will implement Section 498(e) of the Higher Education Act, which specifies that the Department may require individuals who exert significant control at private institutions to assume personal liability. The Department anticipates it is most likely to require an individual to assume personal liability on behalf of the institutions or groups of affiliated institutions that pose the largest financial risk to the United States, including institutions that annually receive tens or even hundreds of millions of dollars of Title IV funds and institutions with the most serious and significant sets of concerns related to their compliance with Federal financial aid rules.

To help the public understand the Department's decisionmaking process, the guidance includes a non-exhaustive list of factors the Department may consider when determining whether to pursue personal liability. These include:

—Civil or criminal lawsuits, settlements, or disciplinary or legal actions by the Department or other state or Federal agencies involving Federal student aid or claims of dishonesty, fraud, misrepresentation, consumer harm, or financial malfeasance.

—Significant compliance issues, such as findings stemming from program reviews or audits, unpaid liabilities from either of those processes, or findings of a lack of administrative capability.

—An executive compensation or a bonus structure that could significantly affect the financial health of the institution.

Additional factors and preconditions are delineated in the Department's March 1, 2023 Electronic Announcement (GENERAL–23–11) "Establishing Personal Liability Requirements for Financial Losses Related to the Title IV Programs" which is accessible at the following URL: https://fsapartners.ed.gov/knowledge-center/library/electronic-announcements/2023-03-01/establishing-personal-liability-requirements-financial-losses-related-title-iv-programs.

The Department will consider these factors when assessing institutions that have demonstrated certain statutory indicators of financial risk, such as significant audit findings, or failing to meet financial responsibility requirements.

Going forward, the Department will generally begin making determinations on a case-by- case basis about whether it will require individuals to assume personal liability when their institution's program participation agreement is up for renewal or if they undergo a change in ownership. There also may be instances in which the Department accepts other financial protections to minimize the risk of financial losses in lieu of the signature.

Question. Last October, the Department found a major accreditor, the Southern Association of Colleges and Schools (SACS), out of compliance with regulations and asked it to respond to concerns about SACS' oversight of conflict of interest and tax issues surrounding the conversion of Keiser University (Keiser) to nonprofit status. Keiser has engaged in troubling conduct with respect to this conversion, which has allowed the Keiser family to reap millions in income from the school while operating as a nonprofit. Keiser recruiting practices also have raised concerns and resulted in law enforcement settlements. This year, Keiser sought emergency relief to stop students who say they were defrauded, including former Keiser students, from getting debt relief.

Does the Department plan to hold SACS accountable for lax oversight of Keiser University?

Answer. As noted in your question, on November 7, 2022, the Senior Department Official (SDO) sent a letter to the Southern Association of Colleges and Schools, Commission on Colleges (SACS) requiring SACS to re-review the for-profit to nonprofit conversion of Keiser University. The SDO has required that SACS provide information regarding the conversion in the compliance report, which must be submitted to the Department on or before December 7, 2023, and address all of the noncompliant issues noted in the November 7, 2022, SDO decision letter. Once the compliance report is submitted, the Accreditation Group will conduct its review of the compliance report and the additional information regarding the conversion and possible conflicts of interest.

Question. Will the Department hold Keiser University accountable directly?

Answer. In instances where an institution's nonprofit status is called into question by credible reports that a nonprofit institution may be allowing some part of its net earnings to benefit a private shareholder or individual, the Department will review those concerns in depth during the institution's next recertification cycle.

As noted in a response above to a different question, the Department recently released a proposed rule package titled "Financial Value Transparency and Gainful Employment (GE), Financial Responsibility, Administrative Capability, Certification Procedures, Ability to Benefit (ATB)." See 88 Fed. Reg. 32,300–32,511 (May 19, 2023). These draft rules would expand the Department's authority to consider additional factors, including those that would address the issues raised by your question. For example, the draft rules would provide for additional oversight of an institution's marketing and other recruiting materials in certain circumstances and better ensure institutional compliance with all State consumer protection laws related to closure, recruitment, and misrepresentations.

Your question observes that Keiser University sought emergency relief in the courts this year. The Department fully respects the right of any institution to file a lawsuit, intervene in a lawsuit, and to defend itself in lawsuit.

Question. Investments in early childhood education have received bipartisan support for laying the foundation to ensure all children have the opportunity for success in school and life, while allowing parents to work and pursue greater economic security. Additionally, building strong Pre-K to grade three programming can improve school readiness and ensure children transition successfully from the early education system to elementary school. The FY 2024 President's Budget Request includes $500 million for a Preschool Incentive Demonstration Program, which would incentivize school districts to establish or expand high-quality preschool in school and community-based settings for children eligible to attend Title I schools.

How will the proposed program encourage grantees to leverage existing Title I funds, along with other Federal, state, and local funds, in support of high- quality preschool, while ensuring coordination with existing Federal early learning programs?

Answer. The Preschool Incentive Demonstration Program would support LEAs to provide mixed-delivery preschool services by braiding Title I and other Federal, state, and local funds to expand access to preschool seats for students eligible to attend participating Title I schools. Grantees may use funds for activities needed to expand access to high-quality preschool for 4-year-olds eligible to attend Title I schools, either at Title I schools or by partnering with existing early learning programs, including Head Start programs, in the community. As required by Title I, grantees would be required to meet, at a minimum, the education performance standards of the Head Start Program Performance Standards, and students must

be served by qualified, high-quality educators, with appropriate student-teacher ratios. Grantees would be expected to use Title I and other Federal funds such as funds from the Individuals with Disabilities Education Act (IDEA), Titles II, and III of the Elementary and Secondary Education Act, and Head Start (where Head Start funds are present in the local community served by the LEA and where local Head Start partners are available), as well as state and local funds, to support preschool expansion. This braiding of funds would help grantees leverage the local infrastructure of early childhood education as they seek to expand high-quality preschool and, as a result, deepen investments in that infrastructure.

Question. The Biden Administration announced last August that it would cancel up to $20,000 in student loans for borrowers under certain income thresholds. While I applaud this targeted debt relief and the payment pauses on student loans, I am concerned that many students will be unprepared to resume payments on October 1, 2023.

Please detail what the Department's outreach plan will be to communicate to students that Federal student loan repayments will be resuming in the fall, including when the Department will start dispersing communication.

Please indicate whether the Department will make communication to borrowers accessible via email, mail, or another format.

Please indicate whether the Department will make the notice accessible to individuals who may need special accommodations due to disabilities and whether the notice will be available in multiple languages.

Answer. On June 30th, the Supreme Court issued a decision invalidating the Biden-Harris Administration's student debt- relief plan to provide up to $20,000 in one-time relief to more than 40 million student loan borrowers. Our administration believes the Supreme Court's decision was wrong. But President Biden and his Administration won't stop fighting to help borrowers get back on their feet. That's why the Biden-Harris Administration announced three actions to support students and borrowers:

First, we are taking action aimed at opening an alternative path to debt relief for working and middle-class borrowers. We started the process to provide relief to as many people as we can, as fast as we can, through the rulemaking process. Under the law, this path will take time, but we are determined to keep fighting for borrowers and we will keep you updated in the months ahead.

Second, the Administration is implementing the most affordable repayment plan ever created, called the Saving on a Valuable Education (SAVE) Plan. Later this summer, borrowers will start saving money under the new plan, which will cut monthly payments to $0 for millions of borrowers making $32,800 or less individually ($67,500 for a borrower in a family of four) and save all other borrowers at least $1,000 per year. Additionally, it will stop runaway interest that leaves borrowers owing more than their initial loan. Eligible borrowers can enroll in the REPAYE plan today and the Department will automatically enroll them in the SAVE plan and update their monthly payments as the new terms are implemented later this summer.

Third, under legislation enacted by Congress, the student loan payment pause is ending. Interest will begin accruing on September 1, and payments will be due in October. To help borrowers successfully return to repayment, the Department is creating a temporary on-ramp to protect borrowers from the worst consequences of missed, late, or partial payments, such as negative credit reporting. However, borrowers who can make their payments should do so, as interest will be accruing as of September 1.

We have begun communicating with millions of borrowers about these actions. Throughout the summer we also will be regularly communicating with borrowers, with a particular focus on their unique situation, to help them smoothly return to repayment and access resources, programs, and options that are the best for them, including our new SAVE income driven repayment program.

FSA will also work with its contractors and outside partners to help borrowers navigate their repayment options, including considering applying for loan forgiveness if they are eligible, enrolling in affordable repayment plans, and enrolling in auto-debt payments. It will comply with its standard practices to make its materials accessible to borrowers with disabilities and offer translation services through its call centers. In the FY 2024 Budget, the President has requested additional resources to further FSA's efforts to support borrowers through this critical year.

Question. As the Department revises the Free Application for Federal Student Aid (FAFSA) following the passage of the FAFSA Simplification Act and Fostering Undergraduate Talent by Unlocking Resources for Education (FUTURE) Act, the release date of the new FAFSA is projected to be December 2023. The FAFSA usually is released on October 1 and is open through June 30, with roughly half of all stu-

dents completing the FAFSA between October and January. Students use information from financial aid packages to weigh their postsecondary decisions, which typically are made by May 1.

With the Department planning a release up to 2 months after the usual timeframe, how will the Department ensure that students have the necessary information about financial aid packages to make decisions about postsecondary pathways?

Answer. The FUTURE Act and FAFSA Simplification Act require an unprecedented update to how students and families apply for student aid and how eligibility is determined, giving students a better and simpler experience with the FAFSA. As a result of the changes underway, the Department of Education will now be able to obtain Federal tax information for each applicant, parent, or spouse who provides consent. This will greatly reduce the need for verification of income information and be particularly helpful for the lowest-income FAFSA applicants (i.e., those who are not required to file Federal taxes) and other applicants who are not able to use the IRS Data Retrieval Tool. In order to implement these changes, we must transition to a fundamentally new financial aid system and need analysis formula, and FSA and many colleges will need to develop new software to accommodate this transition. Our top priority is ensuring a smooth and successful transition and minimize the risk of disruptions to the financial aid process.

Despite the later than usual release of the FAFSA, students will have ample time to apply for financial aid. The 2024–25 award year begins on July 1, 2024, with financial aid offers generally prepared in the first quarter of 2024. Financial aid packages are often tentative in the fall and revised after January 1 when appropriations are finalized and the maximum Pell Grant award is determined. The Department will work with our institutional partners to support them in providing students sufficient time to assess their aid packages.

The Department will also launch an enhanced outreach campaign to educate stakeholders about the FAFSA changes, raise awareness about the new FAFSA experience, and prepare students and families to complete the form when it's launched. This outreach will leverage an interactive preview of the new FAFSA experience and the updated Federal Student Aid Estimator, and will encourage students to complete early steps, such as creating an FSA ID, before the new FAFSA goes live.

The Department will also provide weekly reports to provide states and districts with information on how many of their students have completed the FAFSA. This will help states, districts and partners step up their FAFSA completion efforts before too much time has passed.

QUESTIONS SUBMITTED BY SENATOR JEANNE SHAHEEN

Question. Mr. Secretary, it's been more than 3 years now that student loan borrowers' obligation to make payments has been temporarily suspended as a result of the pandemic. You have told me at the past two hearings that the Department was committed to providing certainty for borrowers over when they would have to resume their payments. However, since we spoke last year, the Department has extended this payment pause two more times, including an additional time after the Department had announced a "final" extension that was supposed to end at the end of 2022.

Creating even more confusion, the Department has now set its official deadline for the end of the payment pause as: either 60 days after the Supreme Court rules on the President's student debt cancellation executive order or 60 days after June 30, 2023, whichever date comes first. Now, I understand that the Supreme Court's timeline and decision is not under the control of the Department, but I am concerned that this is a particularly challenging situation for borrowers who need certainty over when their payments will resume.

How is the Department working to ensure that the country's approximately 45 million student loan borrowers are adequately prepared for the reinstatement of their payment obligations?

How is the Department working to provide particularly targeted support for the four cohorts of new graduates who have never previously had to make their monthly payments, who will be entering repayment for the first time?

Answer. On June 30th, the Supreme Court issued a decision invalidating the Biden-Harris Administration's student debt- relief plan to provide up to $20,000 in one-time relief to more than 40 million student loan borrowers. Our Administration believes the Supreme Court's decision was wrong. But President Biden and his Administration won't Stop fighting to help borrowers get back on their feet. That's why

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Second, the Administration is implementing the most affordable repayment plan ever created, called the Saving on a Valuable Education (SAVE) Plan. Later this summer, borrowers will start saving money under the new plan, which will cut monthly payments to $0 or millions of borrowers making $32,800 or less individually ($67,500 for a borrower in a family of four) and save all other borrowers at least $1,000 per year. Additionally, it will stop runaway interest that leaves borrowers owing more than their initial loan even when they keep up with their monthly payments. Eligible borrowers can enroll in the REPAYE plan today and the Department will automatically enroll them in the SAVE plan and update their monthly payments as the new terms are implemented later this summer.

Third, under legislation enacted by Congress, the student loan payment pause is ending. Interest will begin accruing on September 1, and payments will be due in October. To help borrowers successfully return to repayment, the Department is creating a temporary on- ramp to protect borrowers from the worst consequences of missed, late, or partial payments, such as negative credit reporting. However, borrowers who can make their payments should do so, as interest will be accruing as of September.

We have begun communicating with millions of borrowers about these actions. Throughout The summer we also will be regularly communicating with borrowers, with a particular focus on their unique situation, to help them smoothly return to repayment and access resources, programs, and options that are the best for them, including our new SAVE income driven repayment program. This includes tailored email campaigns to help borrowers who entered also work with its contractors and outside partners to help borrowers navigate their repayment options, including considering applying for loan forgiveness if they are eligible, enrolling in affordable repayment plans and enrolling in auto-debt payments. In the FY 2024 Budget, the President has requested additional resources to further FSA's efforts to support borrowers through this critical year.

Question. I am concerned about the technical and logistical challenges facing the Department and its student loan servicers with a task of this scale, as well as the potential for financially catastrophic consequences to individuals of any errors made by the Department or its servicers.

How is the Department planning to ensure that all student borrower accounts are successfully transitioned back into repayment?

For borrowers who have continued to make payments during the past 3 years, how is the Department working to ensure these payments are successfully reflected in their accounts?

Answer. As previously mentioned, FSA will work with its contractors and outside partners to ensure that borrowers have the most up-to-date, accurate information on the status of their loans. This includes recommending the most important steps they need to take to prepare for the return to repayment, including considering applying for loan forgiveness if they are eligible, enrolling in affordable repayment plans, and enrolling in auto-debt payments.

Over the past 3 years, we have strengthened accountability for servicer performance including accurate maintenance of borrower records—while modernizing our data infrastructure and embedding further enhancements in the newly awarded contracts for student loan servicing. The new servicing contracts are designed to provide Federal student loan borrowers with a high-quality customer experience and to deliver support for at-risk borrowers so that all borrowers can take advantage of the most affordable ways to repay their loans, avoid default, decrease loan errors, and access loan forgiveness, if they are eligible for it. Vendor accountability is a central goal of the new servicing contracts, which provide rewards for better customer outcomes and impose consequences for failing to meet expectations—including errors crediting borrower accounts. For example, servicers that keep vulnerable borrowers current on their payments will receive a financial performance incentive, and FSA will allocate new accounts to servicers that have proven they are able to keep borrowers current. Likewise, servicers that provide unsatisfactory or untimely service will face financial disincentives.

QUESTIONS SUBMITTED BY SENATOR JOE MANCHIN III

Question. Secretary Cardona, Department of Education data shows that 47 states have reported teacher shortages this school year. The nursing shortage has become so acute that in WV 30% of our licensed hospital beds are unstaffed. We are experiencing a skilled workforce shortage.

There are currently over 50 student loan repayment and forgiveness programs. These include the Public Service Loan Forgiveness, the Nursing Education Loan Repayment Program, the Loan Forgiveness Program for Teachers, and many more. These programs serve to help attract students to work in these skilled professions, some of these programs even attract workers to rural and underserved areas who would be otherwise unable to hire these workers.

Secretary Cardona, are you aware of all these programs and the importance they play in attracting people to professions like teaching and nursing?

Answer. The Department is aware of how programs that provide debt relief for public service make it possible for borrowers to pursue these critical careers. The Department has expended significant effort in particular at improving the Public Service Loan Forgiveness program, which Congress created in 2007 as a promise to borrowers. Prior to the start of this administration, only a few thousand borrowers had received relief from this program, with more than 90 percent of those who applied being denied forgiveness. Now, thanks to the limited PSLF waiver, the Department has approved nearly $45 billion in relief for 653,800 borrowers. We have also issued final regulations that will make it easier for these borrowers to make progress toward forgiveness in the future. Long term, the Department aims to implement data sharing agreements with other agencies to help award credit to eligible borrowers automatically. In addition, we have worked to implement changes to the TEACH Grant program to ensure the next generation of teachers can fully benefit from the program and are not mired in red tape that could saddle them with additional loan debts. These are just a few examples of the many programs that provide critical support to student loan borrowers, including those in rural and underserved areas.

Question. Does the Department of Education provide information to students on the availability of these programs?

Answer. The Department makes borrowers aware of the various loan discharge and forgiveness programs it directly manages, including Public Service Loan Forgiveness, the TEACH Grant program, and others.

Question. The Department of Education manages the Gaining Early Awareness and Readiness for Undergraduate Programs, or GEAR UP. This program provides competitive grants to states to help prepare low-income and first-generation students for post-secondary education starting as early as seventh grade. Grant funds may be used to offer services to students at high-poverty middle and high schools, such as professional development for counselors and instructors, college and career planning, counseling and tutoring services to support college enrollment.

In recent GEAR UP grant Competitions, the Department of Education disrupted the equitable distribution of funds between states and partnerships by not adhering to the legislative distribution formula that provides that States and Partnership applicants can each expect to receive at least 33% of the new award dollars made in a given competition. Through fiscal years 2021, 2022, and 2023 legislation, we have provided congressional directives to ED related to this.

Secretary Cardona, Will the department adhere to our directives to ensure a fair and equitable competition is administered for GEAR UP grants in 2024?

Answer. The Department awards GEAR UP funds consistent with section 404B(a) of the HEA, which requires the Department to ensure that, of the amounts appropriated for GEAR UP, not less than 33 percent will be used to fund State grants and not less than 33 percent will be used to fund Partnership grants. The Department will continue to comply with the statutory requirements when making GEAR UP awards. The Department also intends to comply with the directive to ensure that not less than 33 percent of the new award dollars are allocated to State awards and not less than 33 percent of the new award dollars are allocated to Partnership awards, to the extent practicable, while still maintaining compliance with the statutory requirements.

Question. The Upward Bound Program is one of eight Federal TRIO Programs managed by the Department of Education. Upward Bound programs in West Virginia provide both educational and living options for students during the summer, which are invaluable experiences for students who are interested in pursuing undergraduate or graduate degrees, especially because Federal TRIO Programs are designed to support students who are low-income or come from disadvantaged backgrounds.

Despite its importance, the Upward Bound grant awards last year were released just one week before previous funding was set to expire. This caused great uncertainty for not only the programs, but also the students who attend them. It is unacceptable that these programs and students were caused uncertainty that they would be funded. At a time when youth mental health is at an all-time low, students and families do not need more stress and anxiety.

Secretary Cardona, what actions has the Department taken to ensure that the grant awards are announced in a timely manner this year?

Answer. We agree that it is important to ensure that grantees know their funding status as soon as possible and we make every effort to complete the large and complex Upward Bound grant program actions in a timely manner. The Department continues to work to ensure that both new and non-competing continuation awards are processed and issued in a timely manner. To that end, the Department obligated the FY 2023 Upward Bound non-competing continuation awards on May 12, 2023.

Question. Currently, the Department of Education does not inform borrowers on financial information like interest rates and origination fees before they take out a student loan. I have introduced legislation to improve transparency by directing the Department to develop a consumer-tested, plain language disclosure form with easily identifiable information about a borrower's student loans. I have also introduced legislation that would require lenders to disclose the total amount of interest to be paid over the life of a student loan, based on a standard 10-year repayment plan.

When a student is making important decisions regarding whether or not to go to college, or which college to attend. It's important that they fully understand what loans they are taking out.

Secretary, will you work with me to pass these pieces of legislation and ensure that we are improving student loan literacy of all students and their families?

Answer. I agree that students should have all the information necessary when making the decision of whether, and where, to enroll in higher education. When students borrow for their education, they must complete and sign a Master Promissory Note (MPN), which is a legal document in which students promise to repay their loans. The MPN explains the terms and conditions of the loans, including the interest rate and information on origination fees, late charges, collection costs, and more. The MPN also provides information on repayment and when a borrower will be considered in default.

The Department has also created the College Financing Plan, which is a consumer tool that participating institutions use to notify students about their financial aid package. It is a standardized form that is designed to simplify the information that prospective students receive about costs and financial aid so that they can easily compare institutions and make informed decisions about where to attend school. The "Loan Options" box on the College Financing Plan includes fields for both the interest rate and origination fee of each loan, along with an explanation that, for Federal student loans, origination fees are deducted from loan proceeds. Furthermore, in October 2021, the office of Federal Student Aid issued GEN–DCL–21–70 outlining what institutions should include and avoid when presenting students with their financial aid offers. This DCL includes guidance to institutions to always present grants and scholarship aid separately from loans so that students and families are able to understand what they are borrowing. I look forward to working with you to ensure that students have the necessary and accurate information to make the best higher education decisions for themselves.

Question. The McKinney-Vento Education for Homeless Children and Youth program provides critical assistance for community organizations, schools, and state agencies to help address the needs of homeless children and youth. The West Virginia Department of Education has identified more than 9,500 students who experienced homelessness during the 2021 school year.

Secretary, can you share what the Department is doing to support homeless youth in West Virginia and across the country?

Answer. We are pleased to note that the funding for West Virginia under the McKinney-Vento Education for Homeless Children and Youth (EHCY) program increased by more than $116,000 in the past few years, from $616,624 in FY2020 to $732,962 in FY2023.

The Department has a contract for a National Center for Homeless Education (NCHE) to provide comprehensive technical assistance and implementation support for the McKinney-Vento Education for Homeless Children and Youth (EHCY) program for the past 25 years. In FY 2023, NCHE has developed many reports, webinars, presentations, and convened ad-hoc topical workgroups on American Rescue Plan Homeless Children and Youth (ARP–HCY) implementation topics including increasing the identification of and serving children and youth experiencing homelessness in historically underserved communities; providing wrap-around services

and coordinated referrals and case management through school social workers; hiring systems navigators at the State, regional, and local levels; collaborating and contracting with community-based organizations to provide these services; and preparing for sustainability of programs and services when ARP–HCY funds expire for use at the end of FY 2024. State Coordinators and local liaisons in every school district are the main audiences for this technical assistance, including those in West Virginia.

Furthermore, the Department has commissioned national studies of ARP–HCY to be completed in FY 23 and 24, oversees much information collection and data analysis annually of homeless student performance at the LEA level, and monitors several States per year and asks about EHCY and ARP–HCY implementation and program performance.

Finally, Department and EHCY program staff are active members of the U.S. Interagency Council on Homelessness and have supported the development and implementation of the Federal Strategic Plan to Prevent and End Homelessness issued in December 2022, particularly on pillars of the plan that focus on equity, use of data, provision of support services and prevention of homelessness.

Question. Secretary Cardona, you will recall on May 19, 2022 I sent a letter to your office expressing my serious concerns regarding the delay in announcing the grant slate for TRIO's Upward Bound (UB) awards. At that time, we were 12 days away from current funding expiring. Federal statute (20 USC Sec. 1070a-11(c)(7)) requires the Department of Education to make these awards 8 months prior to the funding expiration date.

The Department sent the first award announcements on May 20, 2022, for programs that started on June 1, 2022. These institutions had just 12 days to recruit and hire staff to run new programs. In cases where funding was lost, individuals learned of their unemployment with less than two weeks' notice.

It is my understanding that TRIO administrators have urged the Department to use these non-competition years (2023 and 2024) to re-adjust the grant competition schedule in time for the next wave of TRIO grant competitions, which will begin with the largest TRIO program—Student Support Services—in FY2025. By starting the grant competition process earlier, the Department can provide sufficient notice to programs and institutions.

I would like to follow up and ask you about the progress on updating the schedule of TRIO grant competitions so that applicants receive notice in sufficient time to implement their projects and we avoid this problem in future competitions.

Answer. As one of the largest discretionary grant programs in the Department, the TRIO program competitions are administratively complex and require considerable Department resources to implement. The Department recently initiated planning to ensure that the FY 2025 new award competitions under TRIO are conducted and issued in a timely manner.

QUESTIONS SUBMITTED BY SENATOR SHELLEY MOORE CAPITO

Written Arrangements

Question. Community and technical colleges that provide apprenticeship programs are producing graduates with the necessary hands on training as well as professional workplace development that will give them an advantage when they enter the workforce. One of my local community colleges approached me with concerns about a Dear Colleague Letter on written arrangements (GEN–22–07) that would impact the college's ability to work with an outside entity and potentially jeopardize their ability to operate an apprenticeship program.

Does the Department take into account the potential impact of their policies on small and rural colleges when they are being developed?

Answer. The Department considers the effects of its policies on institutions, including small and rural institutions, while they are being developed, as well as the implications for students. In doing so we must make sure that institutions follow the requirements of the Higher Education Act. This matters both for protecting taxpayer investments and ensuring that students are well served by their programs and institutions.

Cybersecurity in Schools

Question. In February 2023, Berkeley County Schools in West Virginia had a ransomware attack that took out the entire school district's network, and there have been many other reported incidents like this across the country. With the rise of similar ransomware attacks on our schools.

How is the Department working with K–12 schools and higher education institutions to help schools improve their cybersecurity and better protect students, parents, faculty, and staff's private information?

Answer. The Department has engaged in coordination internally and across agencies. Regarding K–12 cybersecurity:

—In 2022, the Department established an intra-agency cybersecurity working group which meets bi-weekly. In response to ransomware attacks, the working group established a "Cyberhelp" website highlighting the resources to support school districts in preparing for and responding to cybersecurity incidents.

—In January 2023, the Department added one career staff member in the Office of Elementary and Secondary Education who is focused on cybersecurity and will facilitate coordination across the Department and the interagency working group. This includes engagement with SEA, ESA, and LEA partners related to the establishment of a formal coordinating mechanism, such as a Government Coordinating Council (GCC) and exploring ways in which the Readiness and Emergency Management for Schools Technical Assistance Center can expand its existing cybersecurity training, resource materials and briefs to support schools, school districts and state officials who manage both physical and cyber emergency operations.

—In September 2022, the Department's Office of Educational Technology hired a Digital Infrastructure Fellow to increase its capacity for formal Federal, state, and local coordination. Interagency coordination with the Cybersecurity and Infrastructure Security Agency (CISA), the Federal Bureau of Investigation (FBI), the National Security Council (NSC), and the Office of the National Cyber Director (ONCD) has led to meaningful support schools related to P–20 cybersecurity including:

  —Webinars and conference sessions that engaged thousands of K–12 technology leaders around cybersecurity best practices.

  —The forthcoming publication of the Defensible and Resilient K–12 Digital Infrastructure Brief. The Brief, which is co-authored by CISA and ED, provides specific, actionable non-binding recommendations related to cybersecurity for superintendents, state agency chiefs, and their technology leaders.

—The Department's Student Privacy Policy Office (SPPO), through the Privacy Technical Assistance Center (PTAC), provides student privacy-related TA. SPPO also provides best practice documents and videos on cybersecurity topics such as cybersecurity basics, responding to a data breach, responding to a ransomware attack, cloud computing, data destruction, identity management and authentication, and vetting education technology. In addition, SPPO provides a series of webinars and both regional and national presentations on a variety of data security related topics, such as incident response, access controls, and even a popular hackathon.

  Federal Student Aid has also undertaken work to bolster the cybersecurity efforts of Institutions of Higher Education (IHEs).

—In February 2023, the Department released Electronic Announcements on the cybersecurity requirement updates under the Gramm-Leach-Bliley Act clarifying that institutions need to comply with the requirements of the new FTC regulation, as well as new cybersecurity resources available for institutions.

In addition, the IHE Team at FSA is available to answer questions and further explain all current guidelines, as well as provide direct support to schools who are experiencing a cybersecurity issue. The IHE team provides information and resources to the higher ed community on a very frequent basis, including fact sheets, critical cyber threat notifications, and templates for cybersecurity best practices. The IHE Quarterly Cybersecurity Newsletter is sent to over 20,000 recipients. It contains plain speak explanations of technical requirements, as well as free resources from CISA, FBI, and state agencies. FSA has also developed and delivered numerous presentations to higher ed leaders, financial aid administrators, IT professionals, and support organizations (including NASFAA and EDUCAUSE) explaining highly technical concepts and requirements as appropriate for the audience.

The Department plans to release an Electronic Announcement with details for partners on consent and access regarding taxpayer data, uses of taxpayer data, and safeguarding taxpayer data. We will continue to provide support and clear expectations to institutions on how to ensure they are protecting these data.

Online Education

Question. I have heard concerns from colleges that the Department's consideration of changes to the 2011 Dear Colleague Letter on the incentive compensation prohibition and bundled services exemption would impact their ability to offer high quality online programs to students.

As you consider changing this guidance, have you conducted an analysis of the impact of potentially losing programs in critical professions?

Answer. The Department understands that many institutions of higher education have entered into contracts that rely on the bundled services exception to create and expand online programs. That is why we intentionally conducted public hearings and sought public comment to make sure we are hearing from all stakeholders on this issue. Commenters expressed a wide range of views on the impact of the bundled services loophole on institutions' ability to offer online programs. The Department is continuing to review the comments received and we anticipate soliciting further public input as we consider potential changes.

Question. If so, can you share that analysis with Congress?

Answer. Our consideration of this issue, including our work to better understand the size and scope of the market of programs affected by the bundled services exception, is ongoing. These arrangements are not currently required to be reported to the Department and are not publicly disclosed by the major online program managers.

Question. If not, will you commit to conducting an analysis on the potential impact of the guidance change on school programs related to these industries?

Answer. We are committed to taking a thorough and detailed look at the issues related to the bundled services exception.

Question. The Department has recently released a number of policy positions related to online higher education. Quality online higher education degree programs provide access to affordable, quality higher education options for working adults which is an important priority.

Did you or your staff meet with colleges that offer quality online education programs as part of the process of developing your new policy positions around online higher education?

Answer. The Department has conducted numerous meetings with institutions of higher education that offer online programs, the companies that manage online programs, and other stakeholders who are engaged on this topic.

Integrated Student Supports

Question. Integrated student supports (ISS) is an important strategy that has worked well in West Virginia. ISS has a strong evidence base of increasing student achievement and student wellness, and ISS meets ESSA's highest tier of evidence-based standards.

How can school districts leverage various current Federal funding sources, including remaining ESSER funding, Title I–A, Title III, and Title IV–A, among others, to implement ISS in schools?

Answer. ESSER funds have broad allowable uses and we have encouraged States and local school districts to use funds for evidence-based strategies, such as integrated student support services. Our Frequently Asked Questions document specifically addresses how funds can be used in combination with or "braided with" other funds in order to meet the goals of a community. This document also provides many examples of how grantees might use ESSER funding to support evidence-based strategies. In addition, the Department published a COVID–19 Handbook (updated in August 2021) that specifically identifies integrated student supports as an allowable use of funds and a reasonable strategy to address the needs of students impacted by the pandemic.

Similar to ESSER, the Title I, Part A (Title I) program provides for a broad authority for districts and schools to determine how to use their funds. Title I funds must be used to carry out the purpose of Title I to provide all children significant opportunity to receive a fair, equitable, and high-quality education, and to close educational achievement gaps. Any use of funds must be consistent with the school's overall Title I program. In particular, the activity must help facilitate overall purpose of Title I to improve the achievement of students who are failing, or most at risk of failing, to meet the academic content and achievement standards developed by the State. Title I funds in a schoolwide program (SWP) school must address the specific educational needs of students, particularly the lowest-achieving students, in the school identified by the needs assessment and articulated in the comprehensive plan. Similarly, Title I funds in a targeted assistance program (TAP) school must address supplemental educational needs of students who are failing, or most at risk of failing, to meet the State's academic achievement standards. To the extent that ISS activities focus on improving the academic achievement of students served by Title I based on needs identified in a SWP school or the needs of low-achieving students in a TAP school, it would generally be an allowable use of Title I funds to support those activities for students served by the program.

Further, the ESEA authorizes an LEA to use section 1003 school improvement funds for any activity that it determines will help a school identified for comprehensive support and improvement (CSI), targeted support and improvement due to consistently underperforming subgroups (TSI), or additional targeted support and improvement (ATSI) improve student outcomes. Each CSI, TSI, and ATSI plan must include evidence-based interventions and if an LEA uses section 1003 funds to support evidence-based interventions, it must be from one of the highest three tiers of evidence-based standards.

Title III, Part A funds must be used for the purpose of providing supplemental services that improve the English language proficiency and academic achievement of English learners. Title III, Part A funds can be used for Integrated Student Supports if the use of funds is consistent with these purposes. However, note that Title III, Part A prohibits supplanting of other Federal, State, and local funds. In general, it is presumed that supplanting has occurred: (1) if the SEA or LEA uses Title III funds to provide services that the State educational agency (SEA) or LEA was required to make available under other laws; or (2) the SEA or LEA uses Title III funds to provide services that the SEA or LEA provided with State, local, or other Federal funds in the prior year. Therefore, Title III, Part A funds can be used for Integrated Student Supports only if the use of funds is consistent with the purpose of Title III, is supplemental to the LEA's civil rights obligations to ELs under Title VI of the Civil Rights Act of 1964 and the Equal Educational Opportunities Act (EEOA), and the LEA is also using Title III funds to conduct the activities required by Title III.

Under the Title IV–A program, activities that foster safe, healthy, supportive, and drug- free environments that support student academic achievement are allowable under section 4108. Funds may be used to support programs, activities, and professional development and training that are cross-cutting in nature and that can promote safe and supportive learning environments, including strategies such as integrated student services. Integrated student services can provide a comprehensive response to children and youth who are experiencing serious mental health or behavioral challenges and are typically provided as the most intensive and individualized part of a MTSS and involve additional community collaborations.

Charter Schools

Question. My understanding is that the Department's Charter School Program staff will not be allowed to travel to the National Charter Schools Conference in Austin, TX this June for a technical assistance panel due to budget constraints.

Has the Department considered using technical assistance funds under Sec. 4305, which authorizes the Department to "disseminate technical assistance" to CSP grant recipients to allow staff to travel to the conference?

Answer. Notwithstanding authority to disseminate technical assistance, as with most of the Department's programs, Charter Schools Program funds may not be used to support travel expenses of Department staff.

QUESTIONS SUBMITTED BY SENATOR MARCO RUBIO

CCP Influence in American Schools, Colleges, and Universities

Question. The Chinese Communist Party has gained a foothold in our schools. For decades, through initiatives such as the PRC's talent programs, China has recruited U.S.- based scientists and researchers to steal U.S. IP to benefit China's military and economic goals.

How concerned are you about Chinese theft of American universities' IP?

Answer. We are coordinating closely with the Office of Science and Technology Policy on the implementation of National Security Presidential Memorandum 33 and various legislated requirements intended to deal with the PRC's attempts to illicitly acquire information from both the private sector and from academic institutions. It's important that we correctly characterize the threat vectors—much of what the PRC is targeting through its foreign talent recruitment programs, such as the Thousand Talents Program, is pre-publication information. We are also closely coordinating with the National Science Foundation on the development of the Research Security and Integrity Information Sharing and Analysis Organization, or "Risk Assessment Center" established by the 2022 CHIPS and Science Act, as well as the National Counterintelligence Task Force, which will help us better understand and characterize the specific threats faced by American academic institutions.

At the same time, we need to be cognizant that as we address the threat posed by the PRC that we do not attempt to replicate the behavior of the Chinese Communist Party or handicap our ability to attract world-leading talent to our academic

institutions. More than half (55 percent) of American startup companies valued at a billion dollars or more are founded by Immigrants as well as 45 percent of Fortune 500 companies, and many of those were started by students who chose to attend a U.S. university. As the PRC strategy pivots toward supporting indigenous innovation, we need to make sure that our university system supports strong collaborations and exchanges with our allies and partners. That means that the measures that we implement need to not inhibit or discourage, but rather intensify the development of relationships with trusted institutions, abroad.

Question. What programs and/or guardrails to combat the CCP's influence in our schools have you administered since being confirmed?

Answer. Section 117 of the Higher Education Act of 1965 requires institutions of higher education that receive Federal financial assistance to timely disclose all required information to the Department regarding gifts received from and contracts with a foreign source that, alone or combined, are valued at $250,000 or more in a calendar year. See 20 U.S.C. § 1011f. This disclosure requirement is an important measure in ensuring transparency and identifying financial ties between U.S. institutions of higher education and foreign source.

The Department's statutory duties under Section 117 include collecting disclosure reports that institutions are required to file, making data publicly available, and monitoring institutions' compliance with disclosure requirements. The Department is committed to ensuring the robust compliance with Section 117 and is actively engaged with the institutions with open investigations and other stakeholders to ensure that institutions fully understand and comply with their reporting obligations. The Department has reiterated that institutions are expected to exercise reasonable due diligence and make a good faith effort to determine whether a gift or contract involves an agent acting on behalf of a foreign source, which can include an entity or individual acting on behalf of a foreign government. It is important that foreign governments are not permitted to circumvent the reporting requirement by using intermediaries to transfer money, property, or other benefits in a manner that would be contrary to the statute's broad disclosure mandate and the statutory purpose of transparency with regard to gifts from and contracts with foreign sources. No matter the level of due diligence conducted, institutions have the ultimate responsibility to ensure their compliance with Section 117.

The Department continues to collaborate with other Federal agencies through various interagency initiatives relating to research security and foreign malign influence in higher education. Accordingly, the Department is exploring ways in which it can deepen its partnerships with, and broaden its support to, other Federal agencies to contribute toward cross-government efforts in these areas so that we can be better understand how foreign funding may aim to undermine U.S. national security and academic freedom, diversity and openness on higher education campuses. The Department also works with higher education institutions and representative groups to provide technical assistance on compliance with the law.

Foreign gifts and contracts reported by institutions of higher education under section 117, as well as additional information regarding the Department's administration of the statute, is available at the Department's section 117 webpage: https://fsapartners.ed.gov/knowledge-center/topics/section-117-foreign-gift-and-contract-reporting.

CCP Influence in American Schools, Colleges, and Universities

Question. There must also be heightened scrutiny of Confucius Institutes and their successors, which have been tools of the CCP's propaganda efforts in the U.S. The institutes sponsor Confucius Classrooms in U.S. primary and secondary schools. Although the number of these classrooms has decreased, the National Association of Scholars (NAS) has found that some have continued to operate. Additionally, and despite the closure of many Confucius Institutes in the U.S. since 2018, the NAS in March 2023 counted (1) a total of 13 Confucius Institutes in the U.S., (2) at least 28 institutions that have replaced their closed Confucius Institutes with a similar program, (3) at least 58 institutions that have maintained close relationships with their former Confucius Institute partner, and (4) at least five institutions that transferred their Confucius Institutes to a new host.

a. How concerned are you with the relationships that American schools, colleges, and universities have with entities owned, directed, controlled, financed, or influenced by the Government of the People's Republic of China (PRC) or the CCP?

b. Does the department track the presence of such entities in American schools, colleges, and universities?

c. Does the department track the relationships that schools, colleges, and universities have with such entities?

d. Does the department track the relationships that school, college, and university faculty and staff have with such entities?

e. Does the department track such entities' ownership of American schools, colleges, and universities?

f. Please provide an update on how the department is enforcing reporting requirements under Section 117 of the Higher Education Act.

g. Have you identified statutory gaps that Congress should consider closing in regard to foreign gift and contract reporting?

h. To what extent has the department analyzed the influence of the PRC and CCP on American students?

i. How concerned are you about the presence of Confucius Institutes and their successors in American schools, colleges, and universities?

j. Do you believe that the benefits of Confucius Institutes' language and cultural programs outweigh the costs—such as the restraint of academic freedom and interference on academic or extracurricular activities and speech?

k. What additional steps should the Federal Government take to protect American students from such entities' influence, surveillance, or harassment?

l. Are you concerned with the influence of other countries of concern in our schools, colleges, and universities? If so, please elaborate.

Answer. We are aware of the concerns raised by government institutions, including Congress and Members of the law enforcement and intelligence communities, with on-going operations posed by the operation of "rebranded" Confucius Institutes when it comes to foreign influence and academic freedom. We remain in close coordination with other U.S. government departments and agencies to understand trends by foreign countries that could undermine academic freedom, diversity and openness in higher education and that may undermine our U.S. national security.

Student Loan System

Question. The Federal Government should not be using taxpayer dollars to favor one education path over another, yet that is precisely what the Biden Administration's student loan cancellation and pause plans do. The administration has wrongfully and unapologetically taken steps to cancel Federal student loans for millions of borrowers, which has no legal basis, and extend the payment and accrual pause on student loans, which is no longer justified. These moves would cost American taxpayers hundreds of billions of dollars.

Alarmingly, your policies would mean that 85 percent of Americans with no undergraduate debt from college—many of whom did not even go to college in the first place—would bear the burden of those who do. That, Mr. Secretary, is picking favorites. This is politically motivated effort at the expense of working-class Americans and the modernization of our education system.

Are you concerned that temporary student debt relief could lead to higher overall household debt levels and larger future debt burdens?

Students from elite institutions owe a disproportionate share of student debt. The Brookings Institution discussed that students who graduated, or withdrew, in 2017 or 2018 from elite or highly selective colleges and graduate programs owed around 12 percent of all student debt in those years even though they only 4 percent of all borrowers. If the student loan forgiveness policy is not overturned, what will you do for students who did not go to elite or highly selective colleges or programs?

Answer. The student debt relief program would have provided critical pandemic relief to over 40 million borrowers most at risk of delinquency or default when the student loan payment pause ends. These borrowers are working and middle-class Americans—nearly 90% of the relief would have gone to those earning less than $75,000 per year.

Bigger picture, the student loan system is broken and it is saddling students with unaffordable debt. It's keeping borrowers from getting relief that Congress promised them years ago. The broken system hurts students by putting them at risk of default and delinquency. And it also hurts families and the country too by holding back homeownership and opportunity. It undercuts the transformational power of colleges to encourage economic mobility. Investments in our higher education system and the students and borrowers they serve strengthen our country and our society. We all benefit from getting more people to and through affordable college. As you note in your question, the vast majority of student debt is held by borrowers who did not attend highly selective colleges and universities. The Department is fully committed to supporting all student loan borrowers.

The Administration also just finalized regulations creating the most affordable repayment plan ever, called the Saving on a Valuable Education (SAVE) Plan. Later this summer, borrowers will start saving money under the new plan, which will cut monthly payments to $0 for millions of borrowers making $32,800 or less ($67,500

for a family of four) and save all other borrowers at least $1,000 per year. Additionally, it will stop runaway interest that leaves borrowers owing more than their initial loan even when they keep up with their monthly payments. As detailed at length in the final rule, this new plan is focused on helping the most vulnerable borrowers avoid delinquency and default.

Our Administration will continue our important work of making college more affordable and accessible for more low-income and working American families and making the student loan system more manageable for borrowers. Under President Biden's leadership, we have taken unprecedented steps toward this goal, including by working with Congress to increase Pell Grants by $900, which is the largest increase in a decade; taking action to fix a broken Public Service Loan Forgiveness program and discharge more than $42 billion in debt so public service workers can get the loan relief they were promised; and hold colleges accountable when they take advantage of students and borrowers.

Question. Would eliminating accruing interest benefit working-class Americans?

Answer. Yes, borrowers who have the lowest incomes relative to their debt payments derive the greatest benefits from this plan. This means someone making under $15 an hour will not see their loans grow due to runaway interest.

Question. Would placing borrowers in an income-based repayment plan benefit working- class Americans?

Answer. Yes. The income-driven repayment plan helps borrowers avert default and keep their loans manageable. Prior to the pandemic more than 1 million borrowers defaulted on their loans each year. These borrowers are overwhelmingly those who did not complete their programs or earn a degree.

Question. Do you believe that cost should be one of the main considerations when proposing student loan plans?

Answer. The Department is required to consider the costs of proposed regulations compared to their benefits. We only issue regulations when we determine that the benefits outweigh the costs.

A Shift from College For All

Question. Typically, post-secondary education results in higher earnings and is a more reliable route to success for the middle class compared to immediately entering the workforce after high school. But, I think we can both agree that our higher education system is burying working families in debt. And, many times, working families take on this crippling debt for degrees that do not lead to good-paying jobs. A four-year degree does not guarantee a good-paying job nor a stable, middle-class job. Thankfully, Americans are increasingly shifting away from the "college-for-all" mentality and toward the world of options that our marketplace provides. And the number of trades in which one can find apprenticeships is increasing as well.

Is improving workforce development, career counseling, or employment and training services less of a priority for the administration than cancelling student loans?

Answer. Strengthening the preparation of young people and adults for success in postsecondary education and the workforce is central to our agenda at the U.S. Department of Education. The Department's Strategic Plan for Fiscal Years (FYs) 2022–2026 includes three related strategic objectives that are driving our work:

—Strategic Objective 1.4: Promote greater access and supports for youth and adults to engage in learning, succeed in postsecondary education, and increase their employability in high-demand occupations.

—Strategic Objective 4.3: Increase equitable access to secondary and postsecondary programs that have clear on-ramps to both high-quality jobs and additional high- quality postsecondary educational opportunities.

—Strategic Objective 4.4: Improve the alignment across secondary, postsecondary, and career and technical education programs, including through transparent and effective transition processes, inclusive pathways, and clear credentialing requirements.

Because each program office of the Department plays an important role in preparation for postsecondary education and careers, we have an intra-agency team that is focused on expanding access to high-quality career pathway opportunities that lead to good jobs and the middle class. This collaborative effort will leverage each office's expertise, resources, and unique perspectives to create more opportunities for Americans.

The Department's leadership also collaborates closely with their counterparts at the Departments of Commerce, Labor, Transportation, Agriculture, Energy, and other Federal agencies to advance the President's Investing in American agenda to prepare and connect more Americans with the good jobs that are being created by the American Rescue Plan, the Bipartisan Infrastructure Law, the CHIPS and Science Act, the Inflation Reduction Act, and associated private investments. Many

of these jobs do not require a four-year degree. This includes an intentional focus to support Registered Apprenticeship, career and technical education, adult education, and career pathway programs starting in high school.

Question. Outside of requesting more appropriations, do you have any plans to shift more of your department's time and resources to Career and Technical Education (CTE) or other workforce development efforts?

Answer. In addition to requesting $1.7 billion for Career and Technical Education in FY 2024, including increases for State Grants and National Programs, the U.S. Department of Education (ED) is leading Raise the Bar: Unlocking Career Success, an interagency initiative with the support of the Departments of Labor (DOL) and Commerce (DOC), to reimagine how our nation's high schools prepare all students to thrive in their future careers. The initiative highlights four evidence-based strategies, or "keys," to career success for young people, with CTE as a foundation for this work:

—Participation in a comprehensive postsecondary education and career navigation system that puts labor market information into the hands of students and their families to make real decisions about their futures; this guidance supports students' career exploration and education planning and provides information and assistance in pursuing further learning after high school.

—Acquisition of postsecondary credit through dual or concurrent enrollment programs to promote success in postsecondary coursework and give students a head start in earning a postsecondary credential.

—Participation in work-based learning opportunities—including pre-apprenticeship and apprenticeship—for which students receive wages or academic credit, or both.

—Attainment of an in-demand and high-value industry-recognized credential so that every young person can confidently enter the labor market with real skills that employers need, earn a living wage or more after high school, be able to pursue further education, and live independently.

In support of the initiative, ED will produce a suite of practical tools and resources for stakeholders on college and career readiness; create communities of practice to hear directly from the field about the challenges and opportunities in advancing college and career readiness for students; and hold regional convenings to highlight exemplary practices. Through this initiative, we hope to expand opportunities for all students to engage in innovative and equitable pathways that propel them to rewarding futures.

Question. What are you doing to ensure that young Americans are informed of available career options and are not pressured to pursue degrees that are not in their best interests?

Answer. Raise the Bar: Unlocking Career Success emphasizes that it is essential to provide high school students career advising and postsecondary navigation supports early and often, informed by accurate and up-to-date labor market information, so that every student graduates with clear career goals and a plan for achieving them. Assistance navigating the complexities of pursuing different types of postsecondary learning, such as a high-value industry-recognized credential program, Registered Apprenticeship program, and 2- and 4-year degree programs, is especially important.

Opportunities for work-based learning, another key to career success that we highlight in our initiative, also can help young people identify career goals and start building professional networks that they can tap after high school. Well-designed internships, pre- apprenticeships, and Registered Apprenticeships in which students receive one-to-one coaching support from a caring adult and support for planning life after high school can have a positive influence on their futures, with benefits that can continue well into adulthood. Using data from the National Longitudinal Survey of Youth of 1997 and a quasi-experimental research design, researchers found that, for young people from low- income backgrounds, participation in work-based learning—such as cooperative education, an internship, or Registered Apprenticeship—or in an employer mentorship program in high school was associated with holding a high-quality job at age 29, as measured by wages, benefits, hours, and job satisfaction.[5]

Question. What are you doing to reverse the "college-for-all" mentality in the department and in the country more broadly?

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[5] Ross, M., Anderson Moore, K., et al. (2018), Pathways to High Quality Jobs for Young Adults. Washington, DC: Metropolitan Policy Programs at Brookings and Child Trends. Retrieved from: https://www.brookings.edu/research/pathways-to-high-quality-jobs-for-young-adults/.

Answer. We have been outspoken about the need to reimagine how we prepare young people for the future. Too many students do not take advantage of opportunities in high school for career exploration and career-connected learning. This leads to students entering postsecondary education without clear goals beyond attaining a bachelor's degree and without understanding the full array of postsecondary opportunities and valuable credentials in the sub-baccalaureate space.

The Career Connected High Schools program, for which the Department received $25 million in FY 2023, and has requested $200 million in FY 2024, will demonstrate the value of career-connected, high school experiences that are tied to regional economic needs and aligned with various types of postsecondary education so that students who do choose to pursue a postsecondary credential after high school have a head start when they enroll. Funds will build support for strategies and practices that, when taken to scale over time, would strengthen career-based pathways across grades 11–14, erasing current boundaries and barriers between high school, postsecondary education, and employment. The Career-Connected High Schools program will award competitive grants to create new structures and supports to help high school students, with a focus on underserved students, develop and navigate clear pathways to career preparation and postsecondary education, accrue college credit, pursue in-demand, high-value credentials, and gain direct experience and skills in the workplace that lead to high-quality jobs. The Department has received comments on the FY 2023 Notice of Proposed Priorities and plans to make new awards in FY 2024.

The Department expects to launch a competition this summer for the $25 million appropriated in FY 2023 for the Career-Connected High Schools program, but we anticipate that we will be able to fund only a fraction of the applications we will receive. Scaling up the program in FY 2024 would enable the Department to better meet the need and demand of the field for assistance to reimagine how we prepare young people for the future. This issue has broad interest and support and could be further catalyzed given additional opportunity. According to the National Governor's Association, at least 31 governors focused on expanding career and technical education and workforce development opportunities for high school students their 2023 State of the State addresses.[6]

Question. What innovative steps have you taken, or plan to take, to increase coordination between the Education and Labor Departments to improve the training and employment services that the Federal Government funds?

Answer. Leaders in the Office of Career, Technical, and Adult Education in ED, the Employment and Training Administration in DOL, and DOC meet regularly to share information, coordinate related activities, and collaborate on shared initiatives. Raise the Bar: Unlocking Career Success is one shared initiative. The Secretaries of Commerce and Labor joined me in Chicago, Illinois in November 2022 to announce their support of its launch.

Another, more recent shared initiative is our support and collaboration in carrying out the President's Investing in America Workforce Initiatives. The Bipartisan Infrastructure Law, CHIPS and Science Act, and Inflation Reduction Act are catalyzing public- and private-sector investments across the nation—including significant concentrations in key cities and regions. To unleash the full economic and job-creation potential of these investments, the Biden-Harris Administration has identified an initial set of five Workforce Hubs, each centered on key industries. In each Hub, the Administration will partner with state and local elected officials and community leaders to drive effective place-based workforce development efforts that are essential to building an economy from the bottom up and the middle out. Teams from DOL, DOC, DOE, DOT, and the Department are each leading on one of the Hubs, and supporting leaders in every Workforce Hub as they work to secure private-sector and state and local commitments to expand pre-apprenticeship and Registered Apprenticeship programs, develop or expand career and technical education programs aligned to Investing in America jobs and careers, and provide supportive services that are particularly critical to helping underrepresented students and workers succeed.

Freedom of Speech in Colleges and Universities

Question. The department is expected to soon finalize its proposed rule "Nondiscrimination on the Basis of Sex in Education Programs or Activities Receiving Federal Financial Assistance, 87 Fed. Reg. 41390, RIN 1870–AA16 (Proposed Rule)." I have communicated my many concerns with this proposed rule to you. Among

[6] State Education Trends for 2023 (2023). National Governor's Association. Retrieved from: State Education Trends for 2023—National Governors Association (nga.org).

these concerns is the fact that this proposed rule ignores First Amendment free speech and religious freedom protections and parental rights.

Do you believe that requiring teachers, administrators, contractors, and grantees to "affirm" students' "gender identity" violates the First Amendment's guarantees of speech and religion?

Answer. The Department, consistent with determinations of experts and courts, has recognized that treating a student inconsistent with their gender identity can be harmful. The Department does not interpret its Title IX regulations as restricting any rights guaranteed against government action by the U.S. Constitution, including the First Amendment. 34 C.F.R. 106.6(d). The determination as to whether particular conduct by a teacher, administrator, contractor, or grantee act violates Title IX or is protected by the First Amendment requires a fact-specific inquiry. The Department does not make compliance determinations without first conducting an investigation of all of the relevant facts. Please note that the Department is in the process of reviewing and considering public comments on its proposed Title IX regulations. Following the Department's review and consideration of the comments, the resulting final regulations and their effective date will be published in the Federal Register. The preamble to the final regulations will include a summary of the comments received, the Department's response to the comments, and an explanation of any changes made to the regulations that differ from the proposed regulations.

Question. The 2020 Title IX rule made clear that Title IX does not restrict any rights guaranteed by the First Amendment, so it would not limit free speech or the free exercise of religion. Will you commit to making the same guarantee in this rule? If not, why?

Answer. The Department has made clear in many contexts and across administrations that it interprets Title IX consistent with the requirements of the First Amendment. Title IX protects individuals from sex discrimination and does not regulate the content of speech as such. The Department is in a rulemaking process for Title IX and has not proposed any changes to current § 106.6(d) of the Department's Title IX regulations, which states that nothing in the Title IX regulations requires a recipient to "[r]estrict any rights that would otherwise be protected from government action by the First Amendment of the U.S. Constitution."

Question. Do you believe that there are instances in which a school should withhold information from parents about their child's belief that they are transgender?

Answer. The Department affirms and respects parents' integral role in making decisions about their child's education. The Department's Title IX regulations specify that they should not be read in derogation of any legal right of a parent or guardian to act on behalf of their child, 34.C.F.R. § 106.6(g). Title IX does not address the specific question of notifying parents about a child's gender identity.

The Family Educational Rights and Privacy Act (FERPA) affords parents certain rights with respect to the education records of their children. 20 U.S.C. § 1232g, 34 CFR Part 99. When children reach 18 years of age or begin attending a postsecondary institution at any age, they become "eligible students," and all of the rights under FERPA once afforded to the parent transfer to the student. Under FERPA, parents have the right, upon request, to inspect and review their child's education records, including education records that discuss their child's gender identity, if such records exist. 20 U.S.C. § 1232g(a)(1); 34 C.F.R. § 99.10. FERPA does not require a school or school district to affirmatively notify parents about information in their child's education records, but the school or the school district must comply with a parent's request to inspect and review education records no more than 45 days after receipt of a request. Id.

The Department will continue working to ensure that the rights of all parents and students are protected under the laws enforced by the Department.

Question. To what extent does the department track speech policies at universities and offer assistance in the development or improvement of the same?

Answer. The Department does not track speech policies at universities or offer assistance in the development or improvement of those policies.

Question. In Davis v. Monroe County Board of Education, 526 U.S. 629, 651 (1999), the Supreme Court defined student-on-student harassment as conduct that is "so severe, pervasive, and objectively offensive, and that so undermines and detracts from the victims' educational experience, that the victim-students are effectively denied equal access to an institution's resources and opportunities."

Are there instances where schools are defining harassment more broadly than the Supreme Court's definition, and if so, what have been the effects?

Answer. The Department enforces its Title IX regulations and the definition of sexual harassment set forth in those regulations. The Department reviews school harassment policies to the extent they are relevant to an investigation by OCR but does not track definitions of harassment in school policies more generally. Any indi-

vidual may file a complaint with OCR if they believe a school policy violates Title IX or any of the other laws enforced by OCR.

Question. Do you have any concerns with the state of speech policies at colleges and universities?

Answer. The Department believes that protecting First Amendment rights at public colleges and universities and upholding stated free speech policies is essential. The Department will continue to encourage all public educational institutions to protect students' First Amendment rights and private institutions to uphold their free speech policies.

The Department does not track speech policies at colleges and universities. In February 2023, the Department issued a request for information on how the Department's regulations have affected or are reasonably expected to affect decisions surrounding First Amendment and free speech-related litigation in Federal and State court and institutional policies on freedom of speech. The Department is currently reviewing public comments received in response to its request. Public colleges and universities must already abide by the First Amendment, which provides strong protections for free speech and religious freedom, including protecting the rights of student organizations at public colleges and universities.

Question. Do you believe that there is room for colleges and universities to improve their speech policies and make them less restrictive?

Answer. The Biden Administration strongly believes that protecting First Amendment freedoms on public college and university campuses is essential to creating a healthy and dynamic learning community that prepares students to work and think critically and creatively to solve the challenges facing our country in the 21st century. The Department will continue to encourage all public educational institutions to protect students' First Amendment rights and private institutions to uphold their free speech policies.

Whether it is having the freedom to debate issues of the day and engage with new topics in the classroom, gathering for expressive purposes, or engaging in constitutionally protected religious practices, protecting First Amendment freedoms serves students, faculty, staff, and administrators and ensures our colleges and universities are hubs of intellectual innovation and growth for their broader communities and the Nation. We have urged public colleges and universities and their students to engage thoughtfully on these matters, while holding paramount the goal of creating environments in which all students have the opportunity to learn and thrive. We also respect and rely upon the courts to protect First Amendment freedoms.

CONCLUSION OF HEARINGS

Senator BALDWIN. And with that, the Committee will stand in recess.

[Whereupon, at 11:19 a.m., Thursday, May 11, the hearings were concluded, and the subcommittee was recessed, to reconvene subject to the call of the Chair.]

DEPARTMENT OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION, AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 2024

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

[CLERK'S NOTE.—The subcommittee was unable to hold hearings on departmental and nondepartmental witnesses. The statements and letters of those submitting written testimony are as follows:]

DEPARTMENTAL WITNESSES

PREPARED STATEMENT OF AMERICA'S PUBLIC TELEVISION STATIONS AND THE PUBLIC BROADCASTING SERVICE

On behalf of America's 160 public television licensees, collectively operating 336 public television stations serving nearly 97 percent of the American people, we appreciate the opportunity to submit testimony on the importance of Federal funding for local public television stations and PBS. We urge the subcommittee to support $575 million in 2-year advance funding for the Corporation for Public Broadcasting (CPB) in FY 2026, $60 million for the Public Broadcasting Interconnection System in FY 2024 and $31 million for the Ready To Learn program at the Department of Education in FY 2024.

CORPORATION FOR PUBLIC BROADCASTING: $575 MILLION (FY 2026) 2-YEAR ADVANCE FUNDED

Public television plays a key role in educating our children; providing job training; preserving our diverse, dynamic culture and democracy; and keeping Americans informed, safe and healthy.

Federal funding for CPB, which enjoys the overwhelming support of the American people, is essential to making these services available to all Americans, including those in rural and underserved areas. At about $1.40 per person per year, this funding provides an enormous return on investment for all Americans.

Yet these vital community-based services were level-funded for a decade and the FY 2025 enacted funding level of $535 million still leaves the public broadcasting system over $100 million, in inflation-adjusted dollars, behind where the system was 11 years ago. This shortfall continues to present a serious challenge at a time when local stations continue to grow the essential services they provide their communities in public safety, education and civic leadership while also bearing the cost of providing access to content on ever-emerging new platforms.

Public broadcasting respectfully requests that Congress take another substantial step toward securing our current and future public service goals in the FY 2024 appropriations process.

In addition to restoring lost purchasing power, the $575 million that public broadcasting is requesting in FY 2024 for FY 2026 will:

—Enable local stations to continue to provide and enhance lifesaving emergency alerts and warnings, and public safety communications capabilities for missions ranging from early earthquake warning to school safety response,

—Enhance the education of millions of K–12 students and adults, provide additional critical resources and capabilities to teachers and schools, including State curriculum-aligned, teacher-ready, interactive digital learning tools,

—Provide the only preschool education for more than half of America's young children, and

—Provide community-based trusted information on local public affairs, history and culture and serve as the "C–SPAN" of many State governments.

Given the success of local public media, and its potential to do so much more for so many, it is sound policy to increase Federal funding for this valuable service providing an exceptional return on investment.

Partners in Public Safety

Public broadcasting stations throughout the country are leading innovators and essential partners to local public safety officers. In partnership with FEMA, PBS WARN uses the public television interconnection system and local stations' broadcast infrastructure to support the Wireless Emergency Alert (WEA) system that enables cell subscribers to receive geo-targeted text messages in the event of an emergency-reaching citizens wherever they are.

The February 2019 Report from the FEMA National Advisory Council on Modernizing the Nation's Public Alert and Warning System specifically recommends, "Encouraging use of public media broadcast capabilities to expand alert, warning, and interoperable communications capabilities to fill gaps in rural and underserved areas."

In addition, and separate from the WEA system, local public television stations' digital infrastructure and spectrum enable them to provide State and local officials with critical emergency alerts, public safety, first responder and homeland security services and information during emergencies through a process known as datacasting. Datacasting uses broadcast spectrum to send encrypted data and video to first responders with no bandwidth constraints.

In partnership with local public television stations and local law enforcement agencies, the U.S. Department of Homeland Security (DHS) has conducted several successful pilots throughout the country that, in addition to other local initiatives, prove the effectiveness of datacasting in a range of use cases including: flood warning and response; enhanced 911 responsiveness; over-water communications; faster early earthquake warnings; multiagency interoperability; rural search and rescue; high profile, large event crowd control; and assistance with school safety, including in areas that lack broadband or LTE services.

As a result of the successful pilots, the DHS Science and Technology Directorate has partnered with America's Public Television Stations to maximize and promote datacasting technology and the opportunity to partner with local public television stations in communities nationwide.

Additionally, stations are increasingly partnering with their local emergency responders to customize and utilize public television's infrastructure for public safety in a variety of critical ways, with many serving as their States' Emergency Alert Service (EAS) hub for weather and AMBER alerts.

Education

Public media is committed to education and service for all Americans allowing people at all income levels and from all parts of the country-rural and urban-to have access to consistent, high-quality, diverse content for free. This educational content is readily available to children, parents, teachers, senior citizens, those pursuing their high school equivalency degrees, and many others.

Public television's educational broadcast content has helped more than 90 million pre-school age children get ready to learn and succeed in school. Beyond the iconic, proven educational programming, PBS, in partnership with local public television stations and school districts, provides additional content directly to classrooms and homes through PBS LearningMedia—which provides access to tens of thousands of State curriculum-aligned digital learning objects—including videos, interactives, lesson plans and more—for use in K–12 classrooms and at home. Content is sourced from the best of public television in addition to material from the Library of Congress, National Archives, Smithsonian Institution, NASA and other high-quality sources.

Additionally, local public television stations throughout the country have partnered with PBS to bring a first-of-its kind, free PBS KIDS 24/7 broadcast channel and live stream to their communities—providing kids throughout the country with the highest level of educational programming, available through local stations any time. During the COVID–19 pandemic, many stations used this expanded broadcast capacity to directly serve families and students from Pre-K—12 with State standards aligned educational content and instructional content created by teachers. Over the course of a year, 10.4 million children ages 2–8 watch PBS KIDS content

on-air while online PBS KIDS averages 15.4 million monthly users and 371 million monthly streams across PBS digital platforms.

Public television stations are also leaders in adult education. Public television operates the largest nonprofit GED program in the country, helping tens of thousands of second-chance learners earn their high school equivalency degree. In addition, public television stations are leaders in workforce development, including retraining American veterans, by providing digital learning opportunities for training, licensing, continuing education credits, soft skills and more.

Providing Civic Leadership

Public television strengthens the American democracy by providing citizens with access to the history, culture and civic affairs of their communities, their States and their country.

As some of the last locally controlled and operated media, public television stations are deeply committed to localism and rooted in community partnerships.

As a result, public television provides more community public affairs programming, more local history and culture content, more candidate debates at every level of the election ballot, more specialized agricultural news, more community partnerships to deal with issues of concern like veterans' affairs and the opioid crisis, and more civic information of all kinds than any other service in the media universe.

And many local public television stations often serve as the State-level "C–SPAN," covering State government actions and ensuring that all Americans have access to their government on the local, State and Federal level.

In addition, for the 20th year in a row, PBS was ranked the most trusted among national media institutions. That trust is more important than ever.

What truly sets public television stations apart is that stations treat their viewers as citizens rather than consumers.

Public Broadcasting is a Smart Investment

All of this public service is made possible by the Federal funding to CPB. This Federal investment sustains the public service missions of public television, which are distinct from the mission of commercial broadcasting and will not be funded by private sources, as the Government Accountability Office concluded in a 2007 study commissioned by Congress.

The need for Federal investment is particularly acute in small-town and rural America, where lower population density, a lack of corporate and philanthropic support, and challenging topography make the economics of local television and public service more challenging. As a result, public broadcasters are sometimes the only local broadcaster serving rural communities-and only with the help of the Federal investment.

For all stations, Federal funding is the "lifeblood" of public broadcasting, providing indispensable seed money to stations to build additional support from State legislatures, foundations, corporations, and "viewers like you."

For every dollar in Federal funding, local stations raise six dollars in non-federal funding, creating a strong public-private partnership, providing a valuable return on investment and supporting approximately 20,000 jobs across America.

The $575 million that public broadcasting is requesting in FY 2026 is necessary for the continued health of local stations and the public broadcasting system as a whole—and for needed enhancements and expansions of the essential public safety, education, and civic leadership services described above.

Two-Year Advance Funding

Two-year advance funding is essential to the mission of public broadcasting. This longstanding practice, proposed by President Ford and embraced by Congress in 1976, establishes a firewall insulating programming decisions from political interference, enables the leveraging of funds to ensure a successful public-private partnership, and provides stations with the necessary lead time to plan in-depth programming and accompanying educational materials—all of which contribute to extraordinary levels of public service and public trust.

Local stations leverage the 2-year advance funding to raise State, local and private funds, ensuring the continuation of this strong public-private partnership. These Federal funds act as the seed money for fundraising efforts at every local station, no matter its size. Advance funding also benefits the partnership between States and stations since many States operate on 2-year budget cycles.

Finally, the 2-year advance funding mechanism gives stations and producers, both local and national, the critical lead time needed to raise the additional funds necessary to sustain effective partnerships with local community organizations and engage them around high-quality, award-winning programs. Producers and directors like Ken Burns, Henry Louis Gates, Jr., Jamila Wignot, Stanley Nelson and many

others spend years developing programs like Country Music, Ben Franklin, Rita Moreno: Just a Girl Who Decided to Go For It, Amy Tan: Unintended Memoir, Asian Americans, Reconstruction: America after the Civil War, African Americans: Many Rivers to Cross, The U.S. and the Holocaust, The American Buffalo (coming this fall), and many others. It would be impossible to produce this in-depth programming and the curriculum-aligned educational materials that accompany it without the 2-year advance funding.

PUBLIC BROADCASTING INTERCONNECTION:
$60 MILLION

The public television interconnection system is the infrastructure that connects PBS and national, regional and independent producers to local public television stations around the country. The interconnection system is essential to bringing public television's educational, cultural and civic programming to every American household, no matter how rural or remote. Without interconnection, there is no nationwide public media service.

The interconnection system is also critical for public safety, providing key redundancy and resiliency for the communication of presidential alerts and warnings, and ensuring that cellular customers can receive geo-targeted emergency alerts and warnings.

Congress has always provided Federal funding for the interconnection system, which can now be updated incrementally based on rapid advances in technology. In addition to the interconnection system, this account also provides funding for other technologies and services that create infrastructure and efficiencies within the public media system.

Public television is requesting level funding of $60 million for interconnection in FY 2024 to support continued investments in the public television and radio interconnection systems and new shared technologies and services to address urgent needs including: cybersecurity; data analytics and business intelligence; single sign-on service, a content management system and a content delivery network.

This funding request would help build out a suite of interoperable digital platforms and solutions which would effectively and efficiently help stations meet the growing and dynamic needs of digital audiences. This investment would help ensure that every public television and radio station, regardless of size or location, can provide its community with critical services and content on modern technology and platforms, meeting Americans where they are.

READY TO LEARN:
$31 MILLION (DEPARTMENT OF EDUCATION)

The U.S. Department of Education's (ED) Ready to Learn (RTL) competitive grant program, reauthorized in the Every Student Succeeds Act, uses the power of public television's on-air, online, mobile, and on-the-ground educational content to build the literacy and STEM skills of children between the ages of two and eight, especially those from low-income families and has shown proven results.

Through the RTL grant, CPB and PBS have delivered evidence-based, innovative, high-quality content to improve the math, science, and literacy skills of high-need children. CPB, PBS, and local stations are dedicated to ensuring that the kids and families most in need have access to these innovative and educational resources proven to be effective. This is the result of working with researchers, educational and technology advisers, and children's media producers when creating content. The project also focuses on engaging parents and caregivers by offering intergenerational learning opportunities because research shows it leads to important learning gains. RTL investments have supported the production and academic rigor of PBS KIDS series: Sesame Street, Clifford the Big Red Dog, Curious George, The Electric Company, Cat in the Hat, and recently Molly of Denali—a curious and resourceful 10-year-old Alaska Native girl who lives in the fictional village of Qyah, Alaska—and other iconic programming for children.

But this investment does not solely rely on trusted, educational children's programming. Funding supports the distribution of content and resources by local public television stations through community partnerships called Learning Neighborhoods which employ television, online and mobile apps, digital technology, mobile learning labs and on the ground events to reach families. Learning Neighborhoods are an innovative model of community engagement led by a local PBS station and community partners. These include local school districts, State family and youth resource agencies, Head Start centers, libraries, museums, preschools, daycare centers, United Way chapters, businesses, and others—who understand the needs of

their local neighborhoods. The collaborations bring educational resources to children, families, and instructors to offer experiences that improve early learning.

Based on priorities established by ED in 2020 the current CPB and PBS RTL grant partnership is a 5-year comprehensive, learning and engagement initiative called "Learn Together: Connecting Children's Media and Learning Environments to Build Key Skills for Success." CPB and PBS are creating dynamic, new learning experiences produced by diverse media makers that will expose young children to career and workforce opportunities; helping them build vital functional literacy, critical and computational thinking, collaboration, and "World of Work" skills and knowledge.

Results

ED requires RTL grant recipients to conduct research in order to evaluate the effectiveness of the materials and products that are created so content is rigorously tested to assess its impact on children's learning and to ensure that the program continues to offer children the tools they need to succeed in school. Since 2005, more than 100 research and evaluation studies have shown RTL literacy and math content engages children, enhances their early learning skills and allows them to make significant academic gains, helping bridge the achievement gap.

Highlights of recent studies show that:

—Children from low-income households who were provided with RTL-funded Molly of Denali videos, digital games, and activities were better able to solve problems using informational text, —oral, written, or visual text designed to inform—a fundamental part of literacy that paves the way for future learning, particularly in social studies and the sciences. After only nine weeks of access, this impact is equivalent to the difference in reading skills a first-grader typically develops over 3 months.[1]

—Ready To Learn-funded resources from the PBS KIDS series *The Cat in the Hat Knows a Lot About That!* increased science learning in children from low-income households and had a positive impact on children's understanding of core physical science concepts of matter and forces-equivalent to the difference in science knowledge an early elementary student develops over 5 months.[2]

An Excellent Investment

In addition to being research-based and teacher tested, RTL also provides excellent value for our Federal dollars. In the last 5-year grant round, public broadcasting leveraged an additional $50 million in non-federal funding to augment the $73 million investment by the Department of Education. RTL exemplifies how the public-private partnership that is public broadcasting can change lives for the better.

A funding level of $31 million is requested in FY 2024 to support current grantees and further enhance the discoverability and impact of Ready To Learn created content and the quantity and scope of local station outreach to the kids, families, teachers and schools that need it the most.

Given the rigorous, thoughtful educational research and evaluation that goes into the creation of Ready To Learn content, Ready To Learn grants are awarded every 5 years and supported through annual appropriations. Funding in FY 2024 would provide the fifth year of funding in the latest grant round. Providing $31 million for Ready To Learn in FY 2024 will ensure that CPB, PBS and stations can continue to create the highest quality, proven-effective kids educational media, meeting kids, caregivers and teachers where they are on a variety of platforms, while expanding local, on-the-ground outreach through local partners.

CONCLUSION

Americans across the political spectrum rely on and support Federal funding for public broadcasting because we provide essential local education, public safety, and civic leadership services that are not available anywhere else. And none of this would be possible without the Federal investment in public broadcasting.

Federal funding is the great equalizer that ensures that the best of public broadcasting is available in both the urban centers of our great cities and in Native American communities in America's heartland and everywhere in between.

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[1] Kennedy, J. L., Christensen, C., Maxon, T., Gerard, S., Garcia, E., Hupert, N., Vahey, P., & Pasnik, S. (2021).

[2] (Grindal, T., Silander, M., Gerard, S., Maxon, T., Garcia, E., Hupert, N., Vahey, P., Pasnik, S. (2019). Early Science and Engineering: The Impact of The Cat in the Hat Knows a Lot About That! on Learning. New York, NY, & Menlo Park, CA: Education Development Center, Inc., & SRI International.)

Federal funding for CPB is what ensures that young children in Appalachia have the same access to the unparalleled PBS KIDS content as their counterparts in Los Angeles. And Federal funding is what ensures that all households, regardless of their ability to pay for cable or streaming subscriptions have access to local programming and the best of NOVA, Masterpiece, NewsHour, Great Performances, and so much more.

Public broadcasters are the only broadcasters that reach nearly 97% of U.S. households, and it is CPB funding that makes this possible.

For all of these reasons we request that Congress continue its commitment to the highly successful, hugely popular public-private partnership that is public broadcasting by providing $575 million in FY 2026 for CPB, $60 million in FY 2024 for public broadcasting's interconnection system and $31 million in FY 2024 for the Ready To Learn Program.

PREPARED STATEMENT OF THE CORPORATION FOR PUBLIC BROADCASTING

Chairwoman Baldwin, Ranking Member Capito, and distinguished members of the subcommittee, thank you for allowing me to submit this testimony on behalf of America's public media service—public television and public radio—on air, online and in communities throughout our country. The Corporation for Public Broadcasting (CPB) requests $575 million in Fiscal Year (FY) 2026, $60 million in FY 2024 for the maintenance and replacement of the public broadcasting interconnection system and other technologies and services, and $31 million in FY 2024 for the Department of Education's Ready To Learn (RTL) program.

At a time of disruption and decreasing trust in our Nation's institutions, CPB is supporting public media content and services that strengthen the bonds of our civil society. We are proud to be a partner in a new initiative called "More Perfect," which is and alliance of 12 Presidential centers and more than 100 organizations across the country, to strengthen and renew American democracy as we approach 2026, the 250th anniversary of the Nation's birth. Public media, through free, educational content and services, is addressing the civics gap helping Americans of all ages understand their rights and responsibilities as citizens.

CPB is proud to steward the Federal appropriation for public media in ways that strengthen local communities. By statute, over 70 percent of funds appropriated to CPB go directly to local public television and radio stations. Although stations receive funding from other sources, their annual CPB grants serve as an economic foundation for providing crucial educational, informational, and public safety services to the communities they serve. These local benefits of public broadcasting are especially important in rural and underserved areas where there are fewer alternative media options.

In addition to providing financial support to our Nation's more than 1,500 local public television and radio stations, CPB is focused on making strategic investments to 1) create research-based, educational content in core academic areas like reading, math, history, and science, as well as building critical thinking skills; 2) decrease the number of news deserts and increase local reporting; 3) create multimedia content that reflects the diversity of the American people and is available in all the ways they choose to access our content; 4) build greater system capacity by supporting shared technology and services that benefit every station, regardless of size or location, and frees up local resources so stations can then reinvest in their community; and 5) strengthen our Nation's public alert and warning system so that Americans have life-saving and critical information in times of emergency.

CPB supports content and resources for learners of all ages and the educators who teach them. For pre-school children, Daniel Tiger's Neighborhood focuses on life skills, and Elinor Wonders Why focuses on science curiosity and problem solving. For early elementary school children, City Island explores a living city where objects in the city are animated characters who teach civics lessons by showing how communities work together to solve problems. For middle and high school students, CPB supported a new PBS LearningMedia U.S. History Collection to help teachers and students increase their knowledge of U.S. history and further civic learning. The Collection uses content from American Experience and FRONTLINE as well as content produced by local stations to engage and educate students. In 2020, CPB launched a project called By/With/For Youth: Inspiring Next Generation Public Media Audiences to identify new ways in which public media can meet tweens' and teens' educational, civic, and career-readiness needs on the platforms they use every day. Last year, CPB provided funding to 12 stations to produce content "by, with and for" youth. KBTC–TV in Tacoma, WA, created "Ability Awareness," a series of short YouTube videos produced with autistic youth and youth with disabilities that

addresses life skills needed for transitioning to the workplace and independent living. More than 40 grant applications were received from stations.

CPB's "American Graduate: Jobs Explained" is launching this year, building off of more than a decade of work in supporting community-based solutions to help young people succeed in school and in the workplace. CPB is supporting 10 stations across the country to create more than 3,000 short videos about in-demand careers in industries such as manufacturing, health care, green jobs, trades, information technology, and hospitality-some of the fastest-growing and most needed jobs in today's economy. The videos will link to a website providing related career development resources and industry-specific information. With a $575 million appropriation, CPB could fund additional local station work under these educational priorities.

Through the U.S. Department of Education's Ready To Learn (RTL) program, CPB and PBS partner to research, develop, and test innovative new ways to use educational media and resources to advance critical early learning skills for children ages 2–8, especially children in low-income communities. The evidence-based content is distributed by stations across the country. Last month, the new RTL series Work it Out Wombats! premiered on PBS KIDS to teach important computer science inquiry skills. In the first two weeks, the series exceeded streaming metrics for recent PBS KIDS launches with more than 23 million streams and 1.7 million views YouTube. Ready To Learn funding also supports stations to extend these learning resources to local partners working with young children, including Preschool Development Grant Programs, Head Start, Title I schools, libraries, and other community partners.

With the increasing influence of misinformation and disinformation in civil discourse, CPB is addressing urgent civic information needs by supporting local, State, regional, national, and international journalism. Today, public media represents the largest, non-profit news system in the U.S, with roughly 4,150 local journalists. Over the past 15 years, CPB has helped sustain this ecosystem by investing a total of more than $150 million in discretionary funds to journalism, in addition to the money directly allocated annually through Community Service Grants. These discretionary funds have gone to support public media's signature national newsrooms—FRONTLINE, PBS NewsHour, Washington Week, NPR, PRX The World—as well as local and regional journalism. Since 2009, CPB has launched 41 local and regional news collaborations like the Ohio Valley ReSource, six public media stations in Kentucky and Ohio, along with the non-profit news organization Mountain State Spotlight in West Virginia, that provides in-depth coverage of the Ohio Valley region. This year, CPB is investing more than $2 million in station efforts to provide more robust state government coverage and boost public knowledge of how government works at the State and local levels. CPB's support for journalism also includes funding for programming that helps Americans understand the world and their place in it. In 2022, CPB provided $2.48 million to NPR, FRONTLINE, PBS NewsHour, and PRX's The World, to support in-depth, fact-based reporting in Ukraine and other high-risk areas.

CPB funding ensures that public media's content reflects the diversity of our country in race, gender, socio-economic status, geography, ability/disability, and points of view. CPB supports organizations, such as the National Multicultural Alliance, Firelight Media, and the Independent Television Service to help connect diverse stories and perspectives to national audiences, as well as programs such as StoryCorps' Military Voices Initiative, 1A Remaking America, and Twin Cities Public Television's Facing Suicide. CPB is also supporting new music formats called Urban Alternative, which mixes music and information to meet the interests of Millennials and Generation X, and is elevating voices from rural communities through its Coming Home: Connecting to Community initiative.

For more than 30 years, Congress has provided CPB a separate appropriation to maintain and modernize public media interconnection, which is the technological backbone of the public media system and serves as an essential part of our Nation's emergency alerting infrastructure. The $60 million appropriation would support continued investments in the public television and radio interconnection systems and new shared technologies and services including: cybersecurity; data analytics and business intelligence, and an enterprise content management system. Further, it would enable CPB to support shared infrastructure to gain efficiencies and resilience, realize significantly reduced costs for network services, and minimize risk as legacy practices by stations are discontinued. By providing the digital services and technologies at scale, stations can reduce or eliminate funding currently allocated for these projects, which will enable them to focus on providing educational, informational, and public safety services to their communities rather than individually procuring technologies. Moreover, small stations and rural stations greatly benefit

from larger investments in shared infrastructure as they do not have the resources to assess and acquire these technologies.

CPB's FY 2024/2026 requests are necessary to maintain our Nation's public media service. With your support, CPB will continue to serve as a trusted steward of the Federal appropriation and invest these taxpayer dollars in ways that support the educational and informational needs of Americans in their daily lives and prepare them for our shared future. Chairwoman Baldwin, Ranking Member Capito and members of the subcommittee, thank you for allowing me to submit this testimony. I appreciate your consideration of CPB's request.

[This statement was submitted by Statement of Patricia de Stacy Harrison, President and CEO, Corporation for Public Broadcasting.]

PREPARED STATEMENT OF THE NATIONAL PUBLIC RADIO

Chair Baldwin, Ranking Member Capito and Members of the subcommittee,

Thank you for this opportunity to urge the subcommittee to support the FY 2024 President's Budget request for the annual Federal investment in the Corporation for Public Broadcasting (CPB). The Budget requests a 2-year advance appropriation of $575 million for CPB and $60 million to support ongoing maintenance of the public radio and television interconnection systems and rapidly growing system-wide digital infrastructure needs, including cybersecurity, content delivery networks, and data management.

As the President and CEO of National Public Radio (NPR), I offer this statement on behalf of the public radio system, a nonprofit public service media enterprise that includes NPR, more than 1,200 public radio stations, other producers and distributors of public radio programming, and many stations, large and small, that create and distribute content through the Public Radio Satellite System® (PRSS). Every day, public radio connects with millions of Americans on the air, online, through smart speakers and mobile devices, and in-person to explore current news, music, and enduring ideas. Nearly 99 percent of the U.S. population is within the broadcast listening area of one or more public radio stations.

Federal funding to CPB enables local, noncommercial public radio stations to deliver essential daily local news, connect communities to music, culture, and diverse perspectives, and play a key role in civil defense and emergency alerting. This funding is the bedrock of the public broadcasting system, enabling a successful public-private partnership. Nearly 70 percent of the appropriation is distributed directly to local stations that qualify for annual grants. On average, for every $1 in Federal grant money that a public radio station receives, the station raises $8 locally from listener support, businesses, and organizations in their coverage area. Public radio stations are not-for-profit, locally owned, licensed, and managed, and thereby accountable to the community and listeners they serve.

Public radio provides essential daily news, filling the gap for news and information in America's communities with expanded local and regional coverage. Public radio stations support approximately 2,900 local journalists serving their communities with daily news. As other sources of local news have declined over the past decade, public radio stations have increased newsroom positions—expanding our ability to bring trusted, reliable, and independent news and information of the highest editorial standards to listeners in communities across the country.

NPR supports stations in providing local journalism of the highest standard through four regional newsrooms in the Gulf States, Midwest, Texas, and California—an effort that CPB has helped to seed. Another NPR collaboration partially funded by CPB—the Stations Investigations Team—supports local stations' investigative journalism. NPR continues to develop models of collaborative journalism in partnership with local stations to provide access to resources and newsroom positions, such as a data editor, not typically available at the local level and to maximize their efficient use.

As a result, stations have been able to take on more ambitious reporting projects. For example, last August an investigation by the Northwest News Network—a collaboration of stations in Oregon and Washington—and the NPR Station Investigations Team found that the U.S. Department of Energy allowed vanadium battery technology developed in a U.S. government laboratory to be transferred to China, letting this critical technology and American jobs move overseas at the expense of U.S. taxpayers and in violation of its own licensing rules. China has taken that technology and forged ahead in developing its own industry. As a result of this report, the bipartisan Invent Here, Make Here for Homeland Security Act was introduced in the U.S. Senate last year aimed at tightening the export of U.S.-funded

discoveries abroad and was passed as a part of the National Defense Authorization Act.

Stations also are pursuing their own unique local news collaborations. In 2021, Alabama Public Radio (APR), licensed to the University of Alabama, initiated collaborations with the Selma Sun Newspaper, WABE–FM in Atlanta, and WFSU–FM in Tallahassee to broaden the scope of its stories. This enhanced APR's coverage of the tri-state water war between Alabama, Florida, and Georgia. APR also led an effort to recruit and train former print reporters in Mobile, to address the "news desert" left by the demise of the Mobile Press Register, resulting in the 2022–23 series "Should I Stay, or Should I Go," which addressed the flight of educated and skilled workers from Alabama to other States.

Beyond news and information, public radio music-format stations have a key role in supporting noncommercial music in the United States, playing a broad collection of sounds and styles including jazz, blues, classical, folk, alternative, bluegrass, zydeco, roots, and other eclectic genres, and highlighting local artists and music performances. For example, KCBX in San Luis Obispo, Calif., hosts the annual Live Oak Music Festival, a gathering of artists and musicians from across the country to perform traditional folk, bluegrass, gospel, to blues, jazz, soul and world music for local audiences. This annual event has helped KCBX become a music destination and a draw for visitors. Another example is Mountain Stage, a weekly two-hour live music program produced by West Virginia Public Broadcasting and distributed to more than 280 public radio stations nationwide by NPR. Since 1983, Mountain Stage has provided a platform for emerging artists and established stars in folk, blues, country indie rock, synth pop, world music, alternative, and other genres. Such programming supports discovery and creativity, enriching both hearts and minds, and Federal funding for CPB enables stations to provide these musical and cultural opportunities, specifically through CPB's support of music licensing fees across the system.

Public radio is increasingly embracing the multi-platform media marketplace, while continuing to be leaders in traditional radio broadcasting. Public radio stations offer original content through a variety of platforms, including terrestrial radio, satellite radio, the web (desktop and mobile), smart speakers, and podcasts—and on application-driven mobile services on iOS and Android (both phone and tablet) and via aggregators such as Apple Music, Facebook News, Stitcher, and TuneIn. With this multi-platform approach, public radio can serve listeners wherever they are and attract new audiences.

Federal funding for CPB plays an even more important role in supporting stations that serve rural communities. More than 40 percent of public radio stations that qualify for annual grants from CPB are defined as Rural Area Support Stations (RASS), meaning that they have a coverage area population (CAP) density equal to or fewer than 40 people per square kilometer. WXPR in Rhinelander, Wisc., for example, serves listeners across 10,000 square miles in the rural, northern Midwest, with a full-time staff of six; CPB funding enabled WXPR to report critical local and regional news, as well as carry national programming from NPR and other public radio programming providers. Many station operators in urban areas, that may not qualify as a rural station, also serve rural Americans through stations or repeaters in rural communities. During FY 2021, CPB provided more than $52 million to support rural stations, approximately 12 percent of the total appropriation of $445 million for all of public broadcasting.

Due to fundraising challenges in rural areas, rural radio stations rely more on CPB funding than urban stations. CPB grants on average represent 22 percent of a rural radio station's revenue, compared to an average eight percent for the rest of the industry. More than half of all rural grantees rely on CPB for at least 25 percent of their budget, and for 41 stations—many of them located on Native American reservations—CPB funding accounts for 50 percent of their revenue.

RASS stations employ more than 1,862 people nationwide—an average staff of 11 people per station. According to a recent survey, ninety-one percent of rural public radio stations provide local news coverage across platforms on issues ranging from local politics, to economic development, to agriculture and water rights. Nearly 80 percent have a newsroom staff of nine or fewer journalists. Eighty-two percent offer locally-produced music radio programming and 63 percent hold in-studio live sessions with artists, supporting the promotion and preservation of local music and culture.

Public radio would not be possible without the Federal funding provided for the Public Radio Satellite System® (PRSS)—the satellite and terrestrial content distribution system on which the public radio system, including almost all stations, networks, and producers, generally depends. Stations that receive programming distributed by the PRSS range from those located in remote villages in northern Alas-

ka and on Native American reservations in the Southwest, to major market stations in urban areas. The system operates with 99 percent reliability. Through almost 400 downlinks, PRSS transmits almost 300,000 hours of original news and information per year to more than 1,200 stations from NPR, other major content producers, and more than 100 independent radio producers and organizations. Most of the content transmitted is live to stations across the U.S.

CPB's support of PRSS facilitates the cost-effective and efficient distribution of high-quality, educational programming to this country's increasingly diverse population. As part of that mission, the PRSS provides free, or "in kind," satellite transmission services to distribute programming to un-served or under-served audiences with full-time support currently given to Native Voice One serving Native American listeners; Satélite Radio Bilingüe, a Spanish-language service; and the African American Public Radio Consortium.

Public radio also plays a critical role in civil defense. The PRSS receives Presidential alerts (also called Emergency Action Notification (EAN) alerts) fed directly from the Federal Emergency Management Agency (FEMA), which can transmit to public radio stations in the event of a nationwide crisis. NPR/PRSS is named as a resource in at least 20 States' emergency plans, according to the Federal Communications Commission. The PRSS MetaPub program enhances alert accessibility by enabling local public radio stations to issue emergency text and graphic alerts using metadata—such as tornado and hurricane warnings, or evacuation routes—that are visible on screens and synched with over-the-air broadcasts to mobile phones, HD Radio, "connected car" smart dashboards, Radio Data System displays, and via online audio streaming. This program enhances the accessibility of emergency alerts.

Public radio is essential to reaching audiences that lack broadband access, creating a lifeline in emergency situations. Rural public radio stations may be the only emergency alert system in rural communities. Public radio's role is even more important when the power goes out and rural Americans cannot view the television or access the Internet. Broadcast radio is often the only accessible information source in these cases, and the investment in public media ensures that these stations can be resilient in times of crisis to serve their rural communities. And when natural disasters fall short of triggering an emergency alert, public radio stations as local news providers play a critical role in offering live coverage of emergency situations, the State and local government response, and critical community-based information on where audiences can locate public resources. This service would not be possible without a robust, resilient public radio interconnection system.

In closing, public radio provides an essential public service for local communities across the Nation—embracing their diversity, telling their stories, and keeping them informed with trustworthy, independent news, information, and public safety alerts. Your support for the CPB appropriation will ensure that public media can continue to provide these critical services. Thank you for your support of the public broadcasting system.

[This statement was submitted by John F. Lansing, President and CEO, National Public Radio.]

PREPARED STATEMENT OF THE RAILROAD RETIREMENT BOARD

Mr. Chairman and Members of the Committee:

The President's fiscal year 2024 proposed budget for the Railroad Retirement Board (RRB) is $138.575 million. The RRB is requesting $173.744 million. Appropriations for RRB operations are derived from the railroad retirement trust fund system and not the general fund. Appropriations language [1] authorizes the RRB to access available funding from the trust funds to administer comprehensive retirement/survivor and unemployment/sickness insurance benefit programs for railroad workers and their families under the Railroad Retirement (RRA) and Railroad Unemployment Insurance (RUIA) Acts. The RRB also administers certain benefit payments and Medicare coverage for railroad workers under the Social Security Act.

During fiscal year 2022, benefit payments totaled $13.6 billion, net of recoveries and offsetting collections. Of this amount, the RRB paid retirement/survivor benefits totaling $13.5 billion to about 506,000 beneficiaries. The RRB also paid unemployment-sickness benefits totaling $90.4 million, CARES Act benefits totaling ($3.1) million, and vested dual benefits totaling $9.5 million, net of recoveries and offsetting collections. About 6,000 railroad workers received unemployment insurance

[1] "...[s]uch amounts as determined by the Board from the railroad retirement accounts and from moneys credited to the railroad unemployment insurance administration fund." Consolidated Appropriations Act, 2023, Pub. L. 117–328, Division H, Title IV (December 29, 2022).

benefits, approximately 17,000 received sickness insurance benefits (includes CARES Act), and about 4,000 beneficiaries received vested dual benefits. Lastly, the RRB paid $2.2 billion in benefits to about 126,000 beneficiaries on behalf of the Social Security Administration.

The railroad employer and employee contributions are held in trust funds to pay railroad benefits and support RRB operations. Enacted appropriations language authorizes the RRB to access the funds available in the railroad retirement trust fund system in order to finance operations. The Association of American Railroads and the Rail Labor Division of the Transportation Trades Department, American Federation of Labor and Congress of Industrial Organizations (AFL–CIO) continue to support increased appropriations to address the urgent staffing needs and ongoing information technology modernization activities.

PRESIDENT'S PROPOSED FUNDING FOR AGENCY ADMINISTRATION

The President's proposed budget would provide $138.575 million for agency operations and support 712 full-time equivalent (FTE) employees. The RRB requests an additional $35.169 million above the President's proposed $138.575 million for a total of $173.744 million, which includes $10 million for Information Technology (IT) Modernization, to be derived from the railroad retirement trust fund system (not the general fund). RRB's fiscal year 2024 budget includes estimates for rising IT costs as RRB remains in a hybrid or transitional IT environment as well as the impact of the 5.2% cost of living adjustment (COLA). In this hybrid IT environment, RRB must simultaneously allocate staff and funding to sustain critical benefits administration operations via legacy applications and IT systems, maintain early-modernized components of the IT program, and persist through RRB's ongoing IT Modernization Program. Estimates indicate that if FTE employees remained constant at fiscal year 2023 levels the COLA of 5.2% effective January 2024 would increase the cost of current staff by $5.032 million and when coupled with rising non-personnel operating costs, would leave the RRB unable to significantly increase staffing levels. Therefore, the RRB requests an additional $35.169 million to address rising hybrid IT environment costs and acquire staffing resources to sustain critical benefits administration operations, improve benefit payment accuracy and customer satisfaction, until the RRB is able to realize the benefits of IT modernization.

Continued Need for Staffing Investment

The RRB was appropriated $113.5 million in fiscal years 2017–2020, $114.5 million in fiscal year 2021, $124 million in fiscal year 2022 and $128 million in fiscal year 2023, for personnel and general operating costs to support benefits administration, exclusive of funding for IT modernization, reflecting successive years of unfunded COLA increases in salary and associated benefits. Cumulatively, during fiscal years 2017 through 2021, RRB absorbed $7.338 million of COLAs in its stagnant budgets, which led to significantly reduced hiring capacity and sustained deficit staffing levels enterprise wide. While the funding increases received in fiscal years 2022 and 2023, better positioned the RRB to accommodate COLAs of $1.668 million in 2022 and an estimated $2.918 million COLA for 2023, the agency is still unable to increase staffing levels significantly to properly administer our growing administrative workload.

Despite declines in rail employment and the average number of annuitants, RRB's administrative workload continues to increase and justify RRB's additional staffing needs. Unlike some industries, where a decline in employment is indicative of future employment numbers, railroad employment levels tend to fluctuate from year to year based upon market demands. Moreover, a decline in railroad employment does not equate to a decline in the RRB's workload because non-active employees vested in RRB benefits and their eligible family members will ultimately apply to the RRB for benefits. Sustained low staffing levels and significant staff losses over the last several years has forced the agency to focus most of its resources on the timely processing of most initial applications, claims, and related benefit payments. While the agency has been largely successful prioritizing initial benefit awards, the agency has accumulated over 5,000 cases pending either an initial disability decision or an early Medicare (Disability Freeze) decision. Further, the prioritization of initial benefit awards has led to backlogs in cases that require post award adjustment (i.e., a revision or modification to a current benefit payment as a result of an income change or case that did not fully process through RRB's automated systems). Through post award adjustments, the RRB ensures the accuracy of ongoing retirement, survivor, disability and unemployment and sickness benefit payments.

The RRB has accumulated more than 152,000 pending post award actions, where a significant portion represents thousands of railroad retirement beneficiaries who have been paid either too much or too little. Consequently, beneficiaries that have

been paid too much will need to repay a potentially large overpayment that has been accruing for years, at a point in their lives where many are living on fixed incomes needed to meet ordinary living expenses. Conversely, thousands of beneficiaries have been living on a reduced income for years; a situation which was likely exacerbated by higher living expenses due to inflation. Due to prolonged staff shortages, beneficiaries awaiting the processing of post award adjustments, call our front-line customer service representatives to inquire as to the status of their case, only to be met with either a lengthy wait time or a non-informative response. To reiterate, we are grateful to the Congress for the budget increases in fiscal year 2022 and 2023, which has allowed the RRB to hire more staff, despite the impact of COLA, and thus begin to address severe prolonged staffing shortages. For fiscal year 2024 we seek the Congress' support as we endeavor to maintain our hiring cadence and increase staffing levels, where the additional staff will improve benefit payment accuracy, customer satisfaction, and address enterprise-wide staffing deficits and attrition risk.

FINANCIAL STATUS OF THE TRUST FUNDS

Railroad Retirement Accounts.—The net asset value of the National Railroad Retirement Investment Trust (Trust) on September 30, 2022, was $23 billion, a decrease of $5.5 billion from the previous year. Through March 01, 2023, the Trust had transferred $32.481 billion to the RRB for payment of railroad retirement benefits.

The RRB's latest report required by the Railroad Retirement Act of 1974 and Railroad Retirement Solvency Act of 1983 was released in June 2022. The overall conclusion was, barring a sudden, unanticipated, large drop in railroad employment or substantial investment losses, the railroad retirement system will experience no cash flow problems during the next 25 years. The report recommended no change in the rate of tax imposed on employers and employees. The tax adjustment mechanism would automatically increase or decrease tax rates in response to changes in fund balance. Even under a pessimistic employment assumption, this mechanism is expected to prevent cash flow problems for at least 25 years.

Railroad Unemployment Insurance Account.—The RRB's latest annual report required by Section 7105 of the Technical and Miscellaneous Revenue Act of 1988 was issued in June 2022. The report indicated that even as maximum daily benefit rates are projected to rise approximately 50 percent (from $82 to $123) from 2021 to 2032, experience-based contribution rates are expected to keep the unemployment insurance system solvent. Unemployment levels are the single most significant factor affecting the financial status of the railroad unemployment insurance system. However, the system's experience-rating provisions, which adjust contribution rates for changing benefit levels, and its surcharge trigger for maintaining a minimum balance, help to ensure financial stability in the event of adverse economic conditions. No financing changes were recommended at this time by the report.

Thank you for your consideration of our budget request.

[This statement was submitted by Erhard R. Chorlé, Chairman of the Board, John Bragg, Labor Member of the Board, and Thomas Jayne, Management Member of the Board.]

NONDEPARTMENTAL WITNESSES

PREPARED STATEMENT OF THE ACADEMY FOR RADIOLOGY & BIOMEDICAL IMAGING RESEARCH

Chair Baldwin, Ranking Member Capito, and members of the subcommittee, I am Ruth Carlos, MD, MS, FACR, President of the Academy for Radiology & Biomedical Imaging Research (Academy), and a Professor of Radiology and Assistant Chair for Clinical Research at the University of Michigan. The Academy comprises more than 200 academic research departments, patient advocacy groups, industry partners, and imaging societies. It represents thousands of radiologists and researchers in all 50 States. We are the only advocacy organization representing the broad imaging research community by collectively advocating for robust and consistent Federal research funding.[1] It is my pleasure to submit this testimony on behalf of the Academy. We strongly support at least $50.924 billion for the National Institutes of Health's base appropriation. This figure represents an increase of $3.465 billion over FY2023, plus the release of the 21st Century Cures funds. The Academy also supports a proportional increase in funding for the National Institute of Biomedical Imaging and Bioengineering (NIBIB), resulting in at least $473.2 million for FY2024—a $32.2 million increase over the FY2023 enacted level. Nearly 24 Institutes and Centers support imaging-based research on a broad spectrum of biomedical systems, and the Academy champions similar proportional increases to advance these efforts agency-wide. Finally, with the authorization of the Advanced Research Projects Agency for Health (ARPA–H) the Academy supports maintaining a separate appropriation of $1.5 billion in FY2024 for this exciting and groundbreaking agency. The Academy is supportive of ARPA–H, but believes its appropriations should be separate from NIH's advancement of basic science.

Moreover, Congress must work to ensure Federal appropriations are enacted on time to avoid disruptive interruptions to the research process. Through consistent, robust funding for NIH and our National research infrastructure, we can continue to make advancements that will improve the lives of patients. The Academy is extremely grateful for the past 8 years of increased support of NIH and encourages you to prioritize NIH for consistent and dependable funding levels for biomedical research, radiology, and imaging science.

IMAGING RESEARCH SERVES THE MOST VULNERABLE IN OUR COMMUNITIES

In my own research, I study how patient outcomes are affected by cost and accessibility. As new research in diagnostic imaging results in smaller, portable, and more precise technology, underserved populations will benefit disproportionally. Whether these population centers are in rural areas, where infrastructure and resources are lacking, or in urban centers, where access to brick-and-mortar health centers can be similarly difficult, improving diagnostic technology and taking it to the patient improves health outcomes. Research at NIH, and in particular at institutes like NIBIB is pursuing technological advances that will benefit those who most need it. Today, we can screen for breast and lung cancer using mobile platforms to reach patients where they are, including federally qualified health clinics (FQHCs) that may not have access to imaging technology or as part of a community health fair delivering multi-modality health screening. These partnerships reduce patient burden and encourage the use of life saving technologies in populations who would not have received screening or treatment as efficiently 10 or 15 years ago. While our diagnostic tools and technologies are good, we have learned there is dramatic room for improvement that lower health care costs and increase access to potentially lifesaving tools. We can provide people with diagnosis and treatment in ways that are less disruptive to their lives. The cascading benefits of less onerous medical care—in the form of lower costs, more time at home, or improved quality of life—are obvious. Continued investment in our technological foundation and improving the available tools will undoubtably lead to better patient outcomes. There are other examples of innovative biomedical research. Consider the following:

SEEING ALZHEIMER'S DISEASE AND PARKINSON'S DISEASE IN A NEW WAY

Alzheimer's disease is the most common cause of dementia, afflicting 6 million Americans in 2020 and expected to rise to 14 million people by 2060. Almost 1 million Americans currently suffer from Parkinson's disease. Correctly understanding the biological processes that lead to Alzheimer's dementia and Parkinson's disease is critical to the development of new therapies. Imaging is playing an increasingly

[1] https://www.acadrad.org/about-the-academy/.

important role in this research including patient selection for clinical trials and guiding the use of therapies.

The University of Alabama at Birmingham is addressing both conditions with support from NINDS and NIA. First, the Udall Center for Excellence in Parkinson's Disease Research uses positron emission tomography (PET) to show that brain inflammation occurs early in the disease and may contribute to cognitive impairment.[2] Patients with Parkinson's disease have higher levels of a key neuroinflammatory marker, and the work is paving the way for clinical trials to reduce brain inflammation and using PET to monitor treatment response.

Second, the UAB Alzheimer's Disease Research Center is recruiting a well-characterized population of participants, with and without cognitive impairment, representative of the people in Alabama.[3] A pillar of this effort is recruiting participants not adequately represented in most Alzheimer's disease research, including Black/African American individuals and those living in rural locations. PET imaging of amyloid and tau, proteins that abnormally accumulate in the brains of those with Alzheimer's disease, is a major component of this research. With the recent approval of new drugs targeting amyloid, understanding how these imaging biomarkers work in different populations and their relationship to other diseases is critical for effective therapy.

DETECTING HEART DISEASE OVER TIME AND AT THE GYM

Despite all our advancements, cardiovascular disease is still one of the leading causes of death in the United States. According to the Centers for Disease Control and Prevention, in 2020, nearly one in five deaths were related to heart disease. One of the limitations in fighting this widespread problem is the ability to detect emerging heart disease, especially over time. Current applications of ultrasound are limited. Recently a team at the University of California, San Diego, funded by NIBIB and NIA, developed a wearable ultrasound device.[4] This noninvasive patch, measuring approximately one inch square, is flexible and provides images on multiple axis without repositioning. The patch improves ultrasound evaluations by providing more data over time and can be used in high-stress environments, like exercise. Initial tests show the patch produces images at nearly the same quality as traditional ultrasound, over a period of hours and in different situations that were previously unreachable. The ability to evaluate at-risk patients more thoroughly could enable earlier diagnosis of a condition that has largely remained hidden until an emergency arises.

NONINVASIVE, OUTPATIENT TREATMENT FOR BREAST CANCER

Researchers at the University of Utah are pioneering new ways to treat breast cancer tumors in non-invasive ways in outpatient settings.[5] Using focused ultrasound technology and magnetic resonance guiding, researchers can locate and destroy malignant tumors with heat. Put another way: breast cancer patients are being treated without chemotherapy or radiation. This research, funded collaboratively by NIBIB and NCI, may create dramatic improvements in patient experience and outcomes when being treated for breast cancer.

SUMMARY AND CONCLUSION

Sustained and robust NIH funding is crucial to advancing our efforts to understand and treat a myriad of diseases and disorders. NIH has received longstanding, bipartisan support that led to dependable budgets that fund lifesaving research. NIH research reaches every State in the country, with both health and economic benefits. In 2022, NIH funds generated $2.64 in economic activity for every $1 of funded research.[6] Funding NIH's base with at least $50.924 billion will provide the robust support needed to sustain growth and secure advancements in biomedical research. Additionally, keeping NIH funding separated from the exciting efforts underway at ARPA–H will ensure we can take advantage of multiple efforts to achieve success.

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[2] https://www.uab.edu/medicine/udallp50/.

[3] https://www.uab.edu/medicine/alzheimers/.

[4] https://www.nibib.nih.gov/news-events/newsroom/stretchable-wearable-patch-cardiac-ultrasound.

[5] https://discovery.med.utah.edu/2021/focused-ultrasound-as-a-non-invasive-treatment-for-breast-cancer/.

[6] https://unitedformedicalresearch.org/wp-content/uploads/2023/03/UMR__NIHs-Role-in-Sustaining-the-U.S.-Economy-2023-Update.pdf.

While there are many priorities facing our country today, reversing the trend on NIH funding will only delay the discovery of new cures, treatments, and diagnostic technologies that benefit all Americans. I urge you to continue this Committee's longstanding and substantive support for NIH. Thank you for your strong, continued support of NIH, NIBIB, and all the Institutes and Centers working to advance our biomedical research efforts and to improve the lives of patients worldwide.

[This statement was submitted by Ruth Carlos, MD, MS, FACR, President, Academy for Radiology & Biomedical Imaging Research.]

PREPARED STATEMENT OF THE ACADEMY OF RESEARCH

Chair Baldwin, Ranking Member Capito, and Members of the subcommittee,

On behalf of more than 83 million Americans (25%) living with some type of disability in the U.S. and over 2000 physical therapy researchers, the Academy of Research, a component of the American Physical Therapy Association (APTA), thank Chairman Aderholt and Ranking Member DeLauro for the opportunity to provide written testimony to the Appropriations subcommittee on Labor, Health & Human Services, Education, and Related Agencies for the Fiscal Year 2024. We respectfully request $1.8B for the Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD), and $48B for National Institutes of Health (NIH).

Disability affects up to 1 in 4 Americans. Those with disabilities are more likely to have difficulty with mobility, cognition, self-care, and living independently, but have a more difficult time with meeting with a health-care provider. On a positive note, a substantial improvement has been seen in the prevalence of older (>65 years old) Americans experiencing disability. Rehabilitation research explores and examines the biology of disability and comes up with innovative ways to restore, enhance, and optimize lost function and help individuals reach their peak potential.

Research in physical therapy focuses on creating an evidence-based body of knowledge to advance practice and education, shape health policy, maximize integrity of care, and promote positive health of people worldwide. Increasing the visibility of physical therapy research and services, creating connections and promoting partnerships, and inspiring discovery and advancing physical therapy across all areas of clinical practice and research study are cornerstones of the mission of the Academy of Research.

The National Center of Medical Rehabilitation Research (NCMRR) is housed with NICHD. In 2016, the NICHD and the NIH Medical Rehabilitation Coordinating Committee published a landmark Research Plan on Rehabilitation. In this plan, this committee identified six areas of opportunities, needs, and priorities. The Academy of Research's 2023–24 Research Priorities identify the top action items from three of these areas of scientific research to address current and future research efforts in rehabilitation research.

BUILDING RRESEARCH CAPACITY AND INFRASTRUCTURE

The promotion of research in physical therapy is critical for the advancement of the profession. It is researchers with formal training in both clinical practice and research domains such as rehabilitation research, education, and health services research who are uniquely qualified to ask and answer the important clinical questions which can drive our practice forward. The breadth and depth of rehabilitation research has grown and with that growth, the need for rigorously trained physical therapy researchers is critical to continue to advance patient care. A recent survey of program directors in research-intensive physical therapy doctoral program reported that 40% of those programs are reporting a decline in the applicant pool (Buford https://aptaeducation.org/abstract-archive/view.cfm?id=2741301, 2017). We proposed that increased funding to NIH to develop and support the next generation of rehabilitation researchers. This increased funding will be used to promote and support individuals entering graduate school, to finish their doctoral studies, or transitioning in from other fields across basic, clinician, education, implementation and health services sciences. Additionally, there is a need to bridge the gap between postdoctoral and independent investigator status. Success rates for F and K award trainees is predictive of future first R01 awards (Nikaj, Acad Med 2019; Pickett PLoS One 2019). Increased research funding increases the scientific output of university professors, (Hussinger and Carvalho, Industry and Innovation, 2022) boosting our ability to enhance patient care and reduce disability.

RESEARCH DESIGN AND METHODOLOGY

New methods, strategies, and approaches are needed to address challenges such as generating consistent clinical data from heterogeneous conditions. Physical therapy research explores complex phenomena and contexts that involved multiple methodological decision points, interdisciplinary collaboration, and intentionality across all phases of a research study. There is a need to broaden the scope of design and type of methodology by advancing the use of mixed and integrated mixed methods research approaches relevant to physical therapy research. Increased funding can be used to support scientific conferences to educate on research topics, such as Integrated Mixed Methods in Physical Therapy Research. Additionally, with the success of Training in Grantsmanship for Rehabilitation Research (TIGRR) through R25 grant, and the Grant Writing and Mentorship in Education Research (GAMER), we requested that increased funding goes to support research education activities that enhance the training of our rehabilitation research workforce and recruit a diverse group of rehabilitation researchers.

REHABILITATION ACROSS THE LIFESPAN

One area that has major implications on Americans across all age groups is in the area of pain science. The opioid crisis that plagues American public health is, in part, the result of inappropriate management of pain. Physical therapists are uniquely trained to treat pain and work as a part of an interdisciplinary team to treat pain. The Helping to End Addiction Long-term® Initiative, or NIH HEAL Initiative® was created to accelerate scientific solutions to address this public health emergency. We propose that increased funding to NIH to support this bold initiative to address the opioid crisis. The Back Pain Consortium Research program is integrating the biological, biomechanical, psychosocial, along with other processes to understand the interaction between these processes on chronic low back pain. Rehabilitation researchers with other researchers across the country are working on these solutions to help solve this problem.

We thank the subcommittee for its continued commitment to American public health. As you write the FY24 Labor-HHS-Education appropriations bill, we implore you to fund the NIH and NICHD with sufficient funds in order to continue to help the United States remain a leader in rehabilitation and biomedical research. Please contact David Logerstedt, the Academy of Research APTA Federal Affairs Liaison at dlogerstedt@sju.edu or Brian Allen, the American Physical Therapy Association Congressional Affairs Specialist at brianallen@apta.org with any questions.

[This statement was submitted by David Logerstedt, PT, PhD, Academy of Research.]

PREPARED STATEMENT OF ACADEMYHEALTH

Chairwoman Baldwin and Ranking Member Capito, thank you for this opportunity offer testimony regarding funding for Federal agencies that support health services research and health data, including the Agency for Healthcare Research and Quality (AHRQ). AcademyHealth improves health and health care for all by advancing evidence to inform policy and practice. We represent the interests of more than 3,000 health services researchers, health system and technology leaders, patients, policy analysts, and practitioners engaged in those endeavors.

For fiscal year (FY) 2024, AcademyHealth recommends a funding level of not less than $500 million in budget authority for AHRQ. This request reflects sufficient funding for AHRQ to respond to the crises facing rural patients due to hospital closures, the rapid changes in telehealth coverage, the racial, ethnic, socioeconomic, and geographic health outcome disparities faced across the health care system, identifying high-value care for patients with Long-COVID, and more. For this reason, AcademyHealth was proud to join the letter sent to your offices on March 8, 2023 by the Friends of AHRQ calling for this funding level.

While policymakers and health systems take dramatic action to respond to existing healthcare challenges, they are doing so without sufficient research and evaluations on its impact on health outcomes, health equity, the value of care, and healthcare access. For example, as we transition out of COVID–19 as a public health emergency, it is abundantly clear our Nation's goals of having a system that ensures access to high quality, equitable healthcare for all is falling far short of its potential. We have all seen the deep racial, ethnic, geographic, and socioeconomic health disparities and inequities both within and beyond healthcare as people of color have disproportionately seen worse health outcomes, barriers to access, and

low value care. In parallel, the healthcare workforce is facing record burnout and attrition.

AHRQ supports research to improve health care quality, reduce costs, advance patient safety, decrease medical errors, improve equity, and broaden access to essential services. As the lead Federal agency for funding health services research (HSR) and primary care research (PCR), AHRQ is the bridge between cures and care, and ensures that individuals and communities get the best health care at the best value. In order to deliver better and more equitable outcomes, we need to be able to differentiate which healthcare interventions work, for whom they work, and how to implement them, and HSR, PCR, and AHRQ are the process through which we develop that knowledge.

There are three primary areas where AHRQ excels in developing, supporting, disseminating, and delivering the tools needed by the health system that I would like to highlight today: health equity; improvements in rural health care; and better optimization of telehealth.

AHRQ and health services research is the primary tool for identifying, studying, and eliminating health inequities and promoting high-value care for all patients, regardless of their race, gender, language preference, and geography. For example, AHRQ can make health care access fairer for all patients by:

—*Collecting and analyzing data to drive evidence-based policymaking.* AHRQ collects data on healthcare disparities, outcomes, and access to care, all of which aid in identifying where inequities exist and whether they are decreasing over time. Specific data projects managed by AHRQ include Healthcare Cost and Utilization Project (HCUP), which is the Nation's most comprehensive source of hospital data and the Medical Expenditure Panel Survey (MEPS), which is a set of surveys of families, individuals, medical providers, and employers on health status, use of medical care, charges, insurance coverage, and patient satisfaction.

—*Promoting appropriate research and effective dissemination of findings.* AHRQ specializes in the dissemination and implementation of research, including extramural research grants. The Agency creates online resources, such as interactive data tools, research briefs, and fact sheets to disseminate its findings and make them more accessible to healthcare providers, policymakers, and patients. Additionally, AHRQ collaborates with a wide variety of partners at all levels of government, clinicians and health systems, patient organizations, and others to disseminate its findings and provide technical assistance in implementation.

—*Encourage patient-centered care.* AHRQ actively promotes patient-centered care, which recognizes and addresses the unique needs and circumstances of individual real-life patients, particularly those from underserved communities.

AHRQ has designated rural populations as a priority population for their work. As rural health systems struggle with hospital closures, AHRQ is a critical agency for improving high value care to patients in these regions. For example, AHRQ can assist rural hospitals by:

—*Conducting research on best practices for delivering high-quality care in rural settings.* The first step in providing better health outcomes and quality of life for rural communities is identifying unique challenges, including health care quality and access. AHRQ prioritizes rural America's health by confronting their unique needs. The Agency has pioneered projects and programs dedicated to understanding telehealth and its place in improving rural patients' health.

—*Providing technical assistance and training.* While rural areas have seen a rapid-increase in opioid-related deaths, rural doctors and health systems may not have access to new medication recovery options, so AHRQ facilitates innovative education programs that can reach them.

Telehealth has emerged as a critical and widely used tool for providing healthcare outside of physical healthcare spaces. However, while there are benefits to telehealth, there are still many patient-centered challenges that need to be addressed by AHRQ and HSR. Important questions that HSR could address include understanding the training and support of health care professionals and patients need to properly use telehealth (including mental health), the best workforce configurations for deployment of telehealth, which type of traditional patient visits were most effectively transferred to virtual visits and for which patient populations, and how changes in telehealth payment policy did and did not affect the sustainability of telehealth visits and health systems operations.

AHRQ has a strong record of funding and disseminating scalable results on each of these points and more when it comes to measuring quality and delivery of telemedicine. For example:

—*On the safety of telemedicine:* Treatment and Follow-up Care Associated With Patient-Scheduled Primary Care Telemedicine and In-Person Visits in a Large Integrated Health System
—*On the effectiveness of telemedicine:* Impact of Technology-Based Interventions on Patient-Reported Outcomes in Asthma: A Systematic Review
—*On the patient-centered needs of telemedicine:* Contribution of Continuous Virtual Monitoring to Hospital Safety, Quality, and Value of Care for COVID–19 Patient
—*On the efficiency of telemedicine:* Parent Experience and Cost Savings Associated With a Novel Tele-physiatry Program for Children Living in Rural and Underserved Communities
—*On the equitability of telemedicine:* Urban Telemedicine Enables Equity in Access to Acute Illness Care
—*On identifying disparities in telemedicine:* Disparities in Use of Video Telemedicine Among Patients With Limited English Proficiency During the COVID–19 Pandemic

Our funding request of no less than $500 million in FY24 provides AHRQ with the resources that it needs to engage in these three research areas, as well as other work that they are pursuing to save lives while providing better value care. For example, the implementation of just one AHRQ-funded study on reducing hospital acquired conditions prevented an estimated 20,500 hospital deaths and saved $7.7 billion in health care costs from 2014 to 2017. To maximize the translation of research findings across the public health and health care continuum to improved patient care and keep pace with the rapidly evolving and changing health care landscape, additional investments in line with this request for AHRQ are needed.

The accomplishments of the health services research field would not be possible without the leadership and support of this subcommittee. AcademyHealth recognizes the importance of investing Federal funds strategically. We strongly believe that the investment-multiplier AHRQ more than earns a place among your top appropriations priorities.

For more information, please contact Josh Caplan at Josh.Caplan@AcademyHealth.org.

[This statement was submitted by Dr. Lisa Simpson, President and CEO, AcademyHealth.]

PREPARED STATEMENT OF ACCESSIA HEALTH

SUMMARY OF FISCAL YEAR 2024 APPROPRIATIONS RECOMMENDATIONS

—Provide the National Institutes of Health (NIH) with at least $50.9 billion, and provide individual NIH Institutes and Centers with proportional discretionary increases.
—Provide the Centers for Disease Control and Prevention (CDC) with at least $11.6 billion to facilitate timely public health efforts along with proportional discretionary increases for CDC Centers and Divisions.
  —Please provide $6 million for the Chronic Disease Education and Awareness Program at CDC.
—Provide the Health Resources and Services Administration (HRSA) with a funding level of at least $10.5 billion.
—Please support the development and advancement of innovative payment models and efforts to effectively enhance coverage and access, including through additional resources for the Centers for Medicare and Medicaid Services (CMS).

Thank you for the opportunity to submit testimony on behalf of Accessia Health and the community of patients we serve. Chairwoman Baldwin, Ranking Member Capito, and distinguished members of the subcommittee, thank you for the significant ongoing investments in HHS, particularly medical research and public health programs that improve health for patients with debilitating and life-threatening conditions. Please maintain this commitment and further enhance support for medical research and public health programs as you work with your colleagues on appropriations for FY 2024. Further, please continue to provide resources for the development and implementation of innovative models for payment and care delivery that prioritize patients while properly managing precious resources. Thank you again.

ABOUT ACCESSIA HEALTH

Accessia Health pioneered the patient assistance model for people living with specific chronic medical conditions; today our expanded mission incudes providing access and assistance for people regardless of their zip code or diagnosis. We provide financial assistance to pay for prescriptions, medical treatments, expenses, and insurance premiums. Our program services include healthcare education, specialized legal services, and case management. Serving diverse populations is our #1 goal and we seek partners who share our belief that all people deserve to have access to healthcare.

Accessia Health also seeks to innovate in the healthcare space by addressing unmet needs and working with policymakers and other stakeholders to improve patient outcomes while lowering healthcare expenses. All our patient's quality as financially eligible for assistance. For 2023, our top priorities include participating in 340B policy change conversations as well as PBM practices investigations. We rely on best practices in the PBM and PBA infrastructure to provide adequate cost structures for our patients cost sharing responsibilities so having a seat at the table to create best practices in both these arenas is of critical importance to our mission delivery.

ADVOCACY

We advocate for greater access to affordable healthcare and treatment for patients with rare and chronic diseases. Working on both the State and Federal level, we strive to ensure patient voices are heard and patient assistance is protected. Accessia Health also joins with partner coalitions to advocate for increases funding for healthcare programs, including NIH, CDC, and HRSA. We also strive for patient-centered healthcare reforms and care delivery improvements through Congress, the Patient-Centered Outcomes Research Institute, and the Innovation Center at CMS.

We encourage you to adopt the aforementioned funding requests to better meet the unmet needs of patients with serious illness and to address gaps in care through systems innovation and scientific advancements. Our vision, is one where patients living with chronic illness, rare disease, or disability no longer struggle to access the treatment, and assistance they need to lead their best life.

PATIENT PERSPECTIVES

I was diagnosed with Fabry 6 years ago and my husband was diagnosed with Pompe 3 years ago. I don't know what we would do without Accessia Health's help—we would be bankrupt. With both of us having rare diseases, the bills would be astronomical. Everyone at Accessia Health is so helpful. I haven't met one person who isn't kind.

—Lupe and Duane Austin

Accessia Health is a lifesaver. I was diagnosed with a rare genetic disease, Fabry disease, right after I purchased my new home. My treatments are over $40,000 every two weeks. I wasn't sure how I was going to pay my mortgage, it's only with the help of Accessia Health that I'm able to stay in my home and afford my treatments, medical bills and nursing services."

—Lisa Wright

Accessia Health's ACCESS program helped me receive Social Security Disability, which let me adopt my son Jacob.

—Randy Russell

[This statement was submitted by Gwen Cooper, President & CEO, Accessia Health.]

PREPARED STATEMENT OF ACELERO, INC.

Senator Baldwin, Ranking Member Capito, and Members of the subcommittee:

My name is Henry Wilde, and I am the Chief Executive Officer of Acelero, Inc., a Head Start and Early Head Start grantee funded to serve 991 children in Milwaukee and Racine Counties and over 5,000 children nationally. I am also a proud Beloit native, a Chippewa Falls and Wauwatosa descendent, and Madison resident. I am writing to you to express the urgent need to increase Head Start's annual appropriation to at least $16.47 billion for FY24, as recommended by the National Head Start Association (NHSA).

Wisconsin's positive attributes are too numerous to list, but our greatest deficit is this: "In the first national assessment of students since the pandemic, Wisconsin again posted the widest score gaps between Black and white students of any state, now by even greater margins." (https://www.jsonline.com/story/news/education/2022/10/24/naep-report-card-wisconsin-has-widest-score-gap-between-black-and-white-students/69581393007/) At Acelero, we believe, as I think you do, that talent is equally distributed, but opportunity is not. Racial and income-based achievement gaps are the product of vastly different access to resources and opportunities to prepare children to succeed in school and in life. We know that gaps in achievement are not a fait accompli; child outcomes are the product of choices about the degree to which public investment is concentrated in programming that has the greatest potential for impact on low income children. There is no better investment than the Head Start program.

Why does investing in Head Start matter?

Research is clear on early childhood education:

1. A child's brain develops more before age five than any other time in their lives.
2. The achievement gap that we see in third grade National Assessment of Educational Progress (NAEP) scores exists before children enter kindergarten; it does not begin in primary school.
3. Access to high quality early childhood education for low income children, specifically, matters hugely to their long-term trajectories academically and economically.

More than any other program, Head Start provides the opportunity to translate this research into action and ultimately deliver positive outcomes for low income children. In our Head Start programs, we serve children ages birth-to-five; we provide robust educational experiences and comprehensive two-generational programming to support young children's development; and we serve the children in greatest need free of charge.

Our early childhood education program at Acelero Learning has demonstrated what is possible when children have access to high quality programs. In 2021, after the first year of the pandemic (during which children generally suffered significant learning losses), researchers from Brown University conducted pre- and post-assessments of children enrolled in our program. Their study concluded: "Acelero's results cannot be generalized across the field of early childhood education, but it is notable that across age groups and both learning settings [virtual and in-person], Acelero's students made significant gains in domains of print knowledge and numeracy, and children in centers also made significant gains in executive function." (https://annenberg.brown.edu/news/brown-university-annenberg-study-shows-acelero-learning-head-start-children-made-significant).

We know that all Head Start programs are capable of having comparable impact, which is why investment in Head Start and Early Head Start is critical. But today, in light of the evolving labor market, inflation, and the after-effects of COVID–19, Head Start programs like ours face the dire choice of eliminating services to children and families or continuing to operate understaffed and under-enrolled programs.

What is the problem we need to solve?

The immediate challenge we face is that in Milwaukee and Racine, for the past year, we literally cannot serve children, because we cannot hire and retain the staff we need to provide education and family services. At Acelero Learning Wisconsin, in March 2020, nearly 90 percent of our Head Start positions were filled. Unfortunately, as of March 2023, our staffing shortage is over 40 percent; our vacancies have quadrupled in 3 years. As a result of our staffing shortage, we have an outstanding waitlist of 465 children and 36 classrooms that have remained unopened all year—classrooms that could have served nearly 500 children. We have also experienced difficulty retaining our current staff.

Compensation is the greatest driver of our workforce crisis. Early childhood educators have long been underappreciated and undercompensated relative to the value they create and the importance of their work but, in Acelero's 20 plus year history, we have never experienced this confluence of factors. Teachers worked heroically through the pandemic; and perhaps more than ever, homebound parents appreciated how challenging it is to teach young children—but that recognition did not alleviate the taxing emotional and physical burden on early childhood educators. COVID funding from Federal and State governments provided temporary remuneration to account for the criticality of their roles but, since then, the supplementary funding has run out or dwindled, and the impact has effectively been pay cuts to

front line staff. When you pile on top of these pay cuts the fact that Cost of Living Adjustments have not tracked with inflation, it is evident why over the past 3 years, Head Start employee compensation effectively took one step forward and three steps back.

The salary gap between Head Start and other employers has taken on even greater significance in the current labor market. Our employees are as mission driven and dedicated as anyone ever could be, but staff—and potential staff—must make financial decisions in the best interest of their own families, which includes seeking higher paying jobs unrelated to early childhood education in other service industries with significant hiring needs.

What is true for Acelero Learning is also true for other programs in Wisconsin and the Head Start community nationwide. In February of this year, the National Head Start Association surveyed Head Start grant recipients to determine the extent to which workforce struggles continue to be an ongoing problem. The findings mirrored our experience:

—20% of Head Start and Early Head Start classrooms were closed, and 81% of grant recipients with closed classrooms cited staff vacancies as the primary reason.

—19% of staff positions were vacant nationwide, and 65% of respondents cited compensation as the primary reason.

—There were an estimated 137,000 to 275,000 children on Head Start or Early Head Start waiting lists. This equates to 17 to 33% of currently funded slots.

What is the solution?

We are thankful that the President called for an increase in Head Start funding of over a billion dollars in his proposed FY24 budget, including the $575 million to improve compensation for Head Start workers, but that is only a start. This increase would represent a 4.8 percent across the board wage increase, which certainly does not close the gap between Head Start teachers and those with similar qualifications in school district positions, much less allow us to bring all employees up to a living wage, which is our organizational goal.

The National Head Start Association is recommending funding of $16.47 billion for FY24—primarily to address the workforce crisis. This would allow our program and others to remain open, and more importantly, to build back our enrollment to prior levels with an underlying funding base that gives us greater assurance that we can attract and retain the workforce we need to prepare the next generation of children in our communities to be successful in school and in life. If we hope to address the yawning achievement gap here in Wisconsin, we need to not just stabilize early childhood education; we need to maximize its quality and its effectiveness.

We realize that this level of funding will require bipartisan collaboration and the engagement of other committees in Congress. We also know that the subcommittee has the opportunity to visibly and tangibly assert and support Head Start in FY24 and to exert leadership in support of a highly defensible and proven federal-to-local partnership. In the context of the Federal budget, this increase represents a rounding error, but for the nearly million low income children enrolled in the Head Start program—and worse, those children who otherwise will not be served—this funding could be transformational.

We would welcome the opportunity to host any member of the subcommittee—indeed, any Member of Congress—at one of our programs to speak with our parents about the program's impact, observe our phenomenal staff, sit in classrooms with the incredible children we are gifted the opportunity to serve, and see what transformational early care and education looks like in action. As you evaluate FY24 funding requests, we hope this will be a critical data point that informs your decisions.

Thank you for your consideration of this critical request.

[This statement was submitted by Henry Wilde, Chief Executive Officer, Acelero, Inc.]

PREPARED STATEMENT OF THE AD HOC GROUP FOR MEDICAL RESEARCH

The Ad Hoc Group for Medical Research is a coalition of nearly 400 patient and voluntary health groups, medical and scientific societies, academic and research organizations, and industry. We appreciate the opportunity to submit this statement in support of strengthening the Federal investment in biomedical, behavioral, social, and population-based research conducted and supported by the National Institutes of Health (NIH) through a recommendation of at least $51 billion for NIH's foundational work in fiscal year (FY) 2024.

As a result of the strong, bipartisan vision of the House and Senate Labor-HHS-Education subcommittees over the last 8 years, Congress has helped the agency regain some of the ground lost after years of effectively flat budgets. That renewed investment in NIH has advanced discovery toward promising therapies and diagnostics, reenergized existing and aspiring scientists nationwide, and restored hope for patients and their families. As the subcommittee has recognized, to remain a global leader in accelerating the development of innovative prevention strategies, advanced diagnostics, pioneering treatments, and life-changing cures, and in this time of unprecedented scientific opportunity, it is essential that Congress sustain long-term robust increases in the NIH budget.

For FY 2024, the Ad Hoc Group recommends at least $50.924 billion for NIH's foundational work, a $3.465 billion increase over the comparable FY 2023 program level. This funding level, supported by nearly 400 stakeholder organizations, would provide real growth in the base budget above inflation of nearly 5%, expanding NIH's capacity to support promising science in all disciplines. In addition, as the Advanced Research Projects Agency for Health (ARPA–H) ramps up its work in targeted research areas, this broad-based, national community of diverse stakeholders is unanimous in emphasizing that any funding for ARPA–H should supplement, rather than supplant, the essential foundational investment in the NIH.

Importantly, we also recommend a funding allocation for the Labor-HHS-Education subcommittee in FY 2024 that allows for the necessary investment in NIH and other agencies that promote the health of our Nation. We believe that science and innovation are essential if we are to continue to meet current and emerging health challenges, improve our Nation's physical and fiscal health, and sustain our leadership in medical research. The Ad Hoc Group has joined nearly 800 partners in urging congressional leaders to avoid deep cuts to nondefense programs like medical research in FY 2024 and beyond.

NIH: A Partnership to Save Lives and Provide Hope. The partnership between NIH and America's scientists, medical schools, teaching hospitals, universities, and research institutions is a unique and highly productive relationship, leveraging the full strength of our Nation's research enterprise to translate this knowledge into the next generation of diagnostics, therapeutics, and cures. Nearly 85% of the NIH's budget is competitively awarded through nearly 50,000 research and training grants to more than 300,000 researchers at over 2,500 universities, medical schools, and research institutions located in every State, Washington, D.C., and U.S. territories. The Federal Government has an essential and irreplaceable role in supporting medical research. No other public, corporate, or charitable entity is willing or able to provide the broad and sustained funding for the cutting-edge basic research necessary to yield new innovations and technologies of the future.

NIH has supported biomedical research to enhance health, lengthen life, respond to emerging health threats, and reduce illness and disability for more than 100 years. For patients and their families, NIH is the "National Institutes of Hope." The following are a few of the many examples of how NIH research has contributed to improvements in the Nation's health.

—NIH-funded basic research laid the groundwork for the novel mRNA vaccine technology used in the first two Food and Drug Administration (FDA approved SARS–CoV–2 vaccines. Vaccines continue to be one of our most cost-effective public health tools with every $1 spent on routine childhood vaccinations estimated to save $5 in direct costs, and $11 in broader costs to society.

—NIH funding contributed to every one of the 356 new drugs approved by the FDA between 2010 and 2019, including 126 first-in-class products to treat a wide range of diseases.

—In 2020, the gene editing tool CRISPR was successfully used to treat the inherited blood disorders sickle cell anemia and beta-thalassemia, only 8 years after the primordial bacterial immune system was harnessed for therapeutic use in the laboratory.

—Following nearly three decades of NIH-funded research into novel mechanisms of drug action, breakthroughs in the treatment of depression came in 2019 with two new FDA-approved drugs—one for treatment-resistant depression and the first ever treatment for postpartum depression.

—In 2007, induced pluripotent stem cells (iPSC) were discovered when adult cells were re-engineered into early non-differentiated versions of themselves. In 2019, the National Eye Institute launched a first-in-human clinical trial to test the safety of a novel patient-specific iPSC therapy to treat the most common form of Age-related Macular Degeneration, and the leading cause of vision loss in the age 65+ population.

—NIH-supported researchers continue to work toward strategies to better prevent, identify, and treat pain and substance use disorders through the HEAL

(Helping to End Addiction Long-term) Initiative. HEAL aims to support research into new, non-addictive medication and to establish public and private partnerships to develop best practices in communities.

—Today, treatments can suppress HIV to undetectable levels, and a 20-year-old HIV-positive adult living in the U.S. who receives these treatments is expected to live into his or her early 70s, nearly as long as someone without HIV.

—The death rate for all cancers combined has declined in adults since the early 1990s and since the 1970s for children. The cancer death rate for men and women combined fell 32% between its peak in 1991 and 2019, the most recent year for which data were available.

Sustaining Scientific Momentum Requires Sustained Funding Growth. The leadership and staff at NIH and its Institutes and Centers have engaged the broader community to identify emerging research opportunities and urgent health needs and to prioritize precious Federal dollars to areas demonstrating the greatest promise. Sustained robust increases in NIH funding are needed if we are to continue to take full advantage of these opportunities to accelerate the development of pioneering treatments and innovative prevention strategies.

One long-lasting potential impact of investments in NIH is on the next generation of scientists. Sustained increases in NIH funding over the last 7 years have allowed NIH to more than double the investment in early-stage investigators (ESIs). In 2015, NIH only funded about 600 grants for ESIs and the career outlook for early career researchers seemed grim. In FY 2021, NIH was able to fund more than 1,500 grants for ESIs, reinvigorating the spirits of researchers in the biomedical workforce. Sustained increases are needed to allow NIH to continue support of new talent and innovation in medical research.

Even with recent investments in NIH, nearly 4 of every 5 research ideas that are proposed to NIH every year cannot be funded. Additional funding is needed if we are to strengthen our Nation's research capacity, ensure a medical research workforce that reflects the racial, gender, and geographic diversity of our citizenry, and inspire a passion for science in current and future generations of researchers.

NIH is Critical to U.S. Competitiveness. Our country still has the most robust medical research capacity in the world; however, other countries have significantly increased their investment in biomedical science, which leaves us vulnerable to the risk that talented medical researchers from all over the world may return to better opportunities in their home countries. We cannot afford to lose that intellectual capacity, much less the jobs and industries fueled by medical research. The U.S. has been the global leader in medical research because of Congress's bipartisan recognition of NIH's critical role. To continue our dominance, we must reaffirm this commitment to provide NIH the funds needed to maintain our competitive edge.

NIH: An Answer to Challenging Times. Research supported by NIH drives local and national economic activity, creating skilled, high-paying jobs and fostering new products and industries, and catalyzes increases in private sector investment. A $1 increase in public basic research stimulates an additional $8.38 investment from the private sector after 8 years. A $1 increase in public clinical research stimulates an additional $2.35 in private sector investments after 3 years. According to a United for Medical Research report, in FY 2022, NIH-funded research supported nearly 570,000 jobs across the U.S. and generated more than $96 billion in economic activity.

The Ad Hoc Group's members recognize the tremendous challenges facing our Nation and acknowledge the difficult decisions that must be made to restore our country's fiscal health. Robust funding of the NIH, and strengthening our commitment to medical research, is a critical element in ensuring the health and well-being of the American people and our economy. Therefore, for FY 2024, the Ad Hoc Group for Medical Research recommends that NIH receive at least $50.924 billion in base funding to advance the foundational research NIH supports and continue the momentum in our Nation's investment in medical research, and that any funding for ARPA–H supplement our $51 billion recommendation for NIH's base budget, rather than supplant the essential foundational investment in the NIH.

PREPARED STATEMENT OF ADVOCATES FOR COMMUNITY HEALTH

Thank you for this opportunity to provide Outside Witness Testimony for Fiscal Year 2024 Appropriations for the subcommittee on Labor, Health and Human Services, Education and Related Agencies.

Advocates for Community Health requests for FY24:

—$2.88 billion in funding for the Community Health Center Program

—$1 billion for the Teaching Health Center Graduate Medical Education program

—$950 million for the National Health Service Corps (NHSC)
—$25 million for the new Mental Health of the Health Professions Workforce Program
—$28 million for the new Health Care Workforce Innovation Program

Advocates for Community Health is a membership organization of community health centers focused on visionary and innovative policy and advocacy initiatives to affect positive change for community health centers, the patients they serve, and the Nation's health care system as a whole. Rooted in community health, our members are forward-thinking community health centers that lead the way in comprehensive, integrated primary care and cutting-edge innovation to help shape a rapidly evolving health care landscape.

Increasing investment in community health centers is the best investment you can make in health care—delivering cost savings, patient health, and community wellbeing.

There has been consistent data over time that community health centers perform exceptionally well and do so at a lower cost than other providers and other primary care settings.

Across the board, being connected to primary care services leads to better outcomes and lower costs. Recent research has shown that, for every $1 invested in primary care, $13 is saved in downstream costs.[1] Of the 4.3 trillion dollars in health spending in the U.S. every year, the Nation only spends 5% on primary care. However, research has shown that if the U.S. spent closer to 12 percent,[2] it would cut per patient costs and lead to a decrease in overall health care expenditures.

The most effective way to achieve a return on investment from primary care is to invest in community health centers, which are the gold standard of primary care-comprehensive, patient-centered, patient-governed, accountable, competitively funded, and tailored to the needs of local communities. As the National Association of Community Health Centers (NACHC) found in a recent survey, without community health centers, 15 million more patients would be at risk for not having a usual source of primary care.[3]

Community health centers are a cost-effective option for both patients and the health care system alike. After controlling for health status, health insurance coverage, income, age, and other factors, patients who received a majority of their ambulatory care at community health centers had significantly lower annual overall medical expenditures (24%) and ambulatory expenditures (25%) than those who did not.[4] This also held true for Medicaid patients, where health centers save 24% per patient compared to other providers,[5] and Medicare patients, where costs for health centers are 10% lower than physician office patients and 30% lower than outpatient clinics.[6] As noted by Dr. Robert Nocon at the Kaiser Permanente School of Medicine, community health centers were estimated to save a total of $25.3 billion for the Medicaid and Medicare programs in 2021.[7]

Not only do community health centers save the health care system and patients money, but they also serve as economic engines for under-resourced neighborhoods. In 2019, community health centers generated $63.4 billion in total economic activity, of which $32 billion were indirect economic impacts generated from supporting local

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[1] Sherril Gelmon et al., "Implementation of Oregon's PCPCH Program: Exemplary Practice and Program Finding" (Oregon Health Authority, September 2016), https://www.oregon.gov/oha/HPA/dsi-pcpch/Documents/PCPCH-Program-Implementation-ReportFinal-Sept-2016.pdf.

[2] Robert L. Phillips and Andrew W. Bazemore, "Primary Care And Why It Matters For U.S. Health System Reform," Health Affairs 29, no. 5 (May 2010): 806–10, https://doi.org/10.1377/hlthaff.2010.0020.

[3] "Closing the Primary Care Gap: How Community Health Centers Can Address the Nation's Primary Care Crisis", (National Association of Community Health Centers, February 2023), https://www.hcadvocacy.org/wp-content/uploads/2023/02/Closing-thePrimary-Care-Gap__Full-Report__2023__digital-final.pdf.

[4] Patrick Richard et al., "Cost Savings Associated With the Use of Community Health Centers," The Journal of Ambulatory Care Management 35, no. 1 (March 2012): 50, https://doi.org/10.1097/JAC.0b013e31823d27b6.

[5] Robert S. Nocon et al., "Health Care Use and Spending for Medicaid Enrollees in Federally Qualified Health Centers Versus Other Primary Care Settings," American Journal of Public Health 106, no. 11 (November 2016): 1981–89, https://doi.org/10.2105/AJPH.2016.303341.

[6] Dana B. Mukamel et al., "Comparing the Cost of Caring for Medicare Beneficiaries in Federally Funded Health Centers to Other Care Settings," Health Services Research 51, no. 2 (April 2016): 625–44, https://doi.org/10.1111/1475-6773.12339.

[7] Robert Nocon (Kaiser Permanente Bernard J. Tyson School of Medicine). "Testimony on Community Health Centers: Saving Lives, Saving Money before the United States Senate Committee on Health, Education, Labor and Pensions Committee." (March 02, 2023).

businesses.[8] A national and local study by Capital Link has shown that, for every dollar of Federal funding invested in community health centers, $11 is generated in total economic activity through increased spending on related health service expenses, food services, transportation, construction, and more.[9]

Health centers provide these services while caring for more patients than ever before. In 2021, HRSA-funded community health centers provided comprehensive primary care to a record 30.2 million patients, a 43% increase over the past 10 years.[10] As Vermont Community Health Center CEOs Josh Dufresne and Jeff McKee state, "Health centers cannot keep doing more with less."[11]

The present trajectory is unsustainable, and Federal funding for health centers is not keeping pace with rising medical costs and patient population growth.[12] Community health centers' extraordinary growth has dramatically outpaced funding. From Fiscal Year 2015 to Fiscal Year 2021, total community health center funding increased by 11% ($5.1B to $5.7B) while the number of patients served increased by 24% (24.1 million to 30 million).[13] Similarly, the number of health center visits reached a record 124 million in 2021.[14]

Also notable, the quality of care provided by community health centers has not altered or been sacrificed in the face of growth. 1,058 community health centers (77%) have achieved Patient-Centered Medical Home (PCMH) recognition, and community health centers have an eight times greater odds of attaining PCMH certification compared to other types of health care practices.[15] The PCMH model of care enables community health centers to have strong patient outcomes at lower costs despite treating patients who are often sicker, with more complex health care needs, and those who come from a poorer population than in other health care settings.

Unfortunately, even as community health centers continue to leverage successes and look to expand to meet the increasing needs of patients in new and existing communities, they are facing an unprecedented set of financial challenges.

1. *Medicaid Unwinding/Redeterminations:* According to the Geiger Gibson Project on Community Health at George Washington University, the Nationwide redetermination process in State Medicaid programs as continuous coverage comes to an end is estimated to decrease total health center revenue by 4% to 7% nationally, with an associated loss in patient capacity of 1.2 to 2.1 million patients and a staffing capacity loss of 10,700 to 18,500 staff members.[16] This process began on April 1, 2023. Community health centers will continue to serve these patients, but lose the revenue stream.

2. *Expiration of American Rescue Plan Funds:* The expiration of supplemental COVID funding is an additional challenge, as it made up 7% of community health center revenues in 2021.[17] While much of the COVID funding was used for nonrecurring expenses specific to the COVID pandemic, in a survey of our members, we found that community health centers were forced to use this funding to fill crit-

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[8] "Community Health Centers Are Economic Engines" (National Association of Community Health Centers, October 2020), https://www.nachc.org/wp-content/uploads/2020/12/Economic-Impact-Infographic-2.pdf.

[9] "Health Centers Provide Cost Effective Care" (National Association of Community Health Centers, July 2015), http://nachc.org/wpcontent/uploads/2015/06/Cost-Effectiveness_FS_2015.pdf.

[10] "2021 Health Center Program Highlights Uniform Data System Trends," Bureau of Primary Healthcare, Health Resources and Services Administration, August 9, 2022, https://bphc.hrsa.gov/sites/default/files/bphc/data-reporting/uds-2021-data-trendsspeakers.pdf.

[11] Josh Dufresne and Jeff McKee, "Dufresne & McKee: Health Centers Cannot Keep Doing More with Less," VTDigger, January 18, 2023, https://vtdigger.org/2023/01/18/dufresne-mckee-health-centers-cannot-keep-doing-more-with-less/.

[12] Matrix Global Advisors. The Overlooked Decline in Community Health Center Funding. 2022. https://acrobat.adobe.com/link/review?uri=urn:aaid:scds:US:58b05b79-f372-30b3-aa7c-874ee1517dec.

[13] Julia Paradise et al., "Community Health Centers: Recent Growth and the Role of the ACA," KFF (blog), January 18, 2017, https://www.kff.org/medicaid/issue-brief/community-health-centers-recent-growth-and-the-role-of-the-aca/.

[14] Jessica Sharac et al., "Changes in Community Health Center Patients and Services During the COVID–19 Pandemic," KFF (blog), December 21, 2022, https://www.kff.org/medicaid/issue-brief/changes-in-community-health-center-patients-and-servicesduring-the-covid-19-pandemic/.

[15] "Community Health Center Chartbook 2022" (The National Association of Community Health Centers (NACHC), 2022), https://www.nachc.org/wp-content/uploads/2022/03/Chartbook-Final-2022-Version-2.pdf.

[16] https://geigergibson.publichealth.gwu.edu/potential-effect-medicaid-unwinding-community-health-centers.

[17] Jessica Sharac et al., "Changes in Community Health Center Patients and Services During the COVID–19 Pandemic," KFF (blog), December 21, 2022, https://www.kff.org/medicaid/issue-brief/changes-in-community-health-center-patients-and-servicesduring-the-covid-19-pandemic/.

ical gaps, especially in the area of the workforce.[18] Due to the years of flat funding in the community health center program, our centers have been unable to make additional investments in workers at all levels. With this supplemental funding, community health centers were able to prioritize recruitment and retention. As it goes away, they are once again faced with flat budgets against dramatically increasing needs and market rates. Simply put, community health centers do not have the resources to compete with some privately held practices, hospital systems, or corporate-owned or financially backed practices, causing severe challenges for both recruiting and retaining staff. To put this issue into greater context, if community health centers lack the funding and resources necessary to retain and recruit staff at all levels, access to care will suffer.

3. *Erosion of the 340B Program:* The 340B program is being steadily eroded by the actions of state policymakers, pharmaceutical companies, and pharmacy benefit managers, to the detriment of the Nation's safety net providers. In today's health care environment, health centers depend on the 340B program to meet their mission, putting every dollar received back into the communities they are serving. The current reach of community health centers would not be possible without the 340B program, but it is currently being whittled away and the continued loss of revenue from the 340B program will have a direct impact on patient care and access as well as workforce recruitment and retention.

The bottom line is that community health centers are facing enormous financial challenges while serving a larger and more important role in our health care system than ever before. We urge the Senate Appropriations Committee to invest in this important component of the health care safety net.

We argue that such an investment is more than warranted. Not only do community health centers have a proven track record of savings, accountability, and positive economic impact, they are the breeding ground for invaluable innovation to drive further savings and better health outcomes, all while responding to the localized needs of their community. The Health Center Program is a shining example of a vital Federal investment with localized control and impact, and massive systemwide returns in the form of savings, employment, and economic stimulation in otherwise underserved communities.

Community health centers are required to serve every patient who walks through their doors, regardless of their insurance status or ability to pay. But to do so, they need an investment from the Federal Government that matches our communities' needs. This comprehensive, culturally, and linguistically competent care also requires a strong community health center workforce. Rather than disinvest in community health centers and force them to pull back, we need to reinvest to allow them to expand and offer more people their high-quality, low-cost services.

Health centers have proven they can do a great deal with limited resources; but they could do even more with meaningful investment. Community health centers are poised to care for our Nation's underserved, innovate and drive new models of care, produce healthier patients and communities, and save our health care system scarce resources.

Congress has the opportunity to set this vital health care system on the right course for the future. Whether measured in lives or dollars, there is no better health care investment than the Health Center Program.

[This statement was submitted by Amanda Pears Kelly, Chief Executive Officer, Advocates for Community Health.]

PREPARED STATEMENT OF THE AFTERSCHOOL ALLIANCE

On behalf of the Afterschool Alliance, the entire afterschool field, and especially the 1.1 million individuals in Nita M. Lowey 21st Century Community Learning Centers right now, I extend our sincere gratitude for the funding and received in fiscal year (FY) 2023. Those critical resources helped keep many young people and their families supported and connected in the midst of a myriad of challenges. Those challenges continue. There are waiting lists for programs nationwide—programs that are facing the growing labor and material costs. In FY 2024, we ask Congress to build on past success and tackle the challenges of tomorrow by providing the Nita M. Lowey 21st Century Community Learning Centers (CCLC) program within the U.S. Department of Education with $2.01 billion. This is a $750 million increase over FY 2023.

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[18] Internal ACH survey data available upon request.

The Afterschool Alliance is a national non-profit organization that works to ensure that all children and youth have access to quality afterschool and summer learning opportunities. We support a network of more than 26,000 afterschool partners that are expanding learning opportunities for students nationwide and tapping community partners to keep children safe and well-nourished, and provide engaging, hands-on activities that promote positive well-being and raise school attendance, academic achievement, and graduation rates.

Over the past several years, the COVID–19 pandemic presented afterschool programs—and the staff, organizations, students, and families that rely on them—with challenges they never could have anticipated. Programs endured unexpected costs, serious staff and student health considerations, limited access to school facilities during closures, staffing shortages, and much more. The afterschool field rose to the challenge. With local partners, afterschool programs across the country adjusted their operations to address the urgent needs of the children and families in their communities: providing meals, offering care for children of essential workers, finding ways to keep students engaged and connected while learning remotely, providing in-person programs and safe spaces for online learning, and remaining a source of support to students and families. Today, afterschool programs are navigating increased demand from students in need of learning and whole-child supports, along with increased costs, and staffing recruitment and retention challenges. Working with communities that often face intense hardships, afterschool programs remain critical partners ensuring young people are prepared for today and tomorrow; making them strong, resilient, and hopeful. None of this is possible without robust Federal support.

The 21st Community Learning Centers program marks its 25th anniversary this year. Across those years, programs have played a vital role in communities across the Nation by providing a range of vitally important services to students with academic challenges, especially those in low-income communities. These programs are unique collaborations between schools and local communities that provide a balance of academic and whole-child support to students in need. Programs operate before school, during summer months, and in peak after school hours when students can most benefit from a safe learning environment, enrichment activities, and caring adults and mentors. 21st CCLC programs provide:

—opportunities for new, hands-on, academically enriching learning experiences to meet challenging state academic standards;

—a broad array of additional services, programs, and activities, focusing on subjects like science, technology, engineering, and math (STEM), physical fitness and wellness, drug and violence prevention, nutrition and health education, service learning, career-connected learning, youth development, and arts and music;

—activities that connect to in-demand industry sectors or occupations that are designed to reinforce and complement the academic program of participating students, including, but not limited to, financial and environmental literacy, career readiness, internships, apprenticeships and paying jobs; and

—opportunities for families of students to actively and meaningfully engage in their children's education, including opportunities for literacy and related educational development.

Based on the most recently available data, there are currently 10,652 school-based and community centers supported by 21st CCLC; 41 percent are in cities, 38 percent are in suburban areas, and 21 percent are in rural communities. 21st Century Community Learning Centers provide essential support to more than a million students and family members, many of whom are from underserved communities, and offer creative, engaging learning opportunities to kids of all ages and backgrounds. Programs stay open on average 13.8 hours per week, 5 days per week, for 32 weeks per year. More than 96,000 staff serve in 21st CCLCs; 37 percent are certified teachers, 31 percent are community partner staff and youth workers, and 8 percent are college students.

21st Century Community Learning Centers are individualized to each State and community; providers examine the needs of the population and design a program to help students of all ages and prepare them to become college- and career-ready in their transition to post-secondary life. Community-based organizations, schools, nationally affiliated non-profits, colleges and universities, public libraries, park and recreation centers, faith-based organizations, charter schools, museums, and more are all eligible for 21st CCLC funding. But, the "secret sauce" is that these entities come together as partners to provide a quality learning experience for pre-K–12th grade students. For students who attend programs, the opportunities provided through 21st CCLCs are a lifeline that help them reconnect, re-engage, and develop the skills they need to be successful in school and in life. 21st Century Community

Learning Centers orchestrate opportunities that anchor students to peers and caring adults in their schools and communities, and often help them discover their passions, be it robotics, culinary arts, gardening, writing, flying drones, coding, music, creative dance, or calligraphy. Academic supports are paired with personal connections, community partnerships, and structured opportunities that allow students to explore and develop talents and interests that often are not addressed during the regular school day.

The greatest weakness of the 21st Century Community Learning Center program is that there is not enough funding to offer programs to students in many schools and communities. In fact, only 1 out of 3 requests from program providers for 21st CCLC funding is awarded nationally. Over a span of 10 years, $4 billion in local grant requests were denied because of the lack of adequate Federal funding and intense competition. And while the program serves 1.1 million children and families, demand for quality afterschool and summer programs, like those offered through 21st CCLC, continues to grow. Based on a 2022 survey, nearly 25 million students nationwide were on the afterschool waitlist. For every child in afterschool, four were waiting for an available program.

What are the students who are unable to attend programs missing out on? The research is clear that participation in afterschool programs, including 21st CCLC programs, yields a wide array of positive outcomes:

—Statewide evaluations of 21st CCLC programs have found a positive impact on student engagement and motivation in school, with gains seen across grade levels, from elementary to high school.

—Students who regularly participate in 21st CCLC programs improved their school attendance, school engagement, health-related behaviors, and math and reading achievement.

—Regular participation in afterschool programs helped narrow the achievement gap between high- and low-income students in math, improved academic and behavioral outcomes, and reduced school-day absences.

—Businesses want to hire problem solvers and team players. Students learn by doing in afterschool programs and develop the skills they need for the jobs of tomorrow. Students regularly participating in 21st CCLC programs see gains in skills and competencies valued by employers, such as the ability to communicate well, collaborate with others, and think critically.

—Jobs in science, technology, engineering, and math (STEM) are driving global economic growth. Nearly six million students are getting opportunities to develop an interest and explore STEM in afterschool.

—More than 8 in 10 parents say afterschool helps give working parents peace of mind and helps parents keep their jobs.

During the pandemic, 21st CCLCs faced challenges but were able to rise to the occasion and provide critical supports for students and families. Although many States reported disruptions in data collection during the pandemic, promising findings illustrate positive academic and behavioral gains among participants over the past 2 years. For example, a 2021 evaluation of Wisconsin's 21st CCLC programs by the Wisconsin Department of Public Instruction found that students attending programs saw gains. According to teacher surveys, of students who needed to improve, a majority improved their classroom participation and improved their behavior in the classroom. The most recent evaluation of West Virginia's 21st CCLC programs by the West Virginia Department of Education found that participants made both academic and behavioral gains. Students who attended at least 90 days of programming had a higher regular school-day attendance rate than their non-participating peers (96% vs. 93%), as well as had fewer disciplinary referrals than non-participants (0.3 vs. 0.6). Participating students were also more likely than their non-participating peers score at proficiency in math (43% vs. 34%). The most recent evaluation of South Carolina's 21st CCLC programs by the American Institutes for Research found that they had a positive impact on students' academic performance and engagement in learning. According to teacher surveys, at least 3 in 4 students who regularly attended programming and needed to show improvement made gains in their academic performance (85%), class participation (84%), motivation to learn (82%), attentiveness in class (81%), ability to get along with other (79%), classroom behavior (77%), and regularly attending class (76%). And, in a 2022 evaluation of the 21st CCLC programs in Massachusetts by the Massachusetts Department of Elementary and Secondary Education and the National Institute on Out-of-School Time at Wellesley College, 21st CCLC attendees showed growth in social-emotional learning skills and academic performance. More than one-third of attendees improved their ELA scores (35%) and one quarter improved their math scores (25%). According to teacher surveys, the majority of youth who participated in programming showed growth in perseverance (83%), effective communication skills (67%),

self-regulation (66%), and ability to think critically (56%). A majority of students also saw a positive change in their relationships with peers (58%) and adults (57%). The evaluators wrote that the, "...data indicates that 21st CCLC programs may help reduce opportunity and achievement gaps as well as contribute to decreasing high school drop [out] rates."

The afterschool field is grateful for the funds made available by Congress through the CARES Act, CRRSA, and the American Rescue Plan (ARP) Act. A number of States are using the American Rescue Plan Act ESSER set-aside funds to broaden access to evidence-based comprehensive afterschool and summer enrichment programs. Some States have leveraged their 21st CCLC infrastructure at the State and local levels to efficiently invest their COVID–19 relief funds to provide supports to students during the summer and after school. Some States have used these funds to reach populations that have not been served by other funding streams, including intentionally reaching out to smaller providers. States are also collaborating with partners and building out opportunities for technical assistance and professional development to support providers and students.

We are also grateful that Congress recognized that our children and youth lost much more than just academics during this pandemic. A recent CDC survey found alarming self-reported rates of depression, sadness, and even suicidal thoughts amongst our youth. Healthy interactions with their peers and caring adults are more essential than ever. Quality afterschool programs provide a safe place where our students feel a sense of purpose and belonging. It's a place where teamwork, collaboration, and getting out of one's comfort zone are applauded and encouraged. But, sadly, too many school districts are using their Federal dollars for programs that only focus on academics, providing tutoring or summer school, which only address some of the losses our kids are facing. Without increased funding for 21st CCLC, students and families across the Nation will miss out on holistic afterschool and summer opportunities.

Our goal is simple: to ensure that a quality, accessible program is available to every youth and family that wants one. On the quality end, this means ensuring that funding is available to offer professional development and other quality support, including courses for staff in positive youth development, youth choice and voice, making connections with schools, and especially now, courses in trauma-informed care and mental health first aid for youth, as well as for staff. We need more funding to pay experienced staff to stay in this essential work. We need more funding so that parents, including the many women who had to leave their jobs when schools closed during the pandemic, can be part of the workforce. With 24.7 million students unable to access programs, the need for considerable additional Federal support for 21st CCLC is very clear.

When considering funding for FY 2024, I urge you to consider just how important it is to sustain and expand afterschool and summer learning programs for our children, families, communities and for our workforce. Thank you for your attention to this crucial issue. In FY 2024, please provide the Nita M. Lowey 21st Century Community Learning Centers (CCLC) program with $2.01 billion.

[This statement was submitted by Jodi Grant, Executive Director, Afterschool Alliance.]

PREPARED STATEMENT OF THE AIDS INSTITUTE

Dear Chair Baldwin and Members of the subcommittee:

The AIDS Institute, a national public policy, research, advocacy, and education organization, is pleased to offer testimony in support of domestic HIV and viral hepatitis programs in the FY2024 Labor, Health and Human Services, Education, and Related Agencies (L–HHS) appropriation measure. We urge you to significantly increase funding for core public health programs that treat and prevent HIV and viral hepatitis in the United States, as well as fund newer programs that seek to end the HIV and viral hepatitis epidemics.

HIV IN THE UNITED STATES

Approximately 1.2 million people are living with HIV in the U.S. Since the height of the epidemic, there have been tremendous advancements in HIV treatment and prevention. Today, HIV can be treated as a chronic health condition, and when that treatment is successful, it renders HIV untransmissible. The toolbox for HIV prevention has grown substantially, with pre-exposure prophylaxis (PrEP) as an effective biomedical intervention to protect someone from HIV if they are at risk. Despite these advances, progress toward ending the HIV epidemic has plateaued, with ap-

proximately 35,000 new infections each year since 2013. HIV continues to disproportionately gay and bisexual men, Black and Latino people, and people living in the South. There is no one-size-fits all approach to ending HIV, but Federal programs that provide tools to communities that meet the needs of their jurisdictions are vital if we want to end HIV.

ENDING THE HIV EPIDEMIC INITIATIVE

The Ending the HIV Epidemic Initiative (EHE), which was first funded 2019 and developed by members of the Trump Administration, is focused on reducing new HIV infections by 90 percent over 10 years. Resources are focused on 57 jurisdictions with the greatest share of HIV incidence, including Alabama, enabling these jurisdictions to craft and implement community-specific plans to reduce the spread of HIV. With greater funding and continued bipartisan support for EHE, The AIDS Institute believes this nation can make significant progress toward the goal of ending the HIV epidemic. We urge you to fund year four of the EHE Initiative at the following levels: $495 million for the CDC Division of HIV/AIDS Prevention; $330 million for the Ryan White HIV/AIDS Program; $207 million for HRSA's Community Health Center program; $26 million for NIH's Centers for AIDS Research; and $52 million for the Indian Health Service.

CDC HIV PREVENTION

CDC's Division of HIV Prevention focuses resources on those populations and communities most affected by investing in high-impact prevention. Through partnerships with State and local public health departments and community-based organizations, the CDC has expanded targeted prevention programs that work to address prevention gaps. There is no single way to prevent HIV, but jurisdictions use a combination of effective evidence-based approaches including testing, linkage to care, education, PrEP, and harm reduction services. We urge the subcommittee to fund CDC's HIV Prevention program at $1.417 billion, including $100 million for school-based HIV prevention and $495 million for the Ending the HIV Epidemic Plan.

THE RYAN WHITE HIV/AIDS PROGRAM

The Ryan White HIV/AIDS Program provides medications, medical care, and essential coverage completion services to almost half of all people living with HIV in the U.S. The Ryan White Program successfully engages individuals in care and treatment, increases access to HIV medications, and helps nearly 90 percent of clients achieve viral suppression. The cost of medical care has consistently increased over the last decade, yet when adjusted for inflation, Ryan White has not had an increase in funding since 2001. The AIDS Institute requests that the subcommittee fund the Ryan White HIV/AIDS Program at a total of $3.058 billion in FY2023, distributed in the following manner: Part A at $814.1 million; Part B (Care) at $520.0 million; Part B (ADAP) at $968.3 million; Part C at $231 million; Part D at $85 million; Part F/AETC at $58 million; Part F/Dental at $18 million; and Part F/SPNS at $34 million; Ending the HIV Epidemic Plan at $330 million.

MINORITY AIDS INITIATIVE

As racial and ethnic minorities in the U.S. are disproportionately impacted by HIV/AIDS, it is critical that the subcommittee continue to fund the Minority HIV/AIDS Fund and Minority AIDS programs at SAMHSA. We urge the subcommittee to appropriate $105 million for the Minority HIV/AIDS Fund; and $160 million for SAMHSA's Minority AIDS Initiative Program.

PRE-EXPOSURE PROPHYLAXIS

Last year marked the ten-year anniversary of FDA approving the first medication for PrEP, potentially the greatest advent in the fight to prevent HIV. Despite the tremendous promise of PrEP, it is severely underutilized. Of the estimated 1.2 million people who could benefit from PrEP, only 23 percent have a prescription. Only 16 percent of Hispanic/Latino people and 9 percent of Black people who could benefit from PrEP have a prescription. The AIDS Institute believes a national PrEP program is desperately needed and urges your subcommittee to fund a national PrEP program through CDC's Ending the HIV Epidemic funding line and request that $200 million of our requested increase for that program be dedicated to create equitable PrEP access.

VIRAL HEPATITIS IN THE UNITED STATES

Viral hepatitis continues to have a dramatic impact in the United States. Despite highly effective vaccines to prevent hepatitis A (HAV) and hepatitis B (HBV), and curative treatments for hepatitis C (HCV), untreated hepatitis continues to be the leading cause of liver cancer and liver failure, and leads to far too many deaths. Hepatitis is known as a silent killer because it is often asymptomatic until it has led to serious health damage. The CDC estimates that 67% of the estimated 2.4 million people in the US living with HBV and 51% of the estimated 1 million people living with HCV are unaware that they have the virus. The CDC and State health departments simply do not have the resources they need to adequately identify people at risk, screen them for possible infection, vaccinate those for whom it is recommended, and treat those who need it. With so many Americans impacted by viral hepatitis, it is crucial that the U.S. invest more in the evidence-based prevention, testing, surveillance, and treatment programs that will help end this epidemic.

CDC VIRAL HEPATITIS PREVENTION

The CDC's Division of Viral Hepatitis (DVH) is the lead agency combating viral hepatitis at the National level by providing important technical assistance, education, and funding to the States. The division is currently funded at only $43 million, a debilitatingly small amount of funding compared to the financial resources required for health departments, hepatitis providers, and community partners to reverse course on the worsening HBV and HCV epidemics. The HHS Viral Hepatitis National Strategic Plan released in 2021 plots a national course to eliminate the public health threat of viral hepatitis, but achieving that goal will require significant new resources. We urge Congress to appropriate $150 million to the CDC's Division of Viral Hepatitis to reverse the skyrocketing increase in viral hepatitis and achieve the goal of ending the hepatitis epidemics.

INFECTIOUS DISEASE IMPACT OF THE OPIOID CRISIS

In combatting both the viral hepatitis and HIV epidemics, it is crucial to concurrently address the Nation's opioid crisis. Many of the new hepatitis and HIV outbreaks and infections are a result of injection drug use. We urge the subcommittee to appropriate $150 million for the CDC's Infectious Disease and the Opioid Epidemic efforts, which will increase surveillance, prevention and treatment for infectious diseases most associated with injection drug use. A comprehensive response to the opioid epidemic must include infectious disease prevention.

SYRINGE SERVICE PROGRAMS

Syringe service programs (SSPs) are a critical tool in the fight to end the drug use epidemic and eliminate viral hepatitis and HIV. These important public safety programs reduce the spread of infectious disease, prevent overdose deaths, and connect clients to infectious disease and substance use disorder treatment. Extensive research shows that these programs save money and that they do not increase drug use. But there are not enough SSPs to meet the growing need, and appropriations language which prohibits them from using Federal funding makes it difficult for many programs to meet their biggest expense—purchasing sterile syringes for safe consumption. We urge your subcommittee to increase funding for SSPs and to remove all restrictions on Federal funding for syringe service programs, including for the purchase of sterile syringes.

We understand that this year's appropriations bill will be written as many Members of Congress call for austerity. Prevention and treatment of HIV and viral hepatitis are short term investments that result in long-term healthcare savings. The lifetime medical costs of treating a person living with HIV are around $500,000. With over 34,000 acquiring HIV each year, the long-term costs of not ending the epidemic are over $17 billion each year. Reductions in funding for HIV and hepatitis prevention and treatment programs will not only harm the lives of communities most impacted these infectious diseases but could also result in long-term medical costs that far outweigh short-term cost savings.

Thank you for your consideration of this written testimony. If you have questions or would like to discuss these issues further, please do not hesitate to contact me, Rachel Klein at rklein@taimail.org, Nick Armstrong at narmstrong@taimail.org or Naomi Gaspard at ngaspard@taimail.org.

[This statement was submitted by Rachel Klein, Deputy Executive Director, The AIDS Institute.]

PREPARED STATEMENT OF ALL4ED, EDUCATION REFORM NOW, NATIONAL CENTER ON LEARNING DISABILITIES, SCHOOLHOUSE CONNECTION, THE EDUCATION TRUST, UNIDOSUS FOR THE DEPARTMENT OF EDUCATION

Dear Chairwoman Murray and Ranking Member Collins:

Thank you for your continued leadership in fighting for essential Federal resources in response to the persistent challenges students and schools, especially those most marginalized and vulnerable, are facing.

As you begin work on the Fiscal Year 2024 Appropriations process, we—the undersigned civil rights, education, and immigration organizations—write to support a continued emphasis on educational equity as reflected in the policies and funding levels the administration put forward in their FY 2024 budget. The budget proposal comes at a time when the Nation's educational system is in transition. While the most acute aspects of the COVID–19 pandemic have ebbed, the need to fix the longstanding systemic flaws within our school systems that result in racial, social, and economic inequalities remains, alongside the urgent need to make up for lost learning and development opportunities.

The programs and funding levels highlighted below will help address these and other challenges facing students, among them: food insecurity, lost instructional time during the 2019–20, 2020–21, and 2021–22 school years, reduced availability of student supports and education services, inequitable access to learning resources, intermittent access to high-speed home internet, and homelessness, alongside ongoing systemic racial inequities. To that end, as you develop the FY 2024 appropriations legislation, we strongly support the following funding levels for these essential programs:

Elementary and Secondary Education Act (ESEA) Programs:

—In addition to supporting the tripling funding for Title I, Part A, we encourage Congress to:

—Target Title I funds toward the highest poverty school districts. We recommend that any new funding be allocated through the Targeted Grant and Education Finance Incentive Grant (EFIG) formulas or another formula that is more targeted toward high poverty districts, and allocates at least as great a percentage of funds to school districts in the top two quintiles of poverty nationally as the Targeted and EFIG formulas.

—Maintain current flexibility for districts in Title I uses of funds and refrain from requiring specific uses of funds.

—Include a $100 million reservation to support States and districts in making their education spending more equitable, such as establishing voluntary State School Funding Equity Commissions to identify and address funding and educational equity gaps created by State funding formulas, gaps within school districts, and policies regarding resource use.

—At least a $1 billion increase for evidence-based school improvement activities required under section 1003 of ESEA. This could be accomplished through the required state set-aside of Title I, Part A funds (if the Title I allocation is significantly increased, as we recommend above) or through a separate infusion of extra funding, on top of the Title I appropriation, for schools that States identify as in need of support under ESEA. Additional funding for school improvement will help ensure there are sufficient resources to develop, implement, and sustain comprehensive, multi-year plans to address the increased needs of districts and schools serving students most impacted by the pandemic as States use their accountability systems to identify new schools, including those identified for Targeted Supported and Improvement (TSI) based on individual groups of students, for additional support. In particular, these funds can also be used to embed and sustain support services for students most affected by pandemic disruptions beyond the expiration of ESSER funding. We also encourage you to include language to help States improve reporting on the schools receiving 1003(a) funds and how the funds are used, as required by section 1003(i) of ESEA, so there is more transparent information on which students benefit from these resources and the evidence-based strategies schools are using.

—$3 billion for Title II, Part A of ESEA to support local efforts to diversify the teaching workforce, advance teacher leadership, and provide high-quality teacher professional development—including support for high-quality induction and mentorship, training in culturally responsive instruction, supports for English learners and students with disabilities, social and emotional development, restorative justice, and trauma-informed instructional practices.

—$400 million to support teacher leadership opportunities through programs designed to provide high-quality mentorship, induction, and coaching programs,

especially for those programs focused on supporting underrepresented individuals in the teaching workforce such as teachers of color and multilingual teachers.This could be accomplished through a program that focuses on teacher leadership and additional compensation for taking on leadership roles.

—$200 million to support Teacher and School Leader Incentive Grant. Specifically, we support requiring the Department of Education to prioritize funds for teacher leadership models and activities that provide experienced and effective teacher leadership opportunities that allow them to have a greater impact on their school community while remaining in the classroom (and be compensated for additional responsibilities). This could include, for example, distributive leadership models which allow teachers to lead alongside their principal to facilitate positive school wide change; teacher-led instructional improvement efforts focused on specific areas of academic content; opportunities to shape school wide policies and climate, and lead professional learning communities; participation in master teacher programs, teacher mentorship programs, and job-embedded content coaching; and implementation of advisory systems.

—$300 million to provide financial support for teachers pursuing in-demand credentials in shortage areas, such as special education and bilingual education, advanced certification such as National Board Certification, and incentives for teachers with in-demand and advanced credentials to remain in the classroom. Research has demonstrated the impactful role of teacher qualifications on both teaching quality and student achievement.

—$200 million for the Supporting Effective Educator Development (SEED) grant program which funds the implementation of research-based practices to support the preparation and professional learning of teachers, principals, and other school leaders

—$40 million for the School Leadership Recruitment and Support Program to increase student access to well-prepared and diverse school leaders.

—$2 billion for Title III of the Elementary and Secondary Education Act to ensure funding reflects the growing number of English learners and recent immigrant students, supports parent engagement programs and resources in their home language, supports effective dual language learning models, and provides support for more teachers to attain their English Language Development or Bilingual certification and professional development for teachers of ELs through the National Professional Development program within Title III.

—$5.3 billion for Title IV programs, including:

—$2 billion in Title IV, Part A funding for the breadth of academic, mental, physical, social, and emotional student supports and services, such as funding for school counselors, social workers, nurses, and nutrition programs, and for closing the digital divide. Additionally, we encourage Congress to exercise oversight to help ensure the funding provided by the Bipartisan Safer Communities Act is allocated towards student support programs and staff, and evidence-based practices, through possible incentives and supports to assist States in implementing those evidence-based practices in high-need schools.

—$1.8 billion in Title IV, Part B funding to support 21st Century Community Learning Centers, which offer robust afterschool and extended learning time programs.

—$500 million within Title IV, Part D for the Magnet School Assistance Program. Research shows magnet schools support school integration and have positive academic and social outcomes for students, yet the Magnet School Assistance Program has been underfunded.

—$1 billion for Title IV, Part F for Full-Service Community Schools, which encourage coordination of academic, social, and health services through partnerships among public elementary and secondary schools, LEAs, community-based organizations, nonprofit organizations, and other public or private entities.

—$120 million for the Fostering Diverse Schools program, to support racial and socioeconomic diversity in schools. This program would provide planning and implementation grants to help support voluntary, locally lead efforts to foster racially and socioeconomically diverse learning environments. In funding this program it is vital that Congress equip it to address racial and socioeconomic segregation. In the final FY 2022 and FY 2023 appropriations bills, Congress directed, in a bipartisan manner, the Department of Education to utilize ESEA Title IV–A's capacity building and technical assistance reservation to support States and districts in their efforts to foster diversity across and within school districts. The funding through this reservation will likely not be sufficient to address the high degrees of racial and socioeconomic segregation in our Nation's public schools and we support more robust investment in the Fostering Diverse Schools program.

Individuals with Disabilities Education Act (IDEA) Programs:

—$16.259 billion for the Individuals with Disabilities Education Act, Part B, which would provide a significant increase to programs and services authorized by IDEA and create a path for full funding.

—$300 million for IDEA, Part D personnel preparation program to support the development of our Nation's special education educators.

McKinney-Vento Act's Education for Homeless Children and Youth Program:

—$800 million for the McKinney-Vento Act's Education for Homeless Children and Youth (EHCY) program, a program that has a long history of bipartisan support, to increase the identification of students experiencing homelessness, reengage students, and address their academic, social, emotional learning, and basic needs. This is the same level of funding as provided in the American Rescue Plan (ARP) and would provide for continuity of ARP–HCY programming and services, particularly in LEAs that received direct funding to support students experiencing homelessness for the first time through ARP–HCY. Further, we recommend that final FY 2024 appropriations legislation should maintain the flexibility in the use of EHCY funds provided for in ARP–HCY, allowing for wrap-around services that meet the needs of the whole child and facilitate attendance, enrollment, and school success.

Higher Education Act (HEA) Programs:

—$1 billion for the Teacher Quality Partnership Grant Program to support yearlong, paid teacher and school leader residency programs and Grow Your Own (GYO) programs.

—$300 million in the Augustus Hawkins Centers of Excellence Program to support comprehensive teacher preparation at programs at Historically Black Colleges and Universities (HBCUs), Tribal Colleges and Universities (TCUs), and minority-serving institutions of higher education (MSIs).

—Double TEACH Grants from $4,000 to $8,000 so the program more effectively underwrites the cost of comprehensive preparation and lowers inequitable affordability barriers faced by students of color and students experiencing low incomes. To make the program more effective, the loan conversion penalty should be removed, or reformed, and early educators should be made eligible for benefits.

—$165 million for Postsecondary Student Success Grants, which will support the implementation and expansion of evidence-based practices that improve postsecondary retention and completion.

—$60 million for new investments in a Holistic Student Supports program and a new Postsecondary Advancement and Success Technical Assistance Center to facilitate student access to State and local benefits, and provide resources to institutions implementing student support programs.

Data, Innovation, and Connectivity Programs:

—At least $100 million for the Statewide Longitudinal Data Systems (SLDS) program and at least $40 million for the Workforce Data Quality Initiative (WDQI), so state and district leaders can address current and evolving information needs. States need Federal funds to modernize their data systems so that they are oriented toward access, support responsive policymaking, and address the complex challenges emerging from the COVID–19 pandemic. Modernizing state data systems to meet these challenges also requires strong data governance, privacy, and security; joint guidance for SLDS and WDQI grantees will help them develop effective, integrated data systems and the policies and procedures to safeguard that data. Congress should ensure that Federal agencies also offer the technical assistance States need to ensure robust privacy and transparency safeguards are in place.

—$469 million for State Assessment Grants to provide States with the resources necessary to adapt, improve, and conduct critical student assessment activities, which are one necessary component of understanding how the pandemic has impacted student academic learning.

—$7 billion for the Emergency Connectivity Fund. The homework gap is the digital divide that millions of children experienced pre-pandemic and will continue to impede learning without Federal support. The Emergency Connectivity Fund (ECF) created under the ARP has helped schools and libraries provide connections and devices for 15 million children to date. However, demand for the program has outpaced supply by over $2 billion and the funding will be depleted by the end of the current school year. Millions of children could lose the internet access that they need to succeed unless ECF is replenished.

Career and Technical Education Programs:

—$200 million for Career-Connected High Schools to support the expansion of, and equitable access to, advanced coursework and pathways that lead to post-secondary credentials of value and ensure greater alignment between States' policies and systems for high school and higher education.

Advancements to Funding Equity and Targeting Needs:

—Congress should close the comparability loophole within Title I to ensure that low-income schools do not receive less funding than their more affluent counterparts and that such calculations are based on actual expenditures that include teacher salaries.

—Congress should ensure that Federal funds supplement and do not supplant State and local funds, and there is a meaningful way to ensure compliance.

—Congress should address funding equity through oversight ensuring States are in compliance with the FY 2022, FY 2023, and FY 2024 requirements for (1) State Maintenance of Effort to ensure States do not disinvest in education; (2) State Maintenance of Equity to protect the highest-need districts from disproportionate cuts in state funding; and (3) District Maintenance of Equity to protect our most vulnerable schools from disproportionate cuts (including funding and staff).

—Congress should include language to initiate an annual report of K–12 education funding with state-by-state information on the adequacy, effort, and equity of K–12 education funding formulas. Such a report should also identify any areas of progress and include recommendations.

—Congress should ensure local community members, educators, families, and students are involved in determining how funds are spent, programs are implemented, and a part of evaluation and accountability for those expenditures, including by undertaking robust monitoring and enforcement of community and stakeholder engagement provisions in existing laws such as ESSA and the ARP.

Resources for critical Department of Education operations:

—Congress should ensure the Department of Education has adequate dedicated funding for the agency to monitor and enforce the critical legal protections for students accessing their education, including under McKinney-Vento's Education for Homeless Children and Youth Program (EHCY) (particularly at the State and local liaison levels), Title I and Title III of ESEA, IDEA, and Section 504 of the Rehabilitation Act; and to properly exercise the mission of the Office for Civil Rights. Further, we urge the Congress to ensure that the Department of Education utilizes funding to improve all existing data collection activities—which are key levers to monitor the implementation of critical legal protections for students—so data is collected effectively, reported timely, and available in a public and accessible manner.

We support the funding levels highlighted above and believe they represent a continued commitment to students, educators, and families as we continue to combat the lasting effects of COVID.

Sincerely,

All4Ed
Teach Plus
Education Reform Now
The Education Trust
National Center on Learning Disabilities
UnidosUS
SchoolHouse Connection

PREPARED STATEMENT OF ALLEN INSTITUTE

The Allen Institute appreciates the strong, sustained investments in biomedical research that Congress has made at the National Institutes of Health (NIH) in recent years. To ensure that the United States remains a world leader in life sciences and health innovation, it is vital that the subcommittee continues to prioritize support for NIH-funded research and training programs in fiscal year (FY) 2024. For FY 2024, the Allen Institute urges the subcommittee to support a program level of at least $50.9 billion in base funding for the NIH. We also urge the subcommittee to ensure that any additional funding provided for the newly created Advanced Research Projects Agency for Health (ARPA–H) supplements and does not supplant foundational advancements in NIH.

The Allen Institute, located in Seattle, Washington, is an independent nonprofit bioscience research institute aimed at unlocking the mysteries of the life sciences in both health and disease by driving foundational research in large scale projects. Our interdisciplinary teams of experts work together to solve the biggest mysteries in bioscience. We conduct expansive research that examines the cellular makeup of the brain, how a healthy immune system fights disease, how our cells are organized, and more. Our scientists collaborate across teams to research fundamental questions about how life and disease work, continuing to push the frontiers of bioscience forward. Such work fuels breakthroughs in human biology and the discovery of new treatments and cures. And our impact is enhanced exponentially by our practice of open science, enabling our investment to propel the field as a whole forward.

For nearly two decades, our tools and resources have served as the foundation for transformative research and discovery. Labs around the world use our open resources to power breakthroughs on Alzheimer's disease, heart disease, cancer, addiction, and more. In addition, the Allen Institute has dedicated itself to supporting STEM education initiatives spanning from the K–12 level and beyond to train the next generation of innovators that will further our understanding of the human body and contribute to the development of life-saving treatments and cures for future generations.

The Allen Institute is about open science; we share our data, protocols, and tools, and we have partnered with the NIH to solve big problems. Below are some examples of how NIH funding drives the Allen Institute's innovative bioscience research and supports its efforts to make scientific data more available and bolster the STEM workforce.

Supporting Transformative Research of Human Health and Disease. The Allen Institute receives a majority of its Federal funding for research from institutes and centers across the NIH, including the National Institute of Mental Health (NIMH), National Institute of Neurological Disorders and Stroke (NINDS), and National Institute on Aging (NIA), among others. For example, in FY 2023, we were awarded five grants totaling $173 million from NIH's Brain Research Through Advancing Innovative Neurotechnologies (BRAIN) Initiative as part of The BRAIN Initiative Cell Atlas Network (BICAN). This funding supports our research that focuses on understanding the components and processes of the brain, the functions of cells, and the intricacies of the human immune system. Through this work, our researchers are able to understand more about the functionality of the body and how it is interconnected at a basic cellular level. This understanding assists in the National effort to develop treatments and cures for diseases such as cancer, Alzheimer's, and COVID–19. Sustained and robust funding for NIH ensures that our world-class researchers will be able to continue and expand their work that supports the development of treatments and cures for diseases that impact millions of Americans every year.

Fostering an Open Science Community. Robust funding for the NIH assists the Allen Institute's efforts to foster a scientific community that prioritizes open access to research data for everyone across the world. Our commitment to open science is supported by the belief that shared understanding feeds new medical discoveries and nurtures breakthroughs in basic knowledge and the development of treatments and cures for a wide range of diseases. When we openly share our data and resources, the Allen Institute allows the global scientific community to make faster progress and new insights into human health. Over 1,500 scientists each day and 550,000 each year access our open resources, helping to spread understanding and assist in global health efforts that can impact the overall health of our Nation and reduce worldwide health and understanding inequities. Our original Allen Mouse Brain Atlas, a comprehensive view of gene expression across the mouse brain, has been cited over 5,000 times in the scientific literature, demonstrating the massive scale of impact that open science can have beyond the original investment. The large suit of open-access tools and databases we created, such as genetically engineered animal models and cell lines, Allen Mouse Brain Common Coordinate Framework (CCF), and mouse and human brain cell type taxonomies, have been widely adopted as high-quality standards in the broad scientific research field.

Bolstering STEM Education Efforts and the Future STEM Workforce. Robust funding for the NIH not only bolsters important research programs—it secures the future of science. Increases in NIH funding enable the Allen Institute to continue efforts leveraging our open science efforts to support the education and training of the future STEM workforce.

Allen Institute tools support teachers to guide students through fully online experiments using our cutting-edge resources, including data from real human brains and cells, without the need for specialized laboratory facilities. These educational resources highlight research-grade data from current cutting-edge projects, capturing

exciting new work and the great unknowns of science beyond the boundaries of a textbook. Students only need an internet connection and computer to use our scientific resources—making our world-class programming easily accessible to most schools. To support educators to use our open resources as teaching tools, we offer a curriculum library for educators teaching at the high school and college level, including materials developed in partnership with teachers and professors to ensure our tools and resources are relevant and useful to the scientists of the future. For example, in our newest major curriculum unit, students review the model neuron they might have encountered in a textbook, then explore online research-grade data from thousands of real neurons—the same data being used by neuroscientists to develop a comprehensive typology of neuron subtypes. Through our Allen Teacher Academy program, launched in 2023, we provide professional development opportunities for educators to visit the Institute, tour labs, meet scientists, and learn about open scientific tools and corresponding educational resources. All programs—field trips, classroom visits to local schools, curriculum resources, educator programs, and more—are offered openly and freely to reduce barriers to access, just like our open science is. These efforts will ensure that STEM innovation continues as a maintained priority for the future workforce and education and training resources will be available to all, reducing educational inequities.

Consistent with our mission and values, the Allen Institute will continue working to conduct innovative research that serves as the foundation for groundbreaking advances in human health. In addition, we will continue to prioritize open science that benefits researchers across the world and builds a well-prepared and stronger STEM workforce ready to take on the challenges of the future for generations to come.

The Allen Institute thanks the Labor-HHS subcommittee for your continued leadership and dedication to ensuring robust, sustained funding for the NIH. We urge you to provide at least $50.9 billion in FY 2024 for the NIH base budget to ensure that innovation, human health, and the STEM workforce remain national priorities.

For more information about our work, please visit https://alleninstitute.org/about/ or contact Eve Granatosky at eve@lewis-burke.com.

[This statement was submitted by Rui Costa, D.V.M., Ph.D., President and Chief Executive Officer, Allen Institute.]

PREPARED STATEMENT OF THE AMERICAN ACADEMY OF ALLERGY, ASTHMA & IMMUNOLOGY

Chair Baldwin, Ranking Member Capito, and members of the subcommittee, thank you for the opportunity to submit outside witness testimony on the U.S. Department of Health and Human Services (HHS) fiscal year 2024 (FY24) appropriations. The American Academy of Allergy, Asthma & Immunology (AAAAI) respectfully requests the subcommittee to include $18.2 million (an increase of $6.1 million) in funding for the Consortium on Food Allergy Research (CoFAR) which is within the National Institute of Allergy and Infectious Diseases (NIAID) at the National Institutes of Health (NIH). In addition, we request report language reflecting the importance of NIH engaging in trans-NIH research on food allergies. AAAAI also urges the subcommittee to include report language to encourage the Centers for Disease Control and Prevention (CDC) and/or other appropriate Federal agencies to support education and awareness related to the need for penicillin allergy evaluation in order to de-label non-allergic patients. Furthermore, AAAAI supports funding of $100 million for the National Healthcare Safety Network and $400 million for the Antibiotic Resistance Solutions Initiative, which enable the CDC to target prevention of healthcare acquired and antimicrobial resistant infections and improve antibiotic prescribing.

Established in 1943, AAAAI is a professional organization with more than 7,000 members in the United States, Canada, and 72 other countries. This membership includes board certified allergist/immunologists, other medical specialists, allied health practitioners and related healthcare professionals—all with a special interest in the research and treatment of patients with allergic and immunological diseases.

FOOD ALLERGIES

Food allergies affect 32 million Americans, including 6 million children. Each year, more than 200,000 Americans require emergency medical care for allergic reactions to food—equivalent to one trip to the emergency room every three minutes.

The Consortium on Food Allergy Research—CoFAR—was established by the NIH within the NIAID in 2005. Since then, CoFAR has discovered genes associated with

an increased risk for peanut allergy and has also identified the most promising potential immunotherapy treatments for egg and peanut allergies, among many other accomplishments. Breakthroughs like these, scaled across other major food allergies, could significantly improve the quality of life for tens of millions of Americans. AAAAI wishes to express its appreciation to the subcommittee and Congress for the passage of the fiscal year (FY) 2023 spending bill, which provided an additional $3 million for CoFAR, increasing its budget to $12.1 million. While CoFAR's annual budget remains a relatively small portion of NIH's budget, it has been able to achieve major strides in the study of food allergy prevention and treatment.

AAAAI enthusiastically supports a $6.1 million increase for CoFAR, which would bring its yearly budget up to $18.2 million. It is crucial that we continue investing in CoFAR to sustain the progress made by breakthrough research that is leading to effective solutions for the 8–10% of the U.S. population living with food allergies. Further, food allergies disproportionately impact low-income communities of color. Higher rates of food allergy, higher frequency of severe allergic reactions, higher rates of food allergy-related treatment in the emergency department, and higher rates of fatal food-induced anaphylaxis are reported in Black Americans. Similarly, data shows that food allergies are more prevalent among Hispanic Americans when compared to White Americans.

AAAAI requests the following NIAID report language that acknowledges the groundbreaking work of CoFAR and encourages robust investment to expand its research breadth and network.

> *Food Allergies*.—The Committee recognizes the serious issue of food allergies which affect approximately eight percent of children and 10 percent of adults in the U.S. The Committee commends the ongoing work of NIAID in supporting a total of 17 clinical sites for this critical research, including seven sites as part of the Consortium of Food Allergy Research (CoFAR). The Committee includes $18,200,000, an increase of $6,100,000, for CoFAR to expand its clinical research network to add new centers of excellence in food allergy clinical care and to select such centers from those with a proven expertise in food allergy research.

In addition to the AAAAI, the CoFAR funding request and report language are supported by the Allergy & Asthma Network, American College of Allergy, Asthma and Immunology, Food Allergy Research and Education (FARE), and the Asthma and Allergy Foundation of America.

ANTIMICROBIAL RESISTANCE (AMR) AND PENICILLIN ALLERGY EVALUATION

The growing threat of antimicrobial resistance, which combined with the dwindling pipeline of novel antibiotic research, requires policies that prevent inappropriate use of antibiotics. One of the primary ways to combat this threat begins with penicillin—the most commonly reported drug allergy. According to the CDC, approximately 10% of the U.S. population self-report being allergic to penicillin, yet 9 out of 10 patients reporting a penicillin allergy are not truly allergic when formally evaluated, such that fewer than 1% of the population is truly allergic to penicillin.[1] In its 2018 Update of Antibiotic Use in the United States: Progress and Opportunities, the CDC cited the importance of correctly identifying if patients are penicillin-allergic in decreasing the unnecessary use of broad-spectrum antibiotics.[2] The AAAAI strongly supports more widespread and routine use of penicillin allergy evaluation for patients with a self-reported history of allergy to penicillin. Evaluation can accurately identify patients who, despite reporting a history of penicillin allergy, can safely receive penicillin. To this end, the AAAAI urges the subcommittee to include language that encourages the CDC and/or other appropriate Federal agencies to undertake physician and patient directed education to heighten awareness of this important issue to increase penicillin allergy evaluation in order to de-label non-allergic patients.

To support CDC's work to target prevention of healthcare acquired and antimicrobial resistant infections and improve antibiotic prescribing, the AAAAI supports funding of $100 million for the National Healthcare Safety Network. We also support funding of $400 million for the Antibiotic Resistance Solutions Initiative, which would benefit from significant new resources to achieve the goals outlined in the 2020–2025 National Action Plan for Combating Antibiotic-Resistant Bacteria, including strengthening antibiotic stewardship to promote best practices for prescribing antibiotics such as penicillin.

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[1] https://www.cdc.gov/antibiotic-use/community/pdfs/penicillin-factsheet.pdf.

[2] https://www.cdc.gov/antibiotic-use/stewardship-report/pdf/stewardship-report-2018-508.pdf.

Thank you for your consideration of these requests.

PREPARED STATEMENT OF THE AMERICAN ACADEMY OF HOSPICE AND PALLIATIVE MEDICINE

Chair Baldwin, Ranking Member Capito, and members of the subcommittee, the American Academy of Hospice and Palliative Medicine (AAHPM or Academy) is grateful for the opportunity to provide testimony for the record and stands ready to work with the subcommittee to advance sound policy that improves care and quality of life for millions of Americans facing serious illness, along with their families and caregivers. We greatly appreciate your significant leadership in efforts to strengthen the palliative care and hospice workforce and advocate for the National Institutes of Health (NIH) to expand and intensify national research programs in palliative care. We thank you for including language in the explanatory statement to the Consolidated Appropriations Act, 2023, urging the NIH to ensure that palliative care is integrated into all areas of research across NIH and requesting an update on plans for this effort in the fiscal year (FY) 2024 Congressional Justification. In FY 2024, AAHPM requests $12.5 million for the National Institute on Aging to implement a trans-Institute, multi-disease strategy to focus, expand, and intensify national research programs in palliative care. This level of funding would allow for the establishment of a comprehensive multi-Institute and multi-Center initiative aimed at a wide variety of palliative care research, training, dissemination, and implementation of projects to intensify the strategic coordination of palliative care research efforts.

AAHPM is the professional organization for physicians specializing in Hospice and Palliative Medicine. Our 5,600 members also include nurses, social workers, spiritual care providers, and other health professionals deeply committed to improving quality of life for the expanding and diverse population of patients facing serious illness, as well as their families and caregivers. Together, we strive to advance the field and ensure that patients across all communities and geographies have timely access to high-quality, equitable palliative and hospice care. For more than 30 years, AAHPM has been dedicated to advancing the discipline of Hospice and Palliative Medicine through professional education and training, development of a specialist workforce, support for clinical practice standards, research, and public policy.

BACKGROUND

The U.S. Census Bureau projects that the population aged 65 and over will approximate 83.7 million by 2050, almost double that in 2012. As the population ages, the number of people living with serious, complex, and chronic illness will continue to grow. (Serious illness is a health condition that carries a high risk of mortality and either negatively impacts a person's daily functioning or quality of life or excessively strains their caregivers.[1]) Many of the problems of our healthcare system—high costs, overutilization, lack of coordination, preventable transitions between healthcare institutions, and poor quality—become particularly evident during extended chronic and serious illness. We believe palliative care offers the solution.

Palliative care is an interdisciplinary model of care aimed at preventing and treating the debilitating effects of serious and chronic illness—such as cancer, cardiac disease, respiratory disease, kidney failure, Alzheimer's, ALS, and MS—and involves the relief of pain and other symptoms that cause discomfort, such as shortness of breath and unrelenting nausea. Palliative care is patient—and family-centered—it focuses on matching treatment to achievable patient goals and supporting patients and their families/caregivers during and after treatment to maximize quality of life. In practice, this involves detailed and skilled communication with patients and families to elicit goals and preferences; expert assessment and management of physical, psychological, and other sources of suffering; and coordination of care across the multiple settings (e.g., hospital, post-acute care, ambulatory clinics, home) that patients can often traverse throughout the course of a serious illness. Palliative care can be provided from the time of diagnosis and offered alongside life-prolonging and curative therapies for individuals living with serious, complex, and eventually terminal illness. Hospice care is palliative care tailored for individuals near the end of life.

AAHPM believes that palliative care providers and organizations, including hospices, are integral to meeting the "triple aim" of better care for individuals, im-

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[1] Kelley AS, Bollens-Lund E. Identifying the Population with Serious Illness: The "Denominator" Challenge. J Palliat Med. 2018 Mar;21(S2):S7–S16. doi: 10.1089/jpm.2017.0548. Epub 2017 Nov 10. PMID: 29125784; PMCID: PMC5756466.

proved health of populations, and lower growth in health care expenditures. Indeed, the National Priorities Partnership has highlighted palliative and end-of-life care as one of six national health priorities that have the potential to create lasting change across the U.S. healthcare system.

An expanding body of medical research has documented the benefits of high-quality palliative and hospice care for patients and families, for hospitals and payers, and for the healthcare system as a whole.[2] Palliative care is associated with enhanced quality of life for patients, higher rates of patient and family satisfaction with medical care, reduced hospital expenditures and lengths of stay, and other positive outcomes—including longer patient survival time. Furthermore, palliative care achieves these outcomes at a lower cost than usual care, by helping patients to better understand and address their needs, choose the most effective interventions, and avoid unnecessary/unwanted hospitalizations and interventions. Hospice care also has been associated with lower cost of care, better outcomes (such as relief of pain), and even longer life, despite its focus on comfort rather than treatment aimed at cure.

Still, too many patients with serious illness experience tremendous physical and psychosocial suffering and, unlike areas of medicine focused on curing or preventing disease, the evidence base for relieving suffering and improving quality of life for seriously ill patients and their caregivers is inadequate.[3,4] To ensure that the millions of Americans with serious illness and their families/caregivers receive the high-quality care that they need and deserve, more research is needed to better understand and address pain and other distressing symptoms related to serious illness, and to improve serious illness care delivery models, communication science, and caregiving science. We also know there are significant disparities in palliative and end-of-life care. New research holds the potential to reduce these disparities in the care of people living with serious illness and their families by integrating historically excluded patients and examining the role of social determinants of health—which for palliative care include loneliness, food access, poverty and financial toxicity, and insufficient or unsafe housing—in care delivery, quality, and outcomes.[5]

FY 2024 APPROPRIATIONS REQUEST

Research related to palliative care and serious illness crosses nearly every Institute, Center, and Office (ICO) at NIH, but also poses challenges because it does not fit neatly within a single ICO. The Academy appreciates that Congress included report language in the joint explanatory statement of the FY 2023 funding bill and previously encouraged palliative care research in the FY 2011 and FY 2019 reports. We are optimistic that the recent language will help improve coordination and expand activities related to palliative care research across NIH. Already, NIH has responded to the appropriations language by including a "summary of ongoing activities" in the FY 2024 Congressional Justification (CJ). The CJ highlights multiple ways that NIH is accelerating research related to palliative care and serious illness, such as by convening a workshop with healthcare providers, researchers, and certain policymakers in December 2022 to identify research opportunities related to care for people with advanced heart failure.

Most importantly, the CJ also describes how the National Institute on Aging (NIA) is "leading efforts to convene subject matter experts" from nearly 10 NIH Institutes to "expand and intensify strategic coordination of palliative care research efforts as well as identify future research topics and questions that pertain to palliative care." AAHPM is encouraged by the inclusion of this language and hopes the subcommittee will support NIH's efforts in this space with the following language for FY 2024:

Palliative Care, Trans-Institute Strategy.—Palliative care is specialized medical care for people living with a serious illness and is focused on treating the discomfort, symptoms, and stress of such illness. Palliative care has the potential to improve patient care, patient-clinician communication, and patient-centered outcomes

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[2] "The Evidence for High-Quality Palliative Care." American Academy of Hospice and Palliative Medicine. Accessed February 15, 2023. https://aahpm.org/uploads/advocacy/The_Evidence_for_High-Quality_Palliative_Care.pdf.

[3] National Academies of Science Engineering and Medicine. Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life. The National Academies Press; 2015:1–612.

[4] Brown E, Morrison RS, Gelfman LP. An Update: NIH Research Funding for Palliative Medicine,2011–2015. J Palliat Med. Feb 2018;21(2):182–187.doi:10.1089/jpm.2017.0287.

[5] "Palliative Care In The Face Of Racism: A Call To Transform Clinical Practice, Research, Policy, And Leadership", Health Affairs Forefront, February 9, 2022.doi: 10.1377/forefront.20220207.574426.

while decreasing unwanted and/or burdensome treatments and enhancing quality of life for people with serious illness, their loved ones, and their care partners. The Committee provides $12,500,000 for NIA to implement a trans-Institute, multi-disease strategy to focus, expand, and intensify national research programs in palliative care. Funding would establish a comprehensive multi-Institute and multi-Center initiative aimed at a wide variety of palliative care research, training, dissemination, and implementation of projects to intensify the strategic coordination of palliative care research efforts. Funding is provided to establish an extramural-based palliative care consortium with no less than three sites to provide technical assistance, pilot and exploratory grant funding, research dissemination, data repositories, data analytics, and career development support for interdisciplinary palliative care. Of this amount, at least $3,000,000 is provided for several multi-year, early-career development grants modeled after NIA's GEMSSTAR program. Appropriations provided in fiscal year 2024 for training is expected to cover 2 years of funding for career development awards. The Committee requests a briefing within 120 days after enactment of this act on how this strategy will be established and implemented, including timelines on when funding opportunities will be issued and when funding will be awarded.

In addition to AAHPM, the requested FY 2024 language is supported by the Patient Quality of Life Coalition which includes more than 40 patient, caregiver, health professional, and health system organizations dedicated to improving quality of care and quality of life for all patients, from pediatrics to geriatrics.

The Academy again thanks the subcommittee for previous report language and requests funding in FY 2024 to support NIH's continued efforts to realize the goal of enhancing palliative care research to improve care and quality of life for the expanding and diverse population of patients with serious illness, as well as their families and caregivers.

PREPARED STATEMENT OF THE AMERICAN ACADEMY OF PEDIATRICS

The American Academy of Pediatrics (AAP), a non-profit professional organization of 67,000 primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists dedicated to the health, safety, and well-being of infants, children, adolescents, and young adults, appreciates the opportunity to submit this statement for the record in support of strong Federal investments in children's health in Fiscal Year (FY) 2024 and beyond. AAP urges all Members of Congress to put children first when considering short and long-term Federal spending decisions, and supports funding levels for the following programs: $30 million for Pediatric Subspecialty Loan Repayment (HRSA), $540 million for Child Abuse Prevention and Treatment Act (CAPTA) programs, $60 million for Firearm Injury and Mortality Prevention Research (CDC/NIH), $13 million for Pediatric Mental Health Care Access Grants (HRSA), $28.134 million for Emergency Medical Services for Children (HRSA), $223 million for the National Center for Birth Defects and Developmental Disabilities (CDC), $356 million for Global Immunizations (CDC), $12 million for implementation of Scarlett's Sunshine Act (CDC/HRSA), and $20 million for the administrative component of the National Vaccine Injury Compensation Program (HRSA).

Pediatric Subspecialty Loan Repayment Program (HRSA):

FY 24 Request: $30 million; FY 23 Level: $10 million.—The AAP appreciates a second year of funding of $1o million in FY23 for the Pediatric Subspecialty Loan Repayment Program, a Title VII health professions program designed to improve access to care for children with special health care needs by offering loan repayment to pediatric subspecialists and child mental health providers who agree to serve in an underserved area. To expand the number of beneficiaries of this program, the Academy respectfully requests $30 million in FY24. The United States' current supply of pediatric subspecialists is inadequate to meet children's health needs. Many children must wait more than 3 months for an appointment with a pediatric subspecialist, and approximately 1 in 3 children must travel 40 miles or more to receive care from a pediatrician certified in certain subspecialties such as developmental behavioral pediatrics. Spotlighting the needs of children with autism spectrum disorder (ASD), as an example, there are approximately 1.5 million children with ASD but there are only about 700 practicing board-certified developmental-behavioral pediatricians. The national wait time for a pediatric developmental evaluation is 5.4 months. In terms of equity, ASD prevalence among Hispanic children is about 16% lower than among white and black children, which suggests that more Hispanic children with autism are not being identified. In addition, black children with ASD

are significantly less likely than white children to have a first evaluation by the age of three.

Child Abuse Prevention and Treatment Act (ACF)

FY 24: $540 million ($270 million each for Title I and Title II); FY 23 level: $175.6 million—$105 million for Title I, including $60 million for Plans of Safe Care, and $70.6 million for Title II.—The Child Abuse Prevention and Treatment Act (CAPTA) is the only Federal law dedicated to primary prevention of child abuse. This critical law is underfunded, and States need additional CAPTA resources to meet the needs of their communities. Title I of CAPTA specifically provides key funding to States to implement the law's many requirements. Title I promotes an effective child protective services system, like the Plans of Safe Care, which is vital for identifying and stopping child abuse and neglect. Title II funds public-private-partnerships that support critical primary prevention services families need to thrive, and that reduce the incidence of child maltreatment. The AAP encourages Congress to adequately fund CAPTA programming, with $270 million for both Title I and Title II in FY 24, as lower rates of maltreatment result in lower expenditures by other Federal programs, improved health and wellbeing, better educational achievement, and higher occupational attainment.

Firearm Injury and Mortality Prevention Research (CDC/NIH):

FY 24 Request: $60 million total; FY 23 Level: $25 million total.—The AAP is tremendously appreciative of and applauds Congress for continuing to provide $25 million total, split evenly between CDC and NIH, for firearm injury and mortality prevention research in FY 23. Gun violence remains a public health problem, but the dearth of research on how best to prevent firearm-related morbidity and mortality makes it difficult to address it. Federally funded public health research has a proven track record of reducing public health-related deaths, whether from motor vehicle crashes or smoking. This same approach should be applied to increasing gun safety and reducing firearm-related injuries and deaths, including suicides, and continuing and expanding CDC and NIH research will be critical to that effort. As such, for FY24, the Academy urges Congress to allocate $60 million for firearm injury and mortality prevention research, with $35 million dedicated to CDC and $25 million to NIH.

Pediatric Mental Health Care Access Grants (HRSA):

FY 24 Request: $13 million; FY 23 Level: $13 million.—The AAP appreciates the support Congress has shown for Pediatric Mental Health Care Access Grants, with $13 million in funding for the program in FY23, as well as robust funding in the American Rescue Plan in recognition of the impact of COVID–19 on child and adolescent mental health. The 48 States, Tribal organizations, and territories who are receiving grants through this program are providing tele-consultation, training, technical assistance, and care coordination for pediatric primary care providers to diagnose, treat and refer children with behavioral health conditions. Research shows pervasive shortages of child and adolescent mental/behavioral health specialists throughout the United States. Integrating mental health and primary care has been shown to substantially expand access to mental health care, improve health and functional outcomes, increase satisfaction with care, and achieve costs savings. In fact, a recent RAND study found that 12.3% of children in States with programs such as the ones funded under this HRSA program had received behavioral health services while only 9.5% of children in States without such programs received these services. In FY24, the AAP urges Congress to provide $13 million in funding for Pediatric Mental Health Care Access Grants so that this proven program can be extended to every State, Tribal organization, and territory.

Emergency Medical Services for Children (HRSA):

FY 24 Request: $28.134 million; FY 23 Level: $24.434 million.—The AAP urges the committee to increase funding for the Emergency Medical Services for Children (EMSC) Program to $28.134 million in FY 24. EMSC is the only Federal program that focuses specifically on improving the pediatric components of the emergency medical services (EMS) system. EMSC aims to ensure state of the art emergency medical care is available for the ill and injured child or adolescent, pediatric services are well integrated into an EMS system backed by optimal resources, and that the entire spectrum of emergency services is provided to all children and adolescents no matter where they live. An additional $3.7 million in funding in FY24 will allow the program to provide increased funding to States to address gaps in children's access to high quality emergency and trauma care as well to support States building mental health capacity for children in emergency departments.

National Center for Birth Defects and Developmental Disabilities (CDC):

FY 24 Request: $223 million; FY 23 Level: $205 million.—The AAP requests $223 million for FY 24 for the National Center for Birth Defects and Developmental Disabilities (NCBDDD). According to the CDC, birth defects affect 1 in 33 babies and are a leading cause of infant death in the United States. NCBDDD conducts important research on fetal alcohol syndrome, infant health, autism, attention deficit and hyperactivity disorders, congenital heart defects, and other conditions like Tourette Syndrome, Fragile X, Spina Bifida and Hemophilia. NCBDDD supports extramural research in every State and has played a crucial role in the country's response to the Zika virus, as well as COVID–19. Increased FY24 funding would be used to build upon and expand work within the Center's priorities such as uniform data collection for neonatal abstinence syndrome; supporting the act Early: Children's Mental Health program, data collection around sickle cell disease, and expansion of the Surveillance for Emerging Threats to Mothers and Babies (SET–NET) program to allow more States to participate and gather needed information to protect pregnant individuals and infants from emerging public health threats.

Global Immunization—Polio and Measles/Other (CDC):

FY 24 Request: $356 million ($276 million for Polio and $80 million for Measles/Other); FY 23 Level: $230 million ($178 million for Polio and $50 million for Measles/Other).—The CDC's global immunization program is one of the most cost-effective and successful public health solutions available and U.S. investments have driven remarkable results. The CDC was a founding member of the Measles and Rubella Initiative, which has vaccinated over 2 billion children and prevented 23.2 million deaths from measles since 2001. Since 1988, the CDC's global polio immunization work has reduced the number of polio cases globally by 99.9 percent, saving more than 10 million children from paralysis and bringing the disease close to eradication. Thanks to sustained funding by the U.S. government through the CDC and USAID and the coordinated efforts of the Global Polio Eradication Initiative (GPEI), the opportunity for a polio-free world is within reach. Unfortunately, the gains from global immunization are in jeopardy. The recent pandemic caused severe disruptions to the delivery of routine immunizations. Recent data from UNICEF shows the largest sustained decline in childhood vaccinations in three decades. Twenty-five million children missed out on lifesaving vaccines—2 million more children than in 2020 and 6 million more children than in 2019. Of the 25 million children who missed out on vaccinations, 18 million did not receive a single vaccination. These "zero dose" children make up a disproportionate share of childhood deaths. To recover from pandemic-related disruptions at least $276 million for polio and $80 million for measles is needed to procure vaccines, support immunization systems, increase surveillance, and improve lab infrastructure—all of which are critical to improve outbreak response.

Activities Authorized under Scarlett's Sunshine Act (CDC/HRSA):

FY 24 Request: $12 million ($8.5 million at CDC for the Safe Motherhood and Infant Health account and $3.5 million at MCHB within the Special Projects of Regional and National Significance account); FY 23: Level: $5 million at HRSA and $3.5 million at CDC.—In passing the Scarlett's Sunshine Act in late 2020, Congress recognized the need for Federal investments in research and prevention of sudden unexpected infant death (SUID) and sudden unexplained death in childhood (SUDC). The law authorized $12 million for HHS to award grants and improve data and monitoring. Full funding for this initiative will strengthen efforts to better understand SUID and SUDC, facilitate data collection and analysis to improve prevention efforts, and support children and families. Requested CDC funding would improve communities' responses to infant and child death cases, inform prevention and clinical care, and help standardize data collection and reporting, as well as procedures and protocols for death scene investigations and autopsies. The grants can also fund safe sleep outreach efforts, which can reduce the risk of SUID. The funds at MCHB would support the expansion and use of the Case Reporting System to provide data summaries and dashboards on all SUIDs and making datasets available to researchers. These MCHB funds can also support bereavement services for affected families, which MCHB cannot currently provide.

National Vaccine Injury Compensation Program Administration (HRSA):

FY 24 Request: $20 million; FY23 Level: $15 million.—The Academy supports increased funding for the administrative component of the National Vaccine Injury Compensation Program (NVICP), which was established in 1988 to ensure an adequate supply of vaccines, stabilize vaccine costs, and establish and maintain an accessible and efficient forum for individuals found to be injured by certain vaccines.

NVICP is an alternative to the traditional tort system for resolving vaccine injury claims and provides compensation to individuals found to be injured by certain vaccines. NVICP claims have increased more than fivefold from 402 claims filed in FY 2012 to 2,057 claims filed in FY 2021 while the administrative funding barely doubled from $6.5 million to $11.2 million during the same period. The steep increase in claims filed is due in large part to the flu vaccine being administered to adults. In fact, most of all petitions filed are now adult claims for alleged injuries from the flu vaccine. Though the number of petitions has risen, the number of staff to administer the claims has not risen at the same level. By hiring more staff and thereby expediting the processing of claims filed in the NVICP, the children and families who have been injured by a vaccine will be able to receive their due compensation in a timely manner. It will also help prepare HRSA to administer the NVICP program if the COVID–19 vaccine is eventually transferred from the Countermeasures Injury Compensation Program and included in NVICP program.

There are many ways Congress can help meet children's needs and protect their health and well-being. Adequate funding for children's health programs is one of them. The American Academy of Pediatrics looks forward to working with Members of Congress to prioritize the health of our Nation's children in FY 2024 and beyond. If we may be of further assistance, please contact the AAP Department of Federal Affairs at 202–347–8600 or pjohnson@aap.org. Thank you for your consideration.

[This statement was submitted by Mark Del Monte, JD, CEO/EVP, American Academy of Pediatrics.]

PREPARED STATEMENT OF AMERICAN ALLIANCE OF MUSEUMS

Chairwoman Baldwin, Ranking Member Capito, and members of the subcommittee, thank you for the opportunity to submit this testimony. My name is Laura Lott, and I am President and CEO of the American Alliance of Museums (AAM). I urge you to provide the Office of Museum Services (OMS) within the Institute of Museum and Library Services (IMLS) with 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 of Representatives Community Project Funding, which we strongly oppose, increasing funding for competitive grants for museums is all the more critical.

I also urge you to provide an additional $20 million to support libraries and museums in conducting facilities condition assessments, facilities master planning, and other key steps toward addressing the multi-billion dollar backlog of capital needs in libraries and museums nationwide. IMLS would distribute the funding, with priority for rural and underserved communities and facilities that pose a severe health or safety threat. These funds and related report language were included in the Senate's FY 2023 Labor-HHS bill (S. 4659 in the 117th Congress). However, the funding was not included in the FY 2023 omnibus.

AAM—representing more than 35,000 individual museum professionals and volunteers, museums of all types, and corporate partners serving the museum fieldstands 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 41 Senators who wrote to you in support of FY 2024 OMS funding. OMS is a vital investment in protecting our Nation's cultural treasures, educating students and lifelong learners alike, and bolstering local economies.

During the COVID–19 pandemic, OMS 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 Wisconsin is $600 million, including 9,444 jobs. For West Virginia, it is a $209 million impact supporting 2,951

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 demand of $109 million in highly rated grant applications the agency received in FY 2022.

The pandemic has inflicted profound damage on U.S. 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. According to a recent survey, 67% of museums have not recovered to 100% of their pre-pandemic attendance numbers. Of those that have not fully recovered, attendance is down on average 30% with many citing lower visitation from K–12 in-person field trips. 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 just a few examples of how OMS helps museums better serve their communities:

—In 2022, the Madison Children's Museum in Madison, Wisconsin, was awarded a $339,000 National Leadership Grant to develop a climate and resiliency framework, developmentally appropriate for children ages birth through 8, that focuses on resiliency and the environment. A coalition of nine children's museums and science centers will jointly develop and test the framework. Each institutional partner will use the framework to develop new programming, an exhibition, or educational content at their museum. Each institution will also commit to lowering their carbon emissions through activities such as buying wind power or installing a solar array. The museum will develop a toolkit that contains the framework and model educational programs and strategies to engage the public. The project will provide museum professionals with culturally relevant climate science education and support in creating locally based creative initiatives and climate solutions for their museums.

—In 2022, the Paine Art Center and Gardens in Oshkosh, Wisconsin, was awarded a $248,980 Museums for America grant to partner with the University of Wisconsin Oshkosh and the Oshkosh Area School District to develop ArtsCore Adventures, a new set of arts integrated field trips and activities for PreK–12 students. These new field trips will enhance the museum's existing ArtsCore program, a professional development program for teachers that provides training in arts integration. Project activities will include staff development to increase capacity to offer new programs; developing and evaluating two to four new pilot Adventures; and fully implementing the new Adventures. At project completion, ArtsCore teacher alumni will have access to at least 10 new ArtsCore Adventures as they develop and implement an arts-integrated cur-

riculum and bring their students to the Paine Art Center and Gardens for engaging field trip experiences.

—In 2022, the Menominee Indian Tribal Archives and the Menominee Cultural Museum in Keshena, Wisconsin, was awarded a $50,000 American Rescue Plan for Native American/Native Hawaiian Museum and Library Services grant to collaborate on a project to improve management, care, and Tribal member access to archival and ethnographic collections. The museum will hire and train two part-time staff to select, catalog, and rehouse collection materials. Other museum staff will receive trainings on archival software and collections care and management. The Tribal archivist will manage the project, which is part of a long-term effort to provide Tribal members with digital access to a broad array of cultural heritage materials, and was delayed as a result of the COVID–19 pandemic's effects on collections stewardship.

—In 2022, the West Virginia Mine Wars Museum in Matewan, West Virginia, received a $24,656 American Rescue Plan for Museums and Libraries grant to deepen community partnerships and support cultural tourism as the area recovers from the COVID–19 pandemic by preserving the apartment of Sid Hatfield (1893–1921), police chief of Matewan and hero to southern West Virginia's union coal miners. The museum also will develop a participatory mural inside the stairwell leading up to Hatfield's apartment. The museum will work with Coalfield Development, a nonprofit organization dedicated to rebuilding Appalachia, and longstanding partner United Mine Workers of America Local 1440. Over the course of a year, the museum will plan, lead, and host community meetings with key stakeholders to envision, identify, and prioritize the many potential uses for this space. Based on these conversations, the project team will generate design mock-ups and programming activities and seek local community feedback on their proposal.

—In 2021, the Huntington Museum of Art in Huntington, West Virginia, was awarded a $143,550 Museums for America grant to expand and enhance its current nature trail system, providing additional opportunities for patrons to interact with and learn about nature. The museum plans to expand the Teubert Sensory Trail, which is specifically designed to meet the needs of visually impaired individuals and people who use wheelchairs, doubling its length. At the same time, they will install educational signage and other conveniences to enhance the sensory and hiking trails. The enhanced trails will make nature more accessible, inviting, and engaging, particularly for those who face barriers to participation.

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.

[This statement was submitted by Laura L. Lott, President and CEO, American Alliance of Museums.]

PREPARED STATEMENT OF THE AMERICAN ASSOCIATION FOR CLINICAL CHEMISTRY

The American Association for Clinical Chemistry (AACC) welcomes the opportunity to provide testimony to the Senate Appropriations subcommittee on Labor, Health & Human Services, Education, and Related Agencies regarding our Nation's fiscal year (FY) 2024 budget priorities. AACC and its partners are urging the subcommittee to support two initiatives vital to improving the quality and efficacy of healthcare in the United States:

—Improving Pediatric Reference Intervals—$10 million for the Centers for Disease Control and Prevention, Division of Laboratory Sciences, Environmental Health Laboratory to improve the quality of pediatric reference intervals used by health practitioners to diagnose, monitor, and treat children.

—Harmonizing Clinical Laboratory Test Results—an additional $7.2 million ($9.2 million in total) for the Centers for Disease Control and Prevention, Division of Laboratory Sciences, Environmental Health Laboratory, to continue its ongoing efforts to harmonize the reporting of clinical laboratory test results, which is vital to providing better, more consistent, and cost-effective healthcare in the United States.

IMPROVING PEDIATRIC REFERENCE INTERVALS

AACC, the American Academy of Pediatrics, the Children's Hospitals Association, and 30 other organizations have written to the subcommittee urging additional funding for the Centers for Disease Control and Prevention (CDC) to improve the quality of pediatric reference intervals (PRIs)—the range of numeric values expected in a healthy child—available to health practitioners to care for their young patients.

When making a diagnosis, the healthcare professional considers a laboratory test value within the context of a reference interval. If the test result falls outside of the defined reference interval for a healthy child—either higher or lower—the practitioner may order a medical intervention to address a health condition or change an ongoing treatment protocol. If the diagnosis or treatment change is incorrect, it could result in patient harm. Therefore, it is critical that the range of values used by practitioners to interpret test results are accurate and reflect normal biological changes.

Whereas the reference intervals for adults are generally reliable, there are considerable inconsistencies and large gaps in the ranges available for children. Healthcare practitioners need reference intervals reflective of healthy children at each unique stage of physical development, from birth through adolescence to adulthood. In addition, the intervals must also take into consideration any variations due to biological factors, such as ethnicity and gender.

Accurate and actionable PRIs are particularly important for our youngest patients, who are often unable to verbally communicate their symptoms. Unfortunately, many current PRIs are outdated and do not reflect normal biologic changes in children. Most laboratories do not have access to appropriate pediatric samples to create their own PRIs and therefore must rely on those outdated PRIs. This situation was highlighted in a recent study in JAMA Peds 2021.[1] In addition, having each laboratory develop their own PRIs will add substantial costs to the healthcare system.

Congress had identified improving PRIs as an issue that needs to be addressed. In the accompanying report language to the Further Consolidated Appropriations Act of 2020, the legislature requested that CDC develop and submit a plan for addressing this matter. The agency outlined its plan in the Department of Health and Human Services fiscal year 2021 congressional justification to Congress (p. 501–502). The plan calls for the CDC to employ its existing infrastructure to initiate and advance this vital work. According to CDC, it can:

—collect clinical samples through its National Health and Nutrition Examination Survey (NHANES), which has the organization and expertise to collect specimens from healthy children that reflect the diversity in the U.S.; and

—utilize its Environmental Health Laboratory (EHL) to generate reference intervals for children and disseminate the information to clinical laboratories. EHL has previously developed common reference intervals used by laboratories and recommended in clinical practice guidelines.

AACC and its partners support providing CDC with an additional $10 million to improve the quality of PRIs critical to caring for our Nation's children.

HARMONIZING CLINICAL LABORATORY TEST RESULTS

Another issue that AACC and its allies request your assistance is the harmonization of clinical laboratory test results. Although laboratory tests are accurate, many laboratories use different methods to diagnose a condition, resulting in practitioners receiving different numeric values and reference ranges for diagnosing that same condition. This lack of harmonization makes it difficult to develop widely applicable clinical guidelines or performance measures that can better inform health care decision-making.

Tests that are harmonized (or standardized) provide the same numeric value for a patient, regardless of the method or instrument used or the setting where the tests are performed. An early example of harmonization is cholesterol, which is widely utilized by the medical community to diagnose heart disease. A 2011 study published in Preventing Chronic Disease reports that early drug intervention based on cholesterol levels saved the health system $338 million to $7.6 billion annually

[1] Lyle Alicia N. et al, Current State of Pediatric Reference Intervals and the Importance of Correctly Describing the Biochemistry of Child Development: A Review. JAMA Pediatrics 2022; 176(7):699–714.

between 1980—2000.[2] Thus, harmonization can improve patient care while also saving money.

In recent years, the subcommittee and Congress have supported expanding CDC's harmonization efforts, resulting in new activities to improve the detection and management of hormone disorders, kidney disease, cancer, and heart disease. CDC is the only laboratory in the U.S. that assists laboratories with achieving accurate and harmonized test results, for several high priority disease biomarkers, such as blood lipids.

With additional funding, CDC will be able to ensure its current harmonization activities and expand its efforts to harmonize new biomarkers used to prevent and treat kidney disease, cancer, diabetes, cardiovascular diseases, and diseases of the endocrine system. This will include new and emerging technologies, such as point of care testing devices, used in patient care and public health. AACC and its partners respectfully request that the subcommittee provide an additional $7.2 million ($9.2 million in total) for CDC to continue and advance its harmonization activities. Congress has provided $2 million annually for this program since FY18. The House passed a $4 million increase for this initiative in the FY20 budget, but it was not included in the final House-Senate agreement.

AACC is a global scientific and medical professional organization dedicated to clinical laboratory science and its application to healthcare. We look forward to working with the subcommittee on these most important issues as it goes through the FY24 budget process. If you have any questions, please email Vince Stine, PhD, AACC's Senior Director of Government and Global Affairs, at vstine@aacc.org.

[This statement was submitted by Shannon Haymond, PhD, DABCC, FAACC, President, American Association for Clinical Chemistry.]

Prepared Statement of the American Association for Dental, Oral, and Craniofacial Research

Chair Baldwin, Ranking Member Moore Capito, and members of the subcommittee, thank you for the opportunity to submit this testimony on behalf of the American Association for Dental, Oral, and Craniofacial Research (AADOCR). For FY 2024, AADOCR is seeking at least $558 million for the National Institute of Dental and Craniofacial Research (NIDCR) and a total of $51 billion for all of the Institutes and Centers at the National Institutes of Health (NIH). Funding at these levels is necessary for the entities' base budgets to keep pace with the disproportionately high level of biomedical inflation.

The NIH, through the biomedical research it conducts and supports, plays a critical role in improving Americans' health and well-being. When the COVID–19 pandemic hit our Nation and the world, the NIH helped safeguard the public health through its significant contributions to the development of testing, vaccines, and treatments. The NIH continues to develop and maintain the resources, both human and scientific, that provide our Nation with the tools it needs to address other diseases and disabilities. AADOCR deeply appreciates Congress' longstanding and bipartisan support for the public health research enterprise.

The NIDCR, established 75 years ago by President Harry S. Truman, is the largest institution in the world exclusively dedicated to researching ways to improve dental, oral, and craniofacial health for all. The Institute supports scientists at all stages of their careers, from high school students to independent researchers, and funds cutting-edge basic, translational, and clinical research to create the scientific foundation for oral health policy and practice. NIDCR shares its research findings and health information with the public, health care professionals, researchers, and policy makers to promote oral health for all.

Investments in NIDCR-funded research during the past half-century have led to improvements in oral health for millions of Americans and continue to show promise in multiple areas impacting the dental and craniofacial complex and overall health of Americans, including the prevention of dental caries (tooth decay) and periodontal (gum) disease, pain biology and management, helping alleviate the opioid crisis, temporomandibular disorders (TMD), regenerative medicine, oral cancer prevention and treatment, and in assessing human papillomavirus (HPV) vaccine efficacy for oral and pharyngeal cancers.

The research being conducted at, and supported by, NIDCR impacts not only the oral health, but the overall health of Americans. Oral diseases not only cause pain, discomfort, social isolation, interruption of school and work, and economic hardship,

[2] Hoerger TJ, Wittenborn JS, Young W. A cost-benefit analysis of lipid standardization in the United States. Preventing Chronic Disease 2011; 8: A136.

but also place undue strain on health systems and reduce economic productivity, leading to direct and indirect costs estimated at $545 billion stemming from dental diseases worldwide.

The oral cavity serves as a window into many health issues, including but not limited to systemic diseases, such as diabetes, HIV/AIDS, and Sjögren's, an autoimmune disease that causes one's immune system to attack parts of its own body. Additionally, researchers are exploring the debilitating loss of salivary gland functioning and saliva production stemming from radiation treatment for head and neck cancers and even from common medications and aging itself. Lack or loss of saliva, which causes xerostomia, or uncomfortable dry mouth, has also been shown to be a risk factor for dental caries.

Oral diseases share many of the same behavioral and social determinants as other noncommunicable diseases such as diabetes and hypertension, including tobacco use, environmental setting, and lack of access to health care, and these vulnerabilities accumulate along the life course and contribute to disparities in oral health outcomes. NIDCR is addressing these health disparities by funding research that investigates how social determinants of health affect oral health and access to dental care.

NIDCR recently launched a national, NIH-wide consortium called the TMD Collaborative for Improving Patient-Centered Translational Research (TMD IMPACT) to help improve clinical care for TMD by establishing a national, interdisciplinary, patient-centered consortium to advance research and help train the next generation of TMD researchers. The research seeks to identify the nerves in the temporomandibular joint and discover new approaches to pain relief.

The Federal investment in NIDCR has also allowed the Institute to build its data repository and registry in several disease and research areas to meet the increasing need for open-source data sharing. These include clinical registries and repositories related to head and neck cancers, orofacial birth defects and craniofacial anomalies, and craniofacial microsomia cohorts to identify genetic risk factors. The Institute also participates in trans-NIH and NIH Common Fund initiatives for data analysis and sharing.

NIDCR-supported research is also expanding into exciting new areas of research, such as the interplay between the oral microbiome—which encompasses over 700 microorganisms, including bacteria, fungi, and viruses—and the immune system. We are increasingly learning that the oral microbiota can help predict or identify a diverse range of oral and systemic diseases, including dental caries, periodontal diseases, oral cancer, colorectal cancer, pancreatic cancer, and inflammatory bowel syndrome. Further research in this area is critical to improving Americans' oral and overall health.

Finally, NIDCR is dedicated to building an inclusive and diverse community in its research training and employment programs. In FY 2022, NIDCR invested over $23 million to support research training and career development programs spanning the career stages of scientists to help build a vibrant and inclusive community of researchers. It's "MIND the Future" (Mentoring an Inclusive Network for a Diverse Workforce of the Future) initiative provides mentored research career development and grant writing activities for postdoctoral and junior faculty scientists from groups traditionally underrepresented in biomedical research to help support their pursuit of academic research careers.

Despite NIDCR's impressive research agenda and scientific accomplishments, the Federal Government's annual investment in the Institute has not kept pace with the overall funding increases provided to NIH over the past several years. Providing NIDCR with at least $558 million in FY 2024 would help bring the Institute's funding into alignment with the overall NIH appropriation and allow NIDCR to build on its myriad successes in its mission to improve dental, oral and craniofacial health.

AADOCR strongly supports the Administration's request of $2.5 billion for the Advanced Research Projects Agency for Health (ARPA–H) and $2.7 billion in new mandatory funding for the NIH to support pandemic preparedness in FY 2024. These investments, however, must not come at the expense of funding for traditional NIH Institutes and Centers. The White House proposal of $48.3 billion for NIH's base budget, a mere 1.7% increase over the comparable FY 2023 funding level, does not come close to keeping pace with biomedical inflation, undermines the future medical research workforce, and risks America's long-term leadership in biomedical research.

We appreciate the opportunity to submit this testimony and thank the subcommittee for its support of biomedical research, including dental, oral, and craniofacial research, in FY 2024 so our Nation's citizens can continue to enjoy the benefits of state-of-the-art and world-leading medical and dental care. We stand

ready to assist the members of this subcommittee in any way we can and are happy to answer any questions you may have.

Thank you.

[This statement was submitted by Alexandre R. Vieira, DDS, MS, Ph, President, American Association for Dental, Oral, and Craniofacial Research.]

PREPARED STATEMENT OF THE AMERICAN ASSOCIATION FOR THE STUDY OF LIVER DISEASES

The American Association for the Study of Liver Diseases (AASLD) thanks this subcommittee for the opportunity to submit outside witness testimony on opportunities to support and improve the health of Americans living with various forms of liver disease, ranging from non-alcoholic fatty liver disease to liver cancer, in the Fiscal Year (FY) 2024 Labor, Health and Human Services, Education and Related Agencies bill and report.

The liver, the largest solid organ in the body, is a master regulator of a diverse array of life sustaining chemical processes. In liver disease, these processes are disrupted. The result is ongoing organ injury, progressive scarring, and the development of cirrhosis and liver cancer. Over 40,000 Americans die each year from these complications. In 2019, liver disease was the fourth leading cause of death for those 45 to 64 years of age, and that figure continues to grow.

We respectfully request that you provide at least $50.9 billion for the National Institutes of Health (NIH) and $140 million for the Centers for Disease Control and Prevention (CDC) Division of Viral Hepatitis (DVH).

ENACT A PLAN TO ELIMINATE HEPATITIS C

At least 2.4 million people in the United States are chronically infected with hepatitis C. Chronically infected individuals may be asymptomatic for years while the virus damages their liver. Left undetected and untreated, hepatitis C may progress to cirrhosis, liver cancer, and potentially even death. Liver transplantation is the only rescue therapy available to those who develop the complications related to cirrhosis and/or liver cancer, but is an expensive and limited option. Every year, one of every five persons on the waiting list for liver transplantation die or become too sick to undergo the transplant.

The high number of individuals unaware of their disease status, the barriers to screening and treatment, and the cost of these medications are the primary impediments to hepatitis C elimination. However, Congress can act to address these challenges, save the lives of many Americans with hepatitis C, and reduce the significant health costs associated with treating patients with liver cancer and liver transplants.

President Biden's FY 2024 budget request outlines a plan to eliminate this curable this virus by:

—Supporting the development of point-of-care diagnostic tests to enable a test-to-treat model;

—Broadening access to curative hepatitis C medications, primarily through a national subscription model; and

—Expanding infrastructure needed to reach, test, and treat all affected individuals.

Besides these components, the plan would accelerate research to find a safe and effective vaccine for hepatitis C, so that the next generation of Americans will be protected from this serious disease. The White House requested a mandatory authorization—an investment of $12.3 billion—for 5 years. This investment will be offset by $7.2 billion in savings, primarily by the reduced Medicaid program and drug costs, for a net cost of $5.1 billion and an incalculable benefit to the millions of lives that will be saved, particularly among our most vulnerable populations who are disproportionately affected by this virus. While this plan requires an authorization outside of the FY 2024 appropriations process, this investment is critical to saving Americans' lives and controlling health costs. AASLD urges you to work with your colleagues to authorize this plan.

APPROPRIATE $140 MILLION FOR CDC DVH TO SUPPORT THE ELIMINATION OF VIRAL HEPATITIS

AASLD is committed to meeting the goal of eliminating viral hepatitis and is grateful that the Biden Administration has developed a plan to eliminate hepatitis C in 5 years. To be successful, this plan will need significant resources for CDC DVH to test and treat for hepatitis C and hepatitis B.

We have the vaccines necessary to prevent hepatitis A and hepatitis B, and while we may not have a hepatitis C vaccine, we now have the therapeutics to cure those infected. However, vaccines and effective therapeutics alone cannot move the country towards elimination; therefore, we urge Congress to provide the investment necessary to support this goal. The overall CDC budget has decreased in real dollars several times in the last decade. We therefore urge you to appropriate $140 million for DVH as a down payment on progress towards elimination.

We recognize that this request represents a $99 million increase in DVH's funding, but this request does not come close to addressing the burden of viral hepatitis in this country. In its 2016 Professional Judgement Budget, the CDC estimated it would take at least $316 million to do this. There is a critical need to enhance the capacity to detect and respond to outbreaks. Increased funding for DVH is also critically important to support the recently updated hepatitis B screening guidelines and adult vaccination programs for hepatitis A and hepatitis B and address the ongoing opioid epidemic, which has been exacerbated by the COVID–19 pandemic.

FUNDING FOR NIH

Robust, sustained, and predictable funding is important to advancing the entire biomedical research enterprise, not just work related to the full spectrum of liver diseases. AASLD is deeply appreciative of the investment Congress has made to provide NIH with the resources for meaningful growth above inflation, and our request of at least $50.90 billion will ensure this trajectory can be maintained and meritorious research in liver disease will continue to be supported.

To meaningfully advance our understanding of liver diseases, all NIH Institutes and Centers (I/Cs) must receive a proportional increase in funding in FY 2024. AASLD would like to stress the importance of the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), the home for liver disease research, receiving at least a proportional increase to NIH. NIDDK is the lead institute for the Liver Cirrhosis Network (LCN), which coordinates clinical trial centers and other cross-cutting work on liver disease. The LCN can be a model approach for other diseases that require numerous I/C stakeholders to collaborate on the groundbreaking research necessary to drive clinical breakthroughs. We also recognize the contributions of the National Institute of Alcoholism and Alcohol Abuse and the National Cancer Institute, both of which touch on numerous aspects of liver disease, including alcohol-associated liver disease and liver cancer.

REPORT LANGUAGE SUBMISSIONS

The AASLD has submitted the following report language submissions for the Committee's consideration:

National Liver Disease Strategy.—The Committee recognizes the growing burden of liver disease, including viral hepatitis, non-alcoholic fatty liver disease, cirrhosis, and liver cancer, and its significant costs to the country's health care system. In 2019, liver disease was the fourth leading cause of death for those 45 to 64 years of age. Despite the growing toll the full spectrum of liver diseases is imposing, there is no strategy to address the breadth of the health and economic effects of this disease in the United States. For these reasons, the Committee directs the Secretary of HHS to develop a department-wide strategic plan to combat liver disease. This strategy should include a framework to guide the development of policies and initiatives to prevent, diagnose, and treat liver disease across Federal agencies. Specifically, the strategy should coordinate efforts to prevent future cases of liver disease through improved disease surveillance and improve liver disease outcomes for current patients by addressing health disparities and inequities. The Committee provides $2 million to support this effort and requests an update on the department's plans to begin this work within 180-days of enactment.

CONCLUSION

Thank you again for the opportunity to submit testimony to the Committee as you begin your work on the FY 2024 appropriations bills. We look forward to working with you to improve the health and well-being of all Americas living with liver disease.

PREPARED STATEMENT OF THE AMERICAN ASSOCIATION OF COLLEGES OF NURSING

Strengthening the Current and Future Nursing Workforce

On behalf of the American Association of Colleges of Nursing (AACN), we would like to thank the subcommittee for its leadership and continued support of nursing

education, the nursing profession, and nursing research. As the National voice for academic nursing, AACN represents more than 865 schools of nursing at private and public universities, who educate more than 565,000 students and employ more than 52,000 faculty.[1] Collectively, these institutions graduate registered nurses (RN), advanced practice registered nurses (APRN), educators, researchers, and frontline providers. As you consider and advance the Fiscal Year (FY) 2024 Labor, Health and Human Services, Education, and Related Agencies (LHHS–ED) appropriations bill, AACN respectfully requests that you provide support of at least $530 million for the Nursing Workforce Development Programs (Title VIII of the Public Health Service Act [42 U.S.C. 296 et seq.] administered by HRSA and at least $210 million for the National Institute of Nursing Research (NINR).

Landscape Overview: The Growing Nursing Workforce Demand Nurses comprise the largest sector of the healthcare workforce, with more than four and a half million RNs and APRNs, which include Nurse Practitioners (NPs), Certified Registered Nurse Anesthetists (CRNAs), Certified Nurse-Midwives (CNMs), and Clinical Nurse Specialists (CNSs).[2] From the classrooms to the frontlines, we know first-hand how critical a well-educated nursing workforce is to providing high-quality health care. This need is only expected to intensify with the Bureau of Labor Statistics projecting the demand for RNs to increase by 6% through 2031, representing the need for an additional 195,400 jobs.[3] Demand for certain APRNs (nurse practitioners, certified registered nurse anesthetists, and certified nurse-midwives) is expected to grow even more, by 40%.[4]

While the COVID–19 public health emergency is set to expire on May 11, 2023, we continue to see the impact the last few years have had on the viability of nursing schools and the pipeline of faculty and students. These impacts illustrate the need for enhanced Federal investment in FY 2024. For example, in 2021, student enrollment in entry-level baccalaureate nursing programs increased by 3.3%.[5] Yet, this increase was 2.3% lower than 2020.[6] Further, nursing schools saw enrollment decline in baccalaureate degree-completion programs and graduate programs at the master's and PhD levels.[7] For the first time since 2001, enrollment in master's programs decreased by 3.8%, which translates to 5,766 fewer students enrolled in 2021 than in the previous year.[8] Declines in graduate nursing programs are of great concern, as these programs help prepare individuals for critical roles in administration, teaching, research, informatics, and direct patient care. Enrollment declines coupled with more than 2,100 full-time faculty vacancies in baccalaureate and/or graduate programs across the country underscores how vital funding for nursing education is to support the preparation of nurses to meet the healthcare needs of all communities, including those in rural and underserved areas.[9]

Educational pathways are just one piece of the puzzle. Strong and historic investments in the current nursing workforce are imperative, especially as we contend with an aging nursing workforce and the toll that the response to COVID–19 has had on the profession. In fact, the median age of RNs is now 52 years, with nurses aged 65 and older making up 19% of the workforce. More than one-fifth of all nurses reported they plan to retire from nursing over the next 5 years".[10] We must minimize the loss of experienced nurses who may prematurely leave the profession, and

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[1] American Association of Colleges of Nursing. (2022) Who We Are. Retrieved from: https://www.aacnnursing.org/About-AACN/Who-We-Are.

[2] National Council of State Boards of Nursing. (2021). Active RN Licenses: A profile of nursing licensure in the U.S. as of April 23, 2021. Retrieved from: https://www.ncsbn.org/nursing-regulation/national-nursing-database/licensure-statistics/active-rn-licenses.page.

[3] U.S. Bureau of Labor Statistics. (2023). Occupational Outlook Handbook-Registered Nurses. Retrieved from: https://www.bls.gov/ooh/healthcare/registered-nurses.htm.

[4] U.S. Bureau of Labor Statistics. (2023). Occupational Outlook Handbook-Nurse Anesthetists, Nurse Midwives, and Nurse Practitioners. Retrieved from: https://www.bls.gov/ooh/healthcare/nurse-anesthetists-nurse-midwives-and-nurse-practitioners.htm.

[5] American Association of Colleges of Nursing. (2022) Nursing Schools See Enrollment Increases in Entry-Level Programs, Signaling Strong Interest in Nursing Careers. Retrieved from: https://www.aacnnursing.org/News-Information/Press-Releases/View/ArticleId/25183/Nursing-Schools-See-Enrollment-Increases-in-Entry-Level-Programs.

[6] Ibid.

[7] Ibid.

[8] Ibid.

[9] American Association of Colleges of Nursing. (2022). Special Survey on Vacant Faculty Positions. Retrieved from: https://www.aacnnursing.org/Portals/42/News/Surveys-Data/2022-Faculty-Vacancy-Report.pdf.

[10] National Council of State Boards of Nursing and the National Forum of State Nursing Workforce Centers (2021) The 2020 National Nursing Workforce Survey. Retrieved from: https://www.journalofnursingregulation.com/article/S2155-8256(21)00027-2/fulltext.

at the same time support nursing schools focused on meeting the current and future demand for nurses.

With increasing demands, an aging population, nursing retirements, and an increase in workplace stress,[11] bold investments in Title VIII Nursing Workforce Development Programs and NINR are imperative, not only as we confront existing health challenges, but as we advance tomorrow's equitable and innovative healthcare solutions.

INVESTMENTS IN NURSING EDUCATION LEAD TO A STRONG NURSING WORKFORCE

For over fifty years, Title VIII Nursing Workforce Development Programs have been a catalyst for strengthening nursing education at all levels, from entry-level preparation through graduate study. Through grants, scholarships, and loan repayment programs, Title VIII Federal investments positively impact the profession's ability to serve America's patients in all areas, bolster diversity within the workforce, and increase the number of nurses needed to respond to public health emergencies and care for our aging population.

Each Title VIII Nursing Workforce Development Program provides a unique and crucial mission to support nursing education and the profession. For example, the Advanced Nursing Education (ANE) program helps increase the number of APRNs in the primary care workforce, including support for more than 8,800 students in Academic Year 2021–2022 alone.[12] In the same timeframe, the Nurse Faculty Loan Program (NFLP) supported 2,806 nursing students who intend to serve as nurse faculty, including 837 newly graduated nurses.[13] As we address social determinants of health and work to build an equitable healthcare system for all patients, it is imperative that we recruit individuals from diverse backgrounds to the nursing profession. Increasing diversity in the profession will not only create lifelong career pathways, but will also improve care quality and access to population-centered care. The Nursing Workforce Diversity (NWD) program serves as a glowing example of a successful Title VIII initiative that accomplishes the goal of strengthening pathways into the nursing workforce. In fact, in Academic Year 2021–2022, the NWD program awarded grants supporting 10,981 nursing students from disadvantaged backgrounds.[14] To ensure the stability of our nursing workforce now and in the future, we request at least $530 million for Title VIII Nursing Workforce Programs in FY 2024.

FROM RESEARCH TO REALITY: NURSING SCIENCE PROTECTS AMERICANS' HEALTH

AACN recognizes that scientific research and discovery are the foundation on which nursing practice is built and is essential to advancing evidence-based interventions, informing policy, and sustaining the health of the Nation. In fact, the ASPE's report recommends to "support research that investigates long-term workforce trends arising from the pandemic and how they can be addressed, including entry and departure issues, impact on facility staffing, and factors associated with health worker morale."[15] As one of the 27 Institutes and Centers at NIH, the NINR is integral to improving care and is on the cutting edge of new innovations that impact how nurses are educated and how they practice. In fact, 80% of research-focused educational training grants at schools of nursing are funded by NINR.[16] With this support, nurse scientists, often working collaboratively with other health professionals, are generating groundbreaking findings and leading translational research.

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[11] American Association of Colleges of Nursing. (2022) Fact Sheet: Nursing Shortage. Retrieved from: https://www.aacnnursing.org/Portals/42/News/Factsheets/Nursing-Shortage-Fact-sheet.pdf.

[12] Health Resources and Services Administration. Fiscal Year 2024 Budget Justification. Pages 153–156. Retrieved from: https://www.hrsa.gov/sites/default/files/hrsa/about/budget/budget-justification-fy2024.pdf.

[13] Health Resources and Services Administration. Fiscal Year 2024 Budget Justification. Pages 165–167. Retrieved from: https://www.hrsa.gov/sites/default/files/hrsa/about/budget/budget-justification-fy2024.pdf.

[14] Health Resources and Services Administration. Fiscal Year 2024 Budget Justification. Pages 157–160. Retrieved from: https://www.hrsa.gov/sites/default/files/hrsa/about/budget/budget-justification-fy2024.pdf.

[15] Assistant Secretary for Planning and Evaluation, Office of Health Policy. Impact of the COVID–19 Pandemic on the Hospital and Outpatient Clinician Workforce Challenges and policy responses. (2022) Retrieved from: https://aspe.hhs.gov/sites/default/files/documents/9cc72124abd9ea25d58a22c7692dccb6/aspe-covid-workforce-report.pdf.

[16] Schnall, R. (2019). National Institute of Health (NIH) funding patterns in Schools of Nursing: Who is funding nursing science research and who is conducting research at Schools of Nursing? Journal of Professional Nursing, 36(1), 34–41. https://www.sciencedirect.com/science/article/pii/S8755722319301164?via=ihub#.

The scope of this research encompasses a range of strategic imperatives such as health equity, social determinants of health, population health, health promotion, and new models of care. To further this vital work, we are requesting a total of at least $210 million for the National Institute of Nursing Research.

Enhanced support for the Title VIII Nursing Workforce Development Programs and NINR is critical to sustaining a strong nursing workforce able to care for our Nation's population. AACN respectfully requests support in FY 2024 of at least $530 million for the Title VIII Nursing Workforce Development Programs and at least $210 million for the National Institute of Nursing Research. Together, we can ensure that such investments promote innovation and improve health care in America.

[This statement was submitted by Cynthia McCurren, PhD, RN, Board Chair, American Association of Colleges of Nursing.]

PREPARED STATEMENT OF THE AMERICAN ASSOCIATION OF COLLEGES OF OSTEOPATHIC MEDICINE

The American Association of Colleges of Osteopathic Medicine (AACOM) appreciates the opportunity to highlight priorities for the osteopathic medical education (OME) community in the Labor, Health and Human Services, Education, and Related Agencies (LHHSE) fiscal year (FY) 2024 U.S. Department of Health and Human Services (HHS) budget. AACOM supports FY24 funding levels for the following priority programs:

—$50.9 billion for the National Institutes of Health (NIH)
—$11.5 billion for the Centers for Disease Control and Prevention
—$10.5 billion for discretionary Health Resources and Services Administration (HRSA)
—$1.51 billion for the Public Health Service Act Title VII and Title VIII Health Professions Workforce Programs
—$564 million for the Agency for Healthcare Research and Quality
—$385 million for the Children's Hospital Graduate Medical Education Program
—$277.2 million for the Teaching Health Center Graduate Medical Education Program
—$176 million for discretionary National Health Service Corps Scholarship and Loan Programs
—$60 million for the Medical Student Education Program
—$54 million for the Primary Care Training and Enhancement Program
—$47 million for the Area Health Education Center Program
—$28 million for the Healthcare Workforce Innovation Program
—Permanent funding for the Rural Residency Planning and Development Program

AACOM leads and advocates for the full continuum of OME to improve the health of the public. Founded in 1898 to support and assist the Nation's osteopathic medical schools, AACOM represents all 40 accredited colleges of osteopathic medicine (COMs)—educating nearly 35,000 future physicians, 25 percent of all U.S. medical students—at 64 teaching locations in 35 U.S. States, as well as osteopathic graduate medical education professionals and trainees at U.S. medical centers, hospitals, clinics and health systems.

COMMUNITY-BASED TRAINING FOR MEDICAL STUDENTS

AACOM urges the LHHSE subcommittee to increase training sites for medical students in rural communities to strengthen the physician workforce for underserved populations. We recommend the LHHSE subcommittee include FY24 funding to establish a new program that increases clinical rotations for medical students in rural communities.

According to the HRSA's Advisory Committee on Interdisciplinary, Community-Based Linkages, there is a growing trend toward providing care in smaller community-based clinics instead of academic hospitals. Large academic medical centers represent only 5 percent of all hospitals in the United States and only 20 percent of all hospital admissions, surgical operations and outpatient visits. The traditional site of clinical training for students in many health professions has been the teaching hospital, often affiliated with a university or other academic center. As the provision of care has shifted to community-based settings, so has the training of medical students. Clinical training in these community-based settings expose medical students to the unique medical needs of rural and underserved populations and prepare them to serve those communities after graduation.

Many community clinics are set in rural or other underserved locations that need more primary care providers, and trainees exposed to underserved populations are more likely to practice in similar settings upon graduation. Research suggests that medical education in a rural location increases the number of medical graduates that will work in a rural community. However, more than three-quarters of all medical schools report concerns with the number of clinical training sites and the quality and supply of preceptors, especially in primary care. To address workforce shortages and expanding needs, the provision of health care is shifting away from expensive and centralized hospitals to encompass more lower-cost, community-based settings.

COMs are at the forefront of training future physicians in these rural and underserved areas. Sixty percent of COMs are located in health professional shortage areas, 64 percent require their students to go on clinical rotations in rural and underserved areas and 88 percent have a Stated public commitment to rural health. Eighty-six percent of doctors of osteopathic medicine (DOs) who have their COM and residency in a State, stay to practice in that state. As experts in the distributed model of training, COMs are committed to community-based training and increased physician practice in rural and underserved areas.

NIH FUNDING AND REPRESENTATION FOR OSTEOPATHIC MEDICINE

AACOM urges the LHHSE subcommittee to direct NIH to create a plan that leads to increased research funding at COMs and expanded representation from COMs on National Advisory Councils and study sections that includes a structured partnership with the OME community and incentives for principal investigators from COMs.

AACOM is concerned that scientists at osteopathic medical schools are underutilized in NIH research and underrepresented on NIH Advisory Councils and study sections. Building on report language highlighting concerns in the FY22 and FY23 omnibus appropriations bills (PLs 117–103 and 117–328), a bipartisan, bicameral group of 23 lawmakers led by Senator Martin Heinrich (D–NM), Senator Roger Wicker (R–MS) and Representative Susie Lee (D–NV) submitted a July 2022 letter urging acting NIH Director Dr. Lawrence A. Tabak to implement a plan to expand funding opportunities for research in osteopathic medicine.

AACOM thanks Congress for acknowledging this disparity. Yet, to date, the NIH has taken no overt action to address the concerns raised by Congress regarding COM underfunding and underrepresentation. COMs receive only 0.1 percent ($62.5 million) of NIH funding compared to 43 percent ($23.6 billion) for MD institutions. Additionally, there are no DOs among the 3,233 study section reviewers (compared to 493 MDs) and only two DOs among the 462 National Advisory Council members (compared to 213 MDs). If this disparity in funding and representation continues, NIH will miss a key opportunity to bolster its capacity to address some of the Nation's most pressing health threats. A plan to increase funding at COMs and representation from COMs on National Advisory Councils and study sections is needed to strengthen research in the areas of primary care, community-based services and health disparities of rural and underserved populations.

AACOM appreciates the opportunity to share our LHHSE FY24 funding priorities and looks forward to continuing to work with the subcommittee on these important matters. For questions or further information, please contact David Bergman, JD, Vice President of Government Relations, at dbergman@aacom.org.

[This statement was submitted by Robert A. Cain, DO, FACOI, FAODME, President and Chief Executive Officer, American Association of Colleges of Osteopathic Medicine.]

PREPARED STATEMENT OF THE AMERICAN ASSOCIATION OF IMMUNOLOGISTS

The American Association of Immunologists (AAI), the Nation's largest professional association of research scientists and physicians who are dedicated to understanding the immune system through basic, translational, and clinical research, respectfully submits this testimony regarding fiscal year (FY) 2024 appropriations for the National Institutes of Health (NIH). AAI recommends an appropriation of at least $51 billion for NIH's base budget for FY 2024. AAI also recommends providing substantial funding for the Advanced Research Projects Agency for Health (ARPA–H) that supplements, but does not supplant, the amount provided for NIH's base budget.

Robust investment in NIH's base budget will support research needed to prevent and treat disease, fund meritorious research projects and talented scientists at all

career stages, and ensure the growth and continued productivity of our Nation's preeminent biomedical research enterprise. Substantial investment in ARPA–H will help this new agency conduct some of the most cutting edge research intended to solve wide-ranging biomedical and health challenges.

THE ROLE OF IMMUNOLOGY IN ADVANCING VACCINE RESEARCH AND DEVELOPMENT

Three years ago, there was little public understanding of immunology. Today, as a result of the COVID–19 pandemic, immunological advances are dinner-table conversation for families across the U.S. and around the world. The rapid, record-breaking development, deployment, and use of safe and effective vaccines to protect against severe acute respiratory syndrome coronavirus 2 (SARS–CoV–2), the virus that causes COVID–19, saved more than 3.2 million lives in the U.S. alone from December 2020 through November 2022.[1] While these vaccines continue to provide strong protection against severe disease, hospitalization, and death, the latest variants (Omicron and its subvariants), which spread much more easily, are a reminder that we must be prepared for the future of COVID–19, including whether a novel variant is able to evade vaccine-induced immunity.

Fortunately, immunological research has already led to the development of the more effective bivalent mRNA vaccine that targets both the original strain and the Omicron variants. Now, there is urgent need for transmission blocking vaccines to prevent infection, especially for vulnerable populations like the elderly and immunocompromised. Currently, there are many such vaccine candidates, administered intranasally, that are being tested in clinical trials.[2] In addition, future vaccines should provide long-lasting protection and help prevent the development of Long COVID.

Respiratory syncytial virus (RSV) is another respiratory illness that poses great risk, especially for older adults and infants. In 2023, the Food and Drug Administration (FDA) approved an RSV vaccine for use in adults 60 years and older, representing a major milestone in the prevention of this disease.[3] A phase III trial of another RSV vaccine candidate showed over 80% efficacy against severe illness in infants, through vaccination during pregnancy.[4] The development of these vaccines is built upon decades of basic scientific discoveries and clinical trials funded by NIH.

Several other important vaccine advances have also been supported by NIH-funded research. Influenza (flu) causes significant morbidity and mortality, especially in the elderly. Recently, scientists at the National Institute of Allergy and Infectious Diseases developed a universal flu vaccine candidate which would provide protection against all known strains of the flu, and are currently testing it in adults, both intramuscularly and intranasally, in a phase I clinical trial.[5] Initial studies from NIH show promising results for a vaccine against the Sudan virus, which caused the recent Ebola outbreak in Uganda and resulted in 142 confirmed cases and 55 deaths.[6] In addition, NIH-funded research launched a new era of HIV vaccine development, including a phase I trial evaluating three experimental mRNA vaccines against HIV.[7]

ADVANCES IN IMMUNOTHERAPY FOR TREATMENT OF CANCER AND AUTOIMMUNITY

Scientists continue to make significant advances in the development of immunotherapies (treatments that utilize a patient's own immune cells to fight disease) for a variety of illnesses, including cancer and autoimmunity. Chimeric antigen receptor (CAR) based therapies have typically involved T cells (CAR–T cell therapy); however, other immune cell types that contribute to effective disease control, like natural killer (NK) cells and macrophages, are now being tested clinically.[8] Currently, all CAR–T cell therapies approved for use target blood cancers, but scientists are also working on ways to create effective CAR therapies for solid tumors.

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[1] https://www.commonwealthfund.org/blog/2022/2-years-covid-vaccines-prevented-millions-deaths-hospitalizations.

[2] https://www.science.org/doi/10.1126/sciimmunol.add9947.

[3] https://www.fda.gov/news-events/press-announcements/fda-approves-first-respiratory-syncytial-virus-rsv-vaccine.

[4] https://www.science.org/content/article/extremely-satisfying-scientists-insight-powers-new-rsv-vaccine-infants#note.

[5] https://www.niaid.nih.gov/news-events/trial-potential-universal-flu-vaccine-opens-nih-clinical-center.

[6] https://www.nih.gov/news-events/news-releases/experimental-nih-sudan-virus-vaccine-protects-macaques.

[7] https://www.nih.gov/news-events/news-releases/nih-launches-clinical-trial-three-mrna-hiv-vaccines.

[8] https://www.cancer.gov/about-cancer/treatment/research/car-t-cells.

NIH research has also advanced our understanding of Type 1 diabetes (T1D), an autoimmune disease that occurs when the immune system impairs the ability of the pancreas to produce insulin, often leading to serious long-term complications for even those treated with insulin therapy. NIH funding has supported research into novel ways of preventing the immune system from attacking insulin-producing cells; for example, a small phase I study showed the safety of adoptive cell transfer of regulatory T cells, which can restore normal immune function and protect remaining insulin producing cell.[9]

BREAKTHROUGHS IN ANTIBODY THERAPEUTICS

Innovative monoclonal antibody (mAb) therapeutics have revolutionized the treatment of, and outcomes for, diseases including cancer, T1D, and some infectious diseases, such as COVID–19. In a recent small clinical trial testing the efficacy of the mAb dostarlimab in patients with a certain type of colorectal cancer, all 12 patients who completed the therapy experienced complete remission.[10] The FDA recently approved the mAb teplizumab to delay progression of T1D in children over 8 and in adults.[11] Additionally, an NIH-funded clinical trial found that another mAb was up to 88.2% effective at preventing malaria infection in adults who live in an endemic area.[12]

THE IMPORTANCE OF NIH AS THE ENGINE FOR NATIONAL AND LOCAL BIOMEDICAL RESEARCH

As the Nation's major funding agency for biomedical research, NIH supports research institutions and scientists throughout the Nation. With more than 84% of its $47.5 billion budget distributed through nearly 50,000 competitive grants "to more than 300,000 researchers at more than 2,500 universities, medical schools, and other research institutions in every State," NIH funding is the economic engine for many American communities, supporting not only scientific discovery but the jobs that accompany a dynamic commercial environment;[13] in FY 2022, NIH funding supported more than 568,500 jobs and accounted for $96.84 billion in economic activity across the U.S.[14] Another ~10% of the NIH budget supports ~6,000 researchers and clinicians who work at NIH facilities in Maryland and around the country.[15] NIH-funded basic research is vital to the development of new drugs to fight disease; it contributed to the discovery of 354 of 356 new drugs that were approved by the FDA from 2010–2019.[16]

As the indisputable leader of biomedical research in the world, NIH leaders and scientists play an indispensable role in responding to both ongoing and emerging health threats. They and their Federal agency colleagues have been essential to guiding the Nation through the COVID–19 pandemic by advancing our understanding of basic science; rapidly establishing effective programs to advance patient care and therapeutic development including Reseearching COVID to Enhance Recovery (RECOVER, which targets Long COVID), Rapid Acceleration of Diagnostics (RADx, which speeds innovation of COVID–19 tests), and Accelerating COVID–19 Therapeutic Interventions and Vaccines (ACTIV);[17]and providing timely and candid advice to the President, Congress, and the American public.

For many years, strong bipartisan support for biomedical research has led to substantial increases in the NIH budget. While these increases are enormously important and appreciated, they have effectively restored the purchasing power of the NIH budget only to its FY 2003 level. This lackluster growth has prevented NIH from taking full advantage of the unprecedented scientific opportunity of the moment and investing as fully as it should in its most valuable resource: the research workforce. Robustly supporting meritorious scientists at all career stages will foster

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[9] https://www.science.org/doi/10.1126/scitranslmed.aad4134.

[10] Cercek A, et al. PD–1 Blockade in Mismatch Repair-Deficient, Locally Advanced Rectal Cancer. N Engl J Med. 2022 Jun 23;386(25):2363–2376. doi: 10.1056/NEJMoa2201445. Epub 2022 Jun 5. PMID: 35660797; PMCID: PMC9492301.

[11] https://www.fda.gov/news-events/press-announcements/fda-approves-first-drug-can-delay-onset-type-1-diabetes.

[12] https://www.niaid.nih.gov/news-events/monoclonal-antibody-prevents-malaria-infection-african-adults.

[13] https://www.nih.gov/about-nih/what-we-do/budget.

[14] https://unitedformedicalresearch.org/wp-content/uploads/2023/03/UMR__NIHs-Role-in-Sustaining-the-U.S.-Economy-2023-Update.pdf.

[15] See endnote 13.

[16] https://jamanetwork.com/journals/jama-health-forum/fullarticle/2804378.

[17] https://recovercovid.org/; https://www.nih.gov/research-training/medical-research-initiatives/radx; https://www.nih.gov/research-training/medical-research-initiatives/activ.

the success of today's biomedical research enterprise and help prepare us for tomorrow's scientific and workforce challenges. Congress must also provide NIH with the resources needed to boldly invest in the next generation of researchers, including trainees, to ensure that a career in biomedical research in the U.S. remains an attractive option to the best and brightest young minds from all around the world.

CONCLUSION

AAI greatly appreciates the subcommittee's history of strong bipartisan support for NIH and urges a base budget of at least $51 billion for FY 2024. Such a robust increase will help NIH invest in vital immunological research to facilitate the discovery of new ways to prevent, treat, and cure disease. It will also help support the growth and development of our outstanding biomedical research workforce and enhance our ability to provide funding for meritorious biomedical scientists at all career stages. In addition, AAI recommends the appropriation of substantial funding for ARPA–H, which has the potential to facilitate transformative medical and scientific breakthroughs, including in human immunology, that could address some of today's thorniest health and biomedical challenges.

[This statement was submitted by Peter E. Jensen, M.D., Chair, American Association of Immunologists.]

PREPARED STATEMENT OF THE AMERICAN ASSOCIATION OF NEUROLOGICAL SURGEONS

The American Association of Neurological Surgeons (AANS) and the Congress of Neurological Surgeons (CNS) urge the subcommittee to provide $11.5 million for Fiscal Year 2024 to fund the Military and Civilian Partnership for the Trauma Readiness Grant Program. The program is under the auspices of the U.S. Department of Health and Human Services, Administration for Strategic Preparedness and Response (ASPR).

The Military and Civilian Partnership for the Trauma Readiness Grant Program, formally known as MISSION ZERO, was signed into law as a part of the Pandemic and All-Hazards Preparedness and Advancing Innovation Act in 2019 (Public Law 116–22). This crucial initiative provides funding to ensure trauma care readiness by integrating military trauma care providers into civilian trauma centers. These partnerships allow our military trauma care providers to gain exposure to treating critically injured patients in our communities and keep their skills sharp to increase readiness for deployment. Additionally, they allow our civilian trauma care providers to gain insight into best practices from the battlefield that can be integrated into civilian trauma care.

Funding for this program will help improve access to life-saving trauma care and ensure that our Nation's military and civilian trauma surgeons are well prepared for every trauma injury—both at home and on the battlefield. Additionally, it will promote greater efficiency of emergency medical and trauma care.

This program was initially recommended as part of the National Academies of Science, Engineering, and Medicine 2016 landmark report, "A National Trauma Care System: Integrating Military and Civilian Trauma Systems to Achieve Zero Preventable Deaths After Injury." The report suggested that one in four military trauma deaths and one in five civilian trauma deaths could be prevented if advances in trauma care reached all injured patients. The report concluded that military and civilian integration is critical to saving these lives on the battlefield and at home, preserving the hard-won lessons of war, and maintaining the Nation's readiness and homeland security.

TRAUMA AS A PUBLIC HEALTH PROBLEM

The ability to deliver trauma care services—comprehensive specialized treatment to victims of blunt force or penetrating injuries, as well as burns—within an hour of injury, called the "golden hour," is critical to survival. In fact, according to the National Center for Health Statistics, traumatic injury—both intentional and unintentional—is the leading cause of death in the first four decades of life (ages one to 44).[1]

Additionally, traumatic injuries are a significant driver of health care costs. Total estimated lifetime medical and work loss costs associated with fatal and nonfatal injuries in the United States was $4.2 trillion in 2019, according to Morbidity and

[1] Centers for Disease Control and Prevention (CDC). National Center for Health Statistics. National Vital Statistics System, Leading Causes of Death. Available at https://www.cdc.gov/nchs/nvss/leading-causes-of-death.htm (last accessed on March 20, 2023).

Mortality Weekly Reports—six times higher than in 2013 ($671 billion). The costs associated with fatal injuries were $2.2 trillion, while nonfatal injuries accounted for over $2 trillion. The 2019 fatal injury cost is substantially higher than the similar estimate in 2013 ($214 billion). This difference reflects a 28% higher number of injury deaths in 2019.[2] In 2017–2018, there were 838.3 million hospital emergency department visits for unintentional injuries. In 2021, 200,955 Americans died due to violence and unintentional injuries.[3] Yet, the Federal investment in ensuring access to life-saving trauma care for all Americans is woefully lacking.

PREVALENCE OF TRAUMATIC BRAIN INJURY

Traumatic brain injury (TBI)—a bump, blow, or jolt to the head that disrupts the brain's normal function—is a major cause of death and disability in the U.S. More than 64,000 Americans died of a TBI-related injury in 2020—about 176 deaths each day. There were more than 223,000 TBI-related hospitalizations in 2019. Also, in 2019, about 15% of all high school students self-reported one or more sports or recreation-related concussions within the preceding 12 months.[4] Those who survive a TBI can face effects that last a few days or the rest of their lives, including impairments related to thinking or memory, movement, sensation (e.g., vision or hearing), or emotional functioning (e.g., personality changes, depression). These issues also have lasting effects on families and communities.

CONCLUSION

The "value" proposition for trauma care is well documented. The cost-efficient care provided by trauma centers, their specialist physicians, and the supporting trauma teams dramatically impacts quality of life. Therefore, as the subcommittee makes difficult choices to prioritize Federal investments in health care, we urge you to appropriate $11.5 million to implement the Military and Civilian Partnership for the Trauma Readiness Grant Program.

Thank you for considering our request.

PREPARED STATEMENT OF THE AMERICAN ASSOCIATION OF NEUROMUSCULAR & ELECTRODIAGNOSTIC MEDICINE

FISCAL YEAR 2024 RECOMMENDATIONS

—Please continue to provide meaningful, annual funding increases for healthcare fraud and abuse programs at the Centers for Medicare and Medicaid Services (CMS) while allowing for flexibility and innovation to address emerging challenges.

—Please provide the National Institutes of Health (NIH) with $50.9 billion in discretionary funding, an increase of $3.5 billion over FY 2023. Please also provide proportional increases for various NIH Institutes and Centers, including the National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS), the National Institute of Allergy and Infectious Diseases (NIAID).

—Please provide distinct, additional funding to support and further implement the new Advanced Research Projects Agency for Health (ARPA–H) at NIH to facilitate robust and swift scientific progress on a variety of neuromuscular conditions.

—Please provide the Centers for Disease Control and Prevention (CDC) with $11.6 billion to bolster support for public health programs that support patient communities, such as the National Neurologic Conditions Surveillance System (NNCSS).

Chairwoman Baldwin, Ranking Member Capito, and distinguished Senators of the subcommittee, thank you for the opportunity to present the views of the American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM) during the consideration of FY 2024 L–HHS appropriations. First and foremost, thank you for the ongoing investment in medical research, patient care, and healthcare fraud pre-

[2] CDC, Morbidity and Mortality Report (MMWR), Cost of Economic Injury-United States, 2019 https://www.cdc.gov/mmwr/volumes/70/wr/mm7048a1.htm.

[3] CDC, 10 Leading Causes of Death, United States, 2020, All Races, Both Sexes. Available at https://wisqars.cdc.gov/cgi-bin/broker.exe (last accessed on March 20, 2023).

[4] CDC, Traumatic Brain Injury & Concussion. Available at https://www.cdc.gov/traumaticbraininjury/get__the__facts.html (last accessed on March 20, 2023).

vention programs. Please maintain this investment and provide further support for FY 2024.

Concerning fraud and abuse, the challenges and opportunities that I will review today are not unique to AANEM but impact a variety of medical professional societies and patient communities who rely on proper EDX testing. My comments are provided in the interest of spotlighting serious issues that continue to undermine patient care and waste Federal healthcare resources. They are also intended to help advance policy tools to efficiently and effectively address these issues. In this regard, please consider the AANEM to be a resource moving forward. Thank you again for this important opportunity.

ABOUT AANEM

AANEM is a nonprofit membership association dedicated to the advancement of neuromuscular (NM), musculoskeletal, and electrodiagnostic (EDX) medicine. Our members-primarily neurologists and physical medicine and rehabilitation (PMR) physicians-are joined by allied health professionals and PhD researchers working to improve the quality of medical care provided to patients with muscle and nerve disorders. Founded in 1953, AANEM currently has nearly 6,700 members across the country. AANEM member physicians are dedicated to diagnosing and managing a variety of nerve and muscle disorders including, but not limited to, amyotrophic lateral sclerosis, muscular dystrophies, and neuropathies, as well as more common conditions, such as pinched nerves and carpal tunnel syndrome.

ABOUT EDX MEDICINE

When functioning properly, nerves send electrical impulses to the muscles to activate them. A nerve disorder means that signals are not getting through like they should. A muscle disorder means that muscles aren't responding to signals correctly. To determine whether your nerves and muscles are working properly, your doctor may recommend you have EDX testing, which generally includes both a nerve conduction study (NCS) and needle electromyography (EMG) testing. Other tests may include imaging, genetic testing, biopsies, biochemical tests, and strength testing. The results of these tests help your doctor diagnose your condition and determine the best treatment.

NCS.—These studies evaluate how quickly and efficiently electrical impulses move through the nervous system. While it may sound straight-forward, proper testing requires sophisticated equipment, an understanding of the patient's health history, and, most importantly, the ability to design/perform the study and interpret the results on-site and in real time.

EMG.—These tests evaluate muscles and nerves through the use of electrodes under the skin. Since the procedure is invasive and highly technical, it is considered to be the practice of medicine by the American Medical Association, requiring training, study, and experience to ensure patient safety and testing efficacy.

ABOUT EDX FRAUD AND ABUSE

In 2014, the HHS OIG published a report entitled, Questionable Billing for Medicare Electrodiagnostic Tests, which found roughly $140 million in suspicious activity annually. But experience tells us that this is just the tip of the iceberg. The toll of patient suffering and hardship as the result of fraudulent EDX testing is incalculable. Unfortunately, since this report was released, the situation has deteriorated rather than improved. Our members have continued to anecdotally note an increase in fraud activity (both through solicitations and by the number of patients they have to repeat testing on due to improperly performed previous tests), which appears to be supported by CMS utilization data. CMS revised the EDX codes in 2013 which has actually made it harder to identify systematic fraud and abuse in this area. Bad actors are aware of the gaps in the current CMS regulatory and enforcement framework that create unique blind spots for EDX testing, and this deficiency continues to be exploited with many criminal endeavors operating in the open for years as sham professional service providers (the small number that are caught and convicted annually has not served as a deterrent). To be clear, the victims continue to be the patients who are improperly subjected to a battery of poorly performed or even unnecessary tests and then are over-billed by these fraudulent providers who have no intention of providing an accurate diagnosis. Oftentimes, these patients were never in need of testing in the first place.

STATEMENT OF AANEM MEMBER DR. VINCE TRANCHITELLA

New NCS codes became effective on January 1, 2013. The new codes were developed as a direct response to fraudulent activity that had led to an exponential increase in billing for NCSs. Unfortunately, the new NCS codes failed to have the desired effect. My most recent fraud case involved 56 EDX studies, all of which were performed AFTER the NCS codes were changed in 2013, and every single one of the reports were deemed so far below the standard of care that none of them could be considered a reliable representation of the true medical status of the patients who received those tests. None of those tests should have been billed or reimbursed.

RECENT EXAMPLES FROM DR. PETER GRANT

EDX fraud wastes healthcare dollars, but, more importantly, the quality of patient care suffers. As an example, a recent case in which I testified in Houston working for the FBI and the US Attorney's Office, many patients' insurance companies were being billed more than $30,000 for a study that should cost $800 to $1200. Of note, when a detailed review was performed, more than 85% of the diagnoses arrived at with these fraudulent studies were incorrect and unreliable. These inappropriate and inaccurate studies did not help these patients find appropriate treatments or solutions to their medical problems. In fact, they often sent these patients down costly and ineffective paths of treatment. In this case alone, the perpetrators were convicted of EDX fraud totaling nearly $5 million.

As is invariably the case with mobile EDX laboratories, quality of care declines substantially while costs skyrocket and the real losers are, unfortunately, the patients. In a case I had in California, a 47-year-old man had a mobile EDX study done that cost him (and his insurance company) more than $7,500 and he was told that his symptoms were from a "pinched nerve in his leg". When I performed the correct study (charging about $750) I found his true diagnosis to be ALS (or Lou Gehrig's disease).

A case in Alabama earlier this year recently led to a guilty plea. According to the Justice Department, the provider conspired with... a Huntsville-based testing company, to bill insurers millions of dollars for electro-diagnostic testing that its technicians performed, regardless of whether there was a medical need for them. Insurers were then billed using the providers' National Provider Identifier (NPI) number, even where they did not conduct the tests, supervise the tests, interpret the test results, or have anything to do with the tests beyond allowing the NPI number to be used for billing purposes.

The fraud identified by the FBI for that case alone was $28 million. https://www.justice.gov/usao-ndal/pr/huntsville-doctor-charged-health-care-fraud-conspiracy.

Here is another recent fraud case from Alabama-https://www.al.com/business/2023/03/alabama-man-gets-more-than-6-years-in-prison-for-9-million-medical-testing-fraud.html.

And another national DoJ case from last year-https://www.justice.gov/usao-sdny/pr/us-attorney-announces-arrest-13-individuals-100-million-healthcare-fraud-money.

[This statement was submitted by Peter A. Grant, MD, EDX Fraud and Abuse Consultant for FBI and OIG, AANEM Past-President.]

PREPARED STATEMENT OF THE AMERICAN CANCER SOCIETY CANCER ACTION NETWORK

The American Cancer Society (ACS) is a nationwide, non-profit health organization dedicated to eliminating cancer as a major health problem. ACS exists because the burden of cancer is unacceptably high. With the goal to improve the lives of cancer patients and their families, ACS stands on three pillars to reduce the National cancer burden—through research, advocacy, and patient support. Notably, ACS is the largest nonprofit funder of cancer research outside the U.S. government, complemented by ACS research that tracks cancer trends in incidence and mortality each year across every area in the Nation. Our advocacy arm, ACS CAN, works at the local, State, and national levels to enhance access to these discoveries and to reduce cancer disparities. Finally, ACS patient support activities are conducted in thousands of communities across the Nation, touching more than 50 million lives per year through enhancing cancer prevention and screening, educating the public, patients, their caregivers and survivors, as well as offering direct services such as providing transportation, navigation, and lodging free of charge to patients in need.

Put simply, the 1.9 million Americans diagnosed each year with cancer are counting on us, and counting on the collaboration amongst the private sector, healthcare systems, and Federal agencies to work together toward progress against the 200 dif-

ferent diseases we call "cancer." Today, 1 in 3 women and 1 in 2 men over their lifetime can expect to hear the words "you have cancer."[1] However, we are at an unprecedented time in history, wherein discoveries have been converted into meaningful progress in cancer prevention, detection, treatment, and in some cases, cure.

Since 1991, when there was a formidable increase in cancer research funding, cancer mortality rates have declined by 33 percent. In total, more than 3.5 million deaths from cancer have been averted due to cancer research funding. It is clear that cancer research does indeed save lives, and more than ever before, the gap between discovery and clinical intervention has narrowed and emboldened a generation of new cancer researchers to strive for better interventions to support patients and their families from prevention to treatment through survivorship. Indeed, the last 10 years alone have resulted in the addition of an entirely new class of cancer therapeutics in the form of immunotherapy, complementing previous standards of surgery, chemotherapy, and radiation therapy. Research has also resulted in the development and implementation of a highly effective vaccine protecting against HPV (human papilloma virus) driven cancers.

Despite considerable gains, much work remains to reduce the burden of cancer. Overall, cancer is the second leading cause of death in the U.S., with more than 600,000 individuals predicted to die from cancer in this year alone. The scientific community has shown that investment in cancer research yields returns in lives saved and is poised to take on these challenges to further reduce death and suffering from cancer. Equally important is investment in research that seeks to understand and measurably mitigate deep disparities that exist in cancer outcomes.

For example, we know that, after skin cancer, prostate cancer is the most common cancer in American men. The American Cancer Society's estimates that in 2023, there will be approximately 288,300 new cases of prostate cancer and approximately 34,700 deaths. While, on average, around one out of eight men will be diagnosed with prostate cancer during his lifetime, Black men are more likely to face this disease, with Black men being 1.7 times more likely to be diagnosed with prostate cancer—and 2.1 times more likely to die of it—than white men.

It is critical the Nation continues its investment in order to further our progress against cancer; therefore, we urge Congress to provide the following funding levels:

NIH ($51 billion); NCI ($9.988 billion): Funding for clinical trials through the NCI is a vital resource through which Americans across the country benefit from research breakthroughs that can be lifesaving. As a data-driven organization dedicated to improving the lives of cancer patients and their families, ACS CAN strongly supports strong funding for cancer research. There has never been a more important time to invest in cancer research, and therefore, to invest in protecting Americans against the second leading cause of death in this country. Progress has been remarkable, and the U.S. scientific community stands ready to accelerate. The 1.9 million Americans who will face cancer diagnosis this year are counting on us. On behalf of all of those we serve, and their families, for Fiscal Year 2024 the American Cancer Society Cancer Action Network urges Congress to provide $51 billion for the NIH base budget, a $3.5 billion increase over the comparable FY 2023 funding level, with an inclusion of $9.988 billion for the NCI. Such an allocation would allow the NIH's base budget to keep pace with the biomedical research and development price index and provide meaningful growth. Such an investment is not only required to accelerate progress against cancer but will provide a needed boost toward maintaining a position of leadership in cancer discovery. Notably, more than 80 percent of Federal funding for the NIH is spent on biomedical research projects at research facilities across the country.

NIH research funding also supported more than 560,000 jobs and more than $96 billion in economic activity in FY2022. Our recommendation of $9.988 billion for the NCI is all the more critical. Given the explosion in impactful discoveries, NCI is currently experiencing a demand for research funding that is far beyond that of any other Institutes or Centers. Between FY2013 and FY2022, the number of unique R01/R37 grant applicants to NCI rose by 45 percent, compared to 20 percent at all other Institutes or Centers during that time. Simply put, six out of every seven grants currently go unfunded.

This is a situation unique to NCI, at a time when cancer researchers are making historic advances in new treatments and therapies. We therefore urge Congress to sustain and increase the pace of discovery through robust enhanced NCI funding and ensure that progress against cancer continues. In short, investment in NCI and

[1] American Cancer Society. Cancer Facts & Figures 2023. Atlanta: American Cancer Society; 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.

NIH is an investment in the American people, and in the American scientific enterprise.

ARPA–H ($1.5 billion): ARPA–H holds the potential to quickly bridge the gap between the research lab and patient by focusing on bold, high-potential and high-impact applied research projects. Its potential for transformative breakthroughs in cancer and other diseases should be supported at least at its current funding level. Importantly, however, funding for ARPA–H should supplement the $51 billion recommendation for NIH's base budget rather than supplant the essential foundational investment in the NIH and NCI.

CDC's DCPC ($472.4 million): About half of the over 600,000 cancer deaths that will occur this year could be averted using existing evidence-based prevention and early detection strategies, many of which are supported by the Centers for Disease Control's Division of Cancer Prevention and Control. Given its important role in cancer prevention, we therefore recommend that CDC's DCPC receive $472.4 million in funding.

We also encourage Congress to adopt the following report language:

NIH OD: Palliative Care, Trans-Institute Strategy: Palliative care is specialized medical care for people living with a serious illness and is focused on treating the discomfort, symptoms, and stress of such illness. Palliative care improves patient care, patient-clinician communication, and patient-centered outcomes while decreasing unwanted burdensome treatments and enhancing quality of life for people with serious illness, their loved ones, and their care partners. The Committee provides $12,500,000 for National Institute of Aging (NIA) to implement a trans-Institute, multi-disease strategy to focus, expand, and intensify national research programs in palliative care. Funding would establish a comprehensive multi-Institute and multi-Center initiative aimed at a wide variety of palliative care research, training, dissemination, and implementation of projects to intensify the strategic coordination of palliative care research efforts. Funding is provided to establish an extramural-based palliative care consortium with no less than three sites to provide technical assistance, pilot and exploratory grant funding, research dissemination, data repositories, data analytics, and career development support for interdisciplinary palliative care. Of this amount, at least $3,000,000 is provided for several multi-year, early-career development grants modeled after NIA's GEMSSTAR program. Funding provided in fiscal year 2024 for training is expected to cover 2 years of funding for career development awards. The Committee requests a briefing 120 days after enactment of this act on how this strategy will be established and implemented, including timelines on when funding opportunities will be issued and funding will be awarded.

CDC: Prostate Cancer: The Committee is aware of the continued rise in prostate cancer deaths and supports the CDC's work to increase public awareness of prostate cancer risks, screening, and treatment in high-risk men. The Committee provides $20,000,000 for the CDC's prostate cancer activities, including $7,000,000 for initiatives to increase outreach and education among high-risk men, especially African American men.

As I stated at the beginning of my testimony, ACS exists because the burden of cancer is unacceptably high. So, I thank you for your continued leadership on funding issues important to improving the lives of cancer patients and their families. Funding for cancer research must continue to be a top bipartisan priority in order to increase the pace of progress to reduce the burden of cancer nationwide.

[This statement was submitted by Lisa Lacasse, President, American Cancer Society Cancer Action Network.]

PREPARED STATEMENT OF THE AMERICAN COLLEGE OF CARDIOLOGY

The American College of Cardiology (ACC) is the global leader in transforming cardiovascular care and improving heart health for all. As the preeminent source of professional medical education for the entire cardiovascular care team since 1949, and now with more than 56,000 members from over 140 countries, the ACC credentials cardiovascular professionals who meet stringent qualifications and leads in the formation of health policy, standards and guidelines. The College is committed to ensuring a world where science, knowledge and innovation optimize patient care and outcomes. To advance these goals, ACC urges members of Congress to appropriate the following funds towards agencies doing vital work in cardiovascular disease (CVD) treatment and prevention:

—$51 billion for the National Institutes of Health (NIH), with $4.273 billion going towards the National Heart Lung & Blood Institute (NHLBI) and $121 million to the NIH Office of Nutrition and Health; and,

—funding for the following programs at the Centers for Disease Control and Prevention (CDC):
—$14 million for the Million Hearts Initiative
—$160 million for the Division for Heart Disease and Stroke Prevention
—$46.7 million for the WISE WOMAN program
—$310 million for the Office on Smoking and Health.

More information on each of these requests is described further below.

NATIONAL INSTITUTES OF HEALTH

ACC would like to thank Congress for recent funding increases for the National Institutes of Health (NIH) in FY 2023. Past support of NIH funding has been instrumental in advancing research in the field of cardiovascular medicine, leading to significant innovations in the care of patients with heart disease.

NIH funding has been critical in supporting basic and clinical research, leading to innovative treatments and preventive measures for CVD, such as statins, ACE inhibitors, and newer anticoagulants. NIH funding has also supported groundbreaking research into understanding the genetic basis of heart disease, which has led to the development of new and more effective therapies.

While the College applauds Congress's past support, more work is needed. CVD remains the leading cause of death among men and women in the United States and is responsible for one in every five deaths nationally. More than 92 million Americans currently suffer from some form of CVD—nearly one-third of the population—but it remains one of the most underfunded fatal diseases, as the NIH only invests four percent of its research dollars in heart research. Despite reduced capacity to fund grants and support new discoveries, the NIH continues to enhance and save millions of lives. The heart disease death rate has continued to drop since the 1970s due to scientific advances and improved heart medications and procedures—but to meet the challenges of an aging population, rising obesity rates and unhealthy diets, the NIH must be at the forefront of medical innovation for years to come. Since many life-saving interventions related to heart disease result from investments in medical research, ACC recommends that the NIH be funded at $51 billion for fiscal year (FY) 2024.

The National Heart, Lung, and Blood Institute (NHLBI) is an essential component of the NIH that conducts and supports research aimed at preventing, diagnosing, and treating heart, lung, and blood diseases. These conditions, which include heart disease, stroke, asthma, and atrial fibrillation, among others, are among the leading causes of death and disability in the United States. The NHLBI has made significant contributions to the understanding and treatment of these conditions through its support of basic, translational, and clinical research. For example, the institute has played a critical role in developing life-saving treatments for heart attack and stroke, including clot-dissolving drugs and interventions such as stents. The NHLBI has also supported impactful research into the genetics of cardiovascular disease, which has led to the development of personalized treatments based on an individual's genetic profile. Therefore, ACC recommends that NHLBI be funded at $4.273 billion to maintain current activities and investment toward new research and emerging technologies related to heart disease.

The Office of Nutrition Research (ONR) has recently been relocated within the NIH to reside within the NIH Office of the Director and is dedicated to advancing nutrition research to improve public health outcomes. The ONR supports and coordinates nutrition research efforts across the NIH and provides leadership in developing research priorities related to nutrition and diet. Investment in the ONR will accelerate nutrition science discoveries and advance the understanding of nutrition's role in preventing and treating chronic diseases, such as obesity, diabetes, and heart disease. Approaching food as a form of preventative medicine can positively impact cardiovascular health as well as health equity and its major drivers (high blood pressure, abnormal blood cholesterol, and Type 2 diabetes). Therefore, the College urges Congress to allocate $121 million to the ONR in FY 2024.

CENTERS FOR DISEASE CONTROL AND PREVENTION

The College also recognizes the significant role of the Centers for Disease Control and Prevention (CDC) and its critical work in preventing heart disease in the United States. The CDC works with a wide range of partners, including other Federal agencies, State and local health departments, and community organizations, to promote cardiovascular health and prevent heart disease through various programs and initiatives.

One of the CDC's key initiatives for preventing heart disease is its Million Hearts program, which aims to prevent 1,000,000 heart attacks and strokes within 5 years.

The program focuses on implementing evidence-based strategies and targets to improve cardiovascular health for all Americans. The initiative aims to achieve this goal by encouraging the public to lead a healthy and active lifestyle, as well as improving medication adherence for aspirin and other medications to manage blood pressure, cholesterol, and smoking cessation. Therefore, ACC recommends that Million Hearts be funded at $14 million to enhance efforts preventing heart attacks and strokes.

The CDC Division for Heart Disease and Stroke Prevention supports efforts to improve cardiovascular health by promoting healthy lifestyles and behaviors, healthy environments, and access to early treatment and affordable detection. The division engages with State and local health departments and a variety of other partners to provide funding and resources, conduct research, track risk factors, and evaluate current programs and policies relating to heart disease. ACC recommends funding the CDC Division for Heart Disease and Stroke Prevention at $160 million to continue its critical initiatives among America's most vulnerable communities.

A key initiative within the Division for Heart Disease and Stroke Prevention is the WISEWOMAN program which aims to improve the heart health of low-income, uninsured, or underinsured women aged 40 to 64 years who are enrolled in the CDC's National Breast and Cervical Cancer Early Detection Program (NBCCEDP), which helps ensure women participating in the NBCCEDP receive a full range of health services. WISEWOMAN is an evidence-based program that has been shown to be effective in reducing the risk of heart disease among participants. Women who participate in the program are more likely to have their blood pressure, cholesterol, and blood glucose levels under control, as well as engage in healthy lifestyle behaviors. ACC encourages lawmakers to build upon the program's past success and provide $46.7 million to the WISEWOMAN program in FY 2024.

The Office of Smoking and Health (OSH) is a department within CDC dedicated to reducing tobacco use's impact on public health. The OSH works to prevent and reduce tobacco use by providing evidence-based research, developing and implementing comprehensive tobacco control programs, and supporting policies that promote tobacco-free environments. Additionally, OSH offers educational materials and support for individuals who want to quit smoking, as well as information for healthcare providers to help them support their patients in quitting smoking. ACC urges Congress to provide OSH with a funding level of $310 million in FY 2024 to continue leading the Nation's efforts in preventing chronic disease caused by tobacco use.

CONCLUSION

On behalf of the ACC's members who work to prevent and treat CVD, ACC would like to thank members of the Appropriations subcommittee for supporting medical innovation as we continue the fight against heart disease. Stable funding for research, surveillance, and healthy lifestyle promotion will save lives and lower healthcare costs in the long term. Please help secure robust NIH and CDC funding to protect our Nation's health for future generations.

For further information about cardiovascular research or ACC's FY 2024 requests, please contact Foster Curry, Congressional Affairs Manager, at FCurry@acc.org.

Sincerely.

[This statement was submitted by B. Hadley Wilson, MD, FACC, President, American College of Cardiology.]

PREPARED STATEMENT OF THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

The American College of Obstetricians and Gynecologists (ACOG), representing more than 60,000 physicians and partners dedicated to advancing the health of individuals seeking obstetric and gynecologic care, is pleased to offer this statement to the Senate Committee on Appropriations, subcommittee on Labor, Health and Human Services, Education, and Related Agencies. We thank Chair Baldwin, Ranking Member Capito, and the entire subcommittee for this opportunity to provide comments on some of the most important programs to support and advance the health of individuals seeking obstetric and gynecologic care.

ACOG commends Congress for making strides in advancing research and data collection to improve the health of individuals seeking obstetric and gynecologic care and their families. Looking ahead, we urge you to make funding of the following programs and agencies a priority in FY24:

—Centers for Disease Control and Prevention (CDC): At least $11.581 billion for the CDC, including $164 million for the Safe Motherhood Initiative;
—National Institutes of Health (NIH): $50.924 billion for the NIH, including at least $1.877 billion for the Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD), and $35 million for CDC and $25 million for NIH to conduct research into firearm morbidity and mortality prevention;
—Health Resources and Services Administration (HRSA): $1 billion for the Title V Maternal and Child Health Block Grant, including $15.3 million for the Alliance for Innovation on Maternal Health (AIM);
—Office of Population Affairs (OPA): $512 million for the Title X Family Planning Program; and
—$500 million for the Agency for Healthcare Research and Quality (AHRQ).

Safe Motherhood and Infant Health Program; Maternal Mortality Review Committees and Perinatal Quality Collaboratives at the CDC: The United States has the highest rate of maternal mortality and severe morbidity of any developed country. The Safe Motherhood Initiative at CDC works with State health departments to collect information on pregnancy-related deaths, supports maternal mortality review committees, tracks preterm births, and improves maternal outcomes through perinatal quality collaboratives. Important strides have been made as nearly every State either currently has, is in the process of implementing, or is making plans to develop a State maternal mortality review committee. We must continue to build on this progress and improve maternal health outcomes. ACOG requests that you fund the Safe Motherhood Initiative at $164 million to help States expand or establish maternal mortality review committees and State-based perinatal quality collaboratives.

Women's Health Research at the NIH: Women represent half of the US population. As such, conditions and diseases that are specific to women's health, or those that present differently in women than men, must be a priority for federally-funded research. Women's health research is a central part of the research mission and portfolio of NICHD, and the Institute has achieved great success in advancing research on women's health throughout the life cycle; maternal, child, and family health; fetal development; reproductive biology; population health; and medical rehabilitation. With sufficient resources, NICHD can build upon its existing initiatives to produce new insights and solutions to benefit all individuals seeking obstetric and gynecologic care and their families. ACOG supports an appropriation of $50.924 billion for the NIH in FY24, including $1.877 billion for NICHD.

Advancing Maternal Therapeutics at the NIH: Each year, more than 4 million individuals give birth in the United States and more than 3 million breastfeed. However, little is known about the effects of most drugs on the woman and her child. In 2015 as part of the 21st Century Cures Act (Sec. 2041 of Public Law 114–255), Congress created the Task Force on Research Specific to Pregnant Women and Lactating Women (PRGLAC) to advise the Secretary of HHS on gaps in knowledge and research on safe and effective therapies for pregnant and breastfeeding individuals. In 2018, PRGLAC produced a report to the Secretary outlining 15 recommendations to facilitate the inclusion of this population in clinical research, and in 2020 an implementation plan was published. ACOG supports the implementation of these recommendations under the oversight of NICHD, working with other relevant NIH Institutes, the CDC, and the Food and Drug Administration, and urges Congress to express its continued support.

Firearm Morbidity and Mortality Prevention (CDC and NIH): In 2020, there were more than 45,000 U.S. firearm-related fatalities. Federally funded public health research has a proven track record of reducing public health-related deaths, whether from motor vehicle crashes, smoking, or Sudden Infant Death Syndrome. This same approach should be applied to increasing gun safety and reducing firearm-related injuries and deaths, and CDC research will be as critical to that effort as it was to these previous public health achievements. The foundation of a public health approach is rigorous research that can accurately quantify and describe the facets of an issue and identify opportunities for reducing its related morbidity and mortality. For FY24, ACOG requests $35 million for CDC and $25 million for NIH to conduct public health research into firearm morbidity and mortality prevention.

Programs to Improve Maternal Health at HRSA: The Title V Maternal and Child Health (MCH) Block Grant at HRSA is the only Federal program that exclusively focuses on improving the health of mothers and children. The Block Grant is a cost-effective, accountable, and flexible funding source used to address critical, pressing, and unique needs of maternal and child health populations in each State, territory, and jurisdiction. HRSA has also invested in the Alliance for Innovation on Maternal Health (AIM), a program that works with States and hospital systems to implement

evidence-based toolkits to improve maternal outcomes and reduce rates of maternal mortality and severe morbidity. For FY24, ACOG requests $15.3 million to support continued implementation of AIM.

Public Health Surveillance at CDC: Uniform, accurate, and comprehensive data is essential for addressing the rising rates of maternal mortality and severe maternal morbidity in the US. Unfortunately, the Nation's public health data systems are antiquated, lack interoperability and data and reporting standards, and are in dire need of security updates. ACOG urges Congress to include a robust investment in public health surveillance, and requests Federal investment to modernize these systems to improve health. ACOG requests $340 million in FY22 for public health surveillance at CDC to implement advanced technologies and train the next generation of data scientists.

Title X Family Planning Program within OPA: Title X is the only Federal program dedicated to providing family planning services for people with low incomes. For many individuals, particularly those who are low-income, uninsured, or adolescents, Title X is essential to their ability to affordably and confidentially obtain birth control, cancer screenings, STI tests and other basic care. Title X has been cut or flat-funded every year for the past decade, and a significant investment is needed to support robust restoration of the program and ensure demand for services is met. ACOG requests $512 million for Title X in FY24 to ensure individuals in need have access to evidence-based care. ACOG urges Congress to show its strong support for transparent, respectful, evidence-based, and comprehensive reproductive health care by funding this critical program.

Investing in Data and Quality at AHRQ: AHRQ is the Federal agency with the sole purpose of improving health care quality. AHRQ produces data with the mission of making health care safer, higher quality, more accessible, equitable, and affordable. AHRQ works with HHS and other partners to ensure that the evidence improves patient safety. ACOG supports $500 million for AHRQ in FY24, which reflects the FY10 funding level for the agency adjusted for inflation and additional funding to respond to the pandemic.

Thank you again for the opportunity to submit our recommendations to the subcommittee, and for your commitment to improving the health of all individuals seeking obstetric and gynecologic care.

[This statement was submitted by Drew Hatter, Federal Affairs Strategist.]

PREPARED STATEMENT OF THE AMERICAN COLLEGE OF OCCUPATIONAL AND ENVIRONMENTAL MEDICINE

Chair Baldwin, Ranking Member Capito, and members of the subcommittee, on behalf of the American College of Occupational and Environmental Medicine (ACOEM) and its 4,000 members, I write to urge you to continue investing in our Nation's health by funding and providing direction on critical health workforce programs applicable to the medical specialty of occupational and environmental medicine (OEM). OEM is a board-certified specialty under the American Board of Preventive Medicine (ABPM) that focuses on the diagnosis and treatment of work-related injuries and illnesses. Founded in 1916, ACOEM is the Nation's largest medical society dedicated to promoting employee health through preventive medicine, clinical care, research, and education. The College represents physicians and other healthcare professionals specializing in OEM who are devoted to promoting optimal health and safety of workers, workplaces, and environments.

As you deliberate on the critical programs to be funded in the FY24 appropriations bills, we respectfully request that $22 million be provided to HRSA's Public Health and Preventive Medicine programs (Public Health Workforce Development), with no less than $12 million allocated to the Preventive Medicine Residency Training Program (PMR)—Authorized under 42 USC 295c. Additionally, we request that direction be provided to HRSA to set aside at least 30 percent of the total PMR funds for awards to OEM residency programs. There is a dire workforce gap concerning the available supply of OEM physicians needed to serve our Nation. This situation will not improve absent dedicated support, as most traditional Federal support pathways for medical specialty training are unavailable to OEM residency programs.

OEM is the medical specialty that focuses on the health of workers, including the ability to perform work; the physical, chemical, biological, and social environments of the workplace; and the health outcomes of environmental exposures. OEM physicians possess a comprehensive skillset essential to protecting the health and well-being of employees and the broader public. Unfortunately, the critical and long-standing shortage of specialized OEM physicians available to meet the needs of

166.69 million workers and their employers across the United States is worsening. Absent strategic and dedicated investment, this workforce shortage is expected to be exacerbated due to the rate of OEM physician retirements vastly outpacing the training of new board-certified OEM specialists.

The previous cycle of the HRSA Preventive Medicine Residency Training Program provided funding to 17 medical residency programs—with only two going to dedicated OEM programs. Additionally, a recent HRSA grant solicitation for the 2023–2027 PMR program period was designed in such a way that limited its accessibility to OEM programs, as opposed to public health and general preventive health medicine programs.

Dedicated funding for training the next generation of OEM physicians would directly benefit U.S. workers and their employers, as companies with unique workplace settings and exposures often utilize their specialized expertise. OEM physicians assist the companies and American workers that bear the most significant burden during any public health emergency and ensure they are better prepared to minimize the effects of such emergencies to maintain operational effectiveness.

The COVID–19 pandemic exposed severe deficits in the U.S. public health infrastructure, with most of the workforce lacking appropriate support for workplace health and safety. The overwhelming majority of workers have no practical benefit from the expertise of OEM practitioners. Often, small and mid-sized companies lack expertise on these issues and are left to interpret complex guidance and regulations. The pandemic brought a clearer vision to organizations of the role of OEM in protecting their employees' health. The pandemic has also forced organizations to look for public health expertise to help contain the virus and has demonstrated the value of occupational safety and health (OSH) professionals, in particular OEM physicians. During the pandemic, OEM physicians provided businesses with tailored assistance on subjects such as surveillance and testing, exposure management, quarantine, work in isolation, personal protective equipment allocation, workplace safety, return-to-work policies, and interpretation of local, State, and Federal public health guidance. They kept the energy, utilities, food distribution, transportation modes, healthcare, and first responders healthy and functioning. Without OEM physicians keeping critical infrastructure sectors operational, many Americans would have been left at home in the dark, cold, and hungry.

OEM physicians are highly trained with 3 years of post-graduate, post-medical school training and are required to complete an MPH or equivalent degree. Unlike most medical residency training programs, OEM programs do not routinely receive Medicare funding through CMS. Current funding through NIOSH, the VA, and HRSA falls short of the total OEM training funding necessary to bridge the gap between the supply of OEM physicians and our Nation's needs.

Notably, inconsistency of available funding and decline in overall funding over the past few decades has been a driver in OEM residency programs being closed. Unfortunately, due to the lack of funding, most OEM residency programs cannot fill their resident slots. In past academic years, OEM training programs were typically only able to fund around 60% of residency slots authorized by the Accreditation Council for Graduate Medical Education (113 residents in training/187 positions approved—2022). This lack of funding for OEM training has created a significant gap in the needs of employers and the workforce.

As of 2022, there were only 3068 Board Certified OEM physicians in the U.S., with an average age of 61. The number of newly board-certified OEM specialists declined from a high of 229 in 1997 to 90 in 2021, falling below 100 for the first time in 2001. In a 2022 survey of OEM residency directors, 50% said they considered giving up the role that year partly due to uncertainty surrounding program funding. These challenges, taken in concert with an understanding of the growing need for American businesses to have access to physicians specializing in physical, chemical, biological, and social environments of the workplace and the health outcomes of environmental exposures, underscore ACOEM's position that there is a dire need to shore up the OEM training pipeline.

Despite more critical funding needs among OEM programs and employers looking for physicians specializing in OEM, in the past, HRSA has disproportionately awarded funding to programs in public health and general preventive medicine. HRSA continues to solicit grant applications and apply requirements for the 2023–2027 PMR program period in a manner that favors public health and general preventive medicine programs over OEM programs. Although HRSA purports that PMR program eligibility is extended to all three preventive medicine specialties (Occupational & Environmental Medicine, Aerospace Medicine, and Public Health & General Preventive Medicine), however, program requirements have been embedded that do not fit in with the core material required for OEM residents to complete their occupational medicine boards successfully. This approach has had the de facto

impact of precluding OEM residency programs from submitting competitive applications for workforce training funding assistance unless they retool the residency program curriculum to include components unrelated to the specialty. Additionally, we strongly recommend that HRSA be directed to streamline the PMR program to account for residency programs that have already been accredited and/or vetted. For example, many OEM programs serve as NIOSH Education and Research Centers. Onerous grant solicitation processes can further discriminate against programs with limited staff and resources to respond and pursue disparate grants.

OEM providers develop deep knowledge of various industries, establishing careers across a broad spectrum of sectors such as clinical care, corporate medicine, public health and regulatory sectors, academia, and research. This expertise empowers them to create policies and protocols that integrate the needs of employers and workers with guidance from NIOSH, OSHA, CDC, and other agencies. Employers that can access the services of OEM physicians can benefit from increased health and safety for workers on-the-job and when returning to work, which can help minimize workers' compensation (WC) costs and result in significant cost savings to employers. OEM physicians appreciate that illness and injury, both in and outside the workplace, can have social, practical, and financial impacts on employers and the U.S. economy as a whole. Additionally, their effect on population health delivers healthier workers to the Medicare system as they enter retirement age.

We appreciate that Congress has recognized the value of HRSA's Preventive Medicine Residency Training Program in the past, and ACOEM thanks the subcommittees for their providing the opportunity to offer feedback and recommendations throughout the FY24 process. Below is proposed complimentary report language for your review and consideration. We are available and willing to engage if you have any questions concerning our request or would like to meet to discuss these critical programs. Thank you for your ongoing support of programs to bolster the U.S. health workforce and commitment to improving health for all Americans.

Sincerely.

[This statement was submitted by Kenji Saito, MD, JD, FACOEM, President, American College of Occupational and Environmental Medicine.]

Proposed Report Language:

HRSA, Health Workforce, Health Professions Education and Training

Public Health and Preventive Medicine. The Committee provides $22,000,000, an increase of $4,000,000, for Public Health Workforce Development. This program line, also called Public Health and Preventive Medicine, funds programs that are authorized in titles III and VII of the PHS Act (Public Law 111–148) and supports awards to schools of medicine, osteopathic medicine, public health, and integrative medicine programs. The $4,000,000 increase is provided for the Preventive Medicine Residency Training Program, with a preference for Occupational and Environmental Medicine residency training programs. Within the total funding provided for the Preventive Medicine Residency Training Program, at least 30 percent shall be set-aside for awards to Occupational and Environmental Medicine residency programs, and HRSA shall administer the award process in a manner that does not inadvertently preclude such programs from eligibility.

PREPARED STATEMENT OF THE AMERICAN COLLEGE OF PHYSICIANS

The American College of Physicians (ACP) is pleased to submit the following outside witness testimony for the record on its priorities, as funded under the U.S. Department of Health & Human Services, for Fiscal Year (FY) 2024. ACP is the largest medical specialty organization and the second-largest physician group in the United States. College members include 160,000 internal medicine physicians, related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness. As the subcommittee begins deliberations on appropriations for FY2024, ACP is urging funding for the following proven programs to receive appropriations from the subcommittee:

—Health Resources Services Administration (HRSA), $10.5 billion, including: Health Workforce, National Health Service Corps (NHSC), $860 million in total program funding; Primary Care Training and Enhancement (PCTE), $71 million; Title X Family Planning Program, $512 million;

—Centers for Disease Control and Prevention (CDC) Injury Prevention and Control, Firearm Injury and Mortality Prevention Research, $35 million; Chronic

Disease Prevention and Health Promotion, Social Determinants of Health, $100 million;

—National Institutes of Health (NIH) Office of the Director, Firearms Research, $25 million;

The United States is facing a physician workforce shortage that is projected to increase to 17,800 to 48,000 by 2034. Therefore, it is imperative to address the physician shortage in general internal medicine and family medicine-the specialties that furnish to most adult and adolescent patients. Evidence clearly shows that increasing the number of primary care physicians (PCPs) helps reduce mortality. People living in counties with only one PCP per 3,500 persons have a life expectancy almost a year less than those individuals living in counties above that level. To reach the one PCP per 3,500 persons ratio in those counties (the Health Resources and Services Administration's (HRSA) threshold of a primary health care shortage area) would require an additional 17,651 PCPs, about 15 more physicians per county. Without critical funding for vital workforce programs, this physician shortage will only grow worse. A report by the National Academy of Sciences, Engineering and Medicine calls on policymakers to increase our investment in primary care as evidence shows that it is critical for achieving health care's quadruple aim (enhancing patient experience, improving population, reducing costs, and improving the health care team experience).

Therefore, we urge the subcommittee to provide $10.5 billion for HRSA programs for FY2024 to improve the care of medically underserved Americans by strengthening the health workforce. The College urges at least $860 million in total program funding for the NHSC in FY2024. The NHSC awards scholarships and loan repayment to health care professionals to help expand the country's primary care workforce and meet the health care needs of underserved communities across the country. In FY2023, with a projected field strength of 20,000 clinicians including over 2,600 physicians, NHSC members are providing culturally competent care to a target of over 15 million patients at more than 18,000 NHSC-approved health care sites in urban, rural, and frontier areas. These funds would help maintain NHSC's field strength by helping to address the health professionals' workforce shortage and growing maldistribution. The $800 million in supplemental American Rescue Plan Act (ARPA) funds have enabled the NHSC to award all qualified applicants to the NHSC scholarship program and loan repayment programs. Accordingly, ACP urges the doubling of the scholarship and loan repayment programs by increasing NHSC's overall program funding to $860 million to meet this need and to sustain the NHSC when ARPA funding for the NHSC is expended.

The health professions' education programs, authorized under Title VII of the Public Health Service Act and administered through HRSA, support the training and education of health care clinicians to enhance the supply, diversity, and distribution of the health care workforce. Within the Title VII program, we urge the subcommittee to fund the Section 747 PCTE program at $71 million in FY2024, to expand the pipeline for individuals training in primary care. ACP urges more funding because the Section 747 PCTE program is the only source of Federal training dollars available for general internal medicine, general pediatrics, and family medicine. For example, general internists, who have long been at the frontline of patient care, have benefitted from PCTE grants for primary care training in rural and underserved areas that have helped prepare physicians for a career in primary care.

Also, within HRSA, ACP supports the administration's request for $512 million for Title X Family Planning in FY2024. The College has extensive policy supporting programs that provide access to essential family planning services, such as Title X. ACP believes that it is essential for women to have access to affordable, comprehensive, nondiscriminatory public or private health care coverage that includes evidence-based care over the course of their lifespans. Accordingly, women should have sufficient access to evidence-based family planning and sexual health information and the full range of medically accepted forms of contraception which can be accessed through Title X Family Planning programs.

The Center for Disease Control and Prevention's mission is to collaborate to create the expertise, information, and tools needed to protect their health—through health promotion, prevention of disease, injury, and disability, and preparedness for new health threats. Within the CDC, the College also supports $35 million for the CDC's Injury and Prevention Control to fund research on firearm Injury and mortality prevention research and support 10 to 20 multi-year studies to continue to continue to rebuild lost research capacity in this area. ACP greatly appreciates funding for this research in FY2020, FY2021, FY2022, and FY2023 after many years of no Federal resources for researching the prevention of firearms-related injuries and deaths. More than ever, this research is needed. In 2021, 45,222 Americans lost their lives

due to firearms, according to the CDC. There were 647 mass shootings in the U.S. in 2022 alone.

The College also supports the administration's budget request of $100 million for the Social Determinants of Health within Chronic Disease Prevention and Health Promotion programs. The public health emergency (PHE) caused by COVID–19 has highlighted the urgent need to collect racial, ethnic, and language preference demographic data on testing, infection, hospitalization, and mortality during a pandemic and on a routine basis when the PHE ends. These data should be shared with local, State, territorial, and Tribal governments. Frequent, granular, and high-quality disaggregated demographic data are needed to fully understand the impact on racial and ethnic minority communities and better offer targeted care not only for COVID–19, but for health care overall.

Lastly, ACP supports $25 million for research related to the prevention of firearms injury and mortality within the NIH Office of the Director. As discussed above, initial investments are important, but increased funding is still needed to overcome the decades-long lack of Federal funding that set back our Nation's response to the public health issue of firearm-related morbidity and mortality, including the NIH's research on the determinants of firearm injury, the identification of those at risk, and the evaluation of innovative interventions.

The College greatly appreciates the support of the subcommittee on these issues and looks forward to working with Congress during the FY2024 appropriations process.

[This statement was submitted by Jared Frost, Manager, Legislative Affairs, American College of Physicians.]

PREPARED STATEMENT OF THE AMERICAN COLLEGE OF RADIOLOGY

Chair Baldwin, Ranking Member Capito, and members of the subcommittee, I am Dr. William T. Thorwarth, Chief Executive Officer of the American College of Radiology (ACR), a professional association representing more than 41,000 diagnostic radiologists, interventional radiologists, radiation oncologists, nuclear medicine physicians and medical physicists. On behalf of the ACR we are honored to present this testimony in support of robust appropriations for biomedical research at the National Institutes of Health (NIH). ACR urges the subcommittee to provide at least $50.9 billion to the NIH for fiscal year (FY) 2024, an increase of $3.5 billion over FY 2023 levels, and in addition the release of the 21st Century Cures funds. Additionally, with the authorization of the Advanced Research Projects Agency for Health (ARPA–H), ACR supports an additional increase to this new agency, while maintaining it as a separate appropriation outside of the NIH base budget, in FY 2024.

As a specialty with a long history of innovation, we know that strong and predictable funding for NIH and our National research infrastructure allows for the continued advancement of scientific discoveries and breakthroughs, improving the lives of patients with a wide spectrum of diseases and disorders, many of whom depend on radiology and imaging tools for prevention, diagnosis, and treatment of disease. ACR is grateful for the subcommittee's past 8 years of increased support of NIH and encourages the continuation of advancing biomedical research in radiology and imaging science, including within institutes such as the National Cancer Institute (NCI) and the National Institute of Biomedical Imaging and Bioengineering (NIBIB). In this testimony I will briefly describe four examples of how robust NIH funding has improved radiology patient care.

IMPACTING THE FUTURE OF MEDICAL IMAGING

ACR has historically been a leader in the radiology clinical trial space, helping to develop and implement new prevention, diagnosis, and treatment approaches at a faster pace for a variety of diseases and disorders. One of the most successful examples of advancing imaging practices through clinical research is the ACR-led National Lung Screening Trial (NLST). NLST was conducted by the American College of Radiology Imaging Network, a medical imaging research network focused on the conduct of multicenter imaging clinical trials, and the Lung Screening Study group established by the NCI to examine the feasibility of improving survival of lung cancer patients.[1]

The NLST study compared two ways of detecting lung cancer: low-dose computed tomography (CT), and standard chest X-ray. The study found that participants who

[1] https://www.cancer.gov/types/lung/research/nlst.

received low-dose CT scans had a 15 to 20 percent lower chance of dying from lung cancer than participants who received standard chest X-rays. The NLST study confirmed that screening with the use of low-dose CT reduces mortality from lung cancer, confirming the effectiveness of imaging for patients at risk for lung cancer. Thanks to the NLST study, low dose CT screening for lung cancer is now a widely available and critical tool in the early diagnosis of this deadly disease, helping to save thousands of lives each year.

ADVANCEMENTS IN CARDIAC IMAGING DIAGNOSIS

Heart disease is the leading cause of death in the United States, accounting for 1 in every 5 deaths in 2020.[2] ACR is pleased to be included in the NIH funded RESCUE trial (Randomized Evaluation of Patients with Stable Angina Comparing Utilization of Noninvasive Examinations), which has significant impact on patient evaluation. RESCUE compared two diagnostic imaging approaches, using coronary computed tomography angiography (CCTA) and single photon emission computed tomography myocardial perfusion imaging (SPECT MPI).[3] The two tools were compared to see which was most effective to assess the severity of ischemic heart disease in patients with stable angina symptoms. The CCTA treatment was shown to be as effective as the SPECT treatment, providing evidence supporting a "CCTA-first" strategy for the diagnosis and management of these patients. A non-invasive diagnostic test, such as the tools used in this study, improves care for the patients, and advances the optimization of cardiac care. This study will have a long-term impact for those currently suffering from heart disease, or who may in the future.

ENCOURAGING CUSTOMIZED BREAST CANCER SCREENING

A third ACR driven, NIH-funded, clinical trial I would like to highlight for the subcommittee, is the Tomosynthesis Mammographic Imaging Screening Trial (TMIST). TMIST is a current study that will help researchers learn the best way to find breast cancer in women who have no symptoms.[4] This trial compares two types of mammograms, the standard digital mammograms (2–D) and a newer technology called tomosynthesis mammograms (3–D). This study focuses on detecting breast cancer before it becomes advanced, aiming to reduce the morbidity and mortality of women who develop breast cancer. TMIST is a multi-faceted study that uses integrated diagnostics to attempt to predict the likelihood of breast cancer in an individual. Family history, age, genetic markers, and breast density are examples of the data collected in this study to learn the behavior of breast cancer, with the intent to customize breast cancer detections strategies.

CREATING A CENTRAL PUBLIC REPOSITORY OF MEDICAL IMAGES

A final example of an ACR and NIH partnership is with the NCI and Booz Allen Hamilton project to develop an NCI-designated central public repository of medical images and associated clinical data from lung cancer screening patients. This will be used in artificial intelligence (AI) algorithm development and validation within the research community. A comprehensive "AI ready" dataset to use for algorithm training and validation is currently absent, particularly one that collects diverse, high-resolution annotated images accompanied with patient demographic characteristics, clinical history, cancer status, and CT imaging parameters. This repository will provide an opportunity for the development of new AI and machine learning algorithms beyond single institution experiences and will enable enhancements to equitable clinical care, leading to improvements in the diagnosis and treatment of lung cancer.

ACR will facilitate collection and harmonization of images and corresponding data from a total of 15,000 lung cancer screening patients from up to 15 clinical sites within the United States. NCI has set specific requirements for subject level representativeness for race and ethnicity. Socioeconomic status variables will also be collected, which will expand the breadth and application of the dataset, provide downstream AI and social science research applications, and lay groundwork for future data collection efforts and collaborations.

SUMMARY AND CONCLUSION

Radiology and medical imaging impact a wide array of diseases and disorders, impacting at some level, all Americans. The use of imaging tools stretches farther than

[2] https://www.cdc.gov/heartdisease/facts.htm.
[3] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5443342/.
[4] https://www.cancer.gov/about-cancer/treatment/clinical-trials/nci-supported/tmist.

the examples described for lung cancer, heart disease, and breast cancer. Radiology and imaging are essential in almost all aspects of early detection, diagnosis, and treatment, and should be included in all of NIH's Institutes and Centers, as it is in NCI and NIBIB. Radiology and imaging are used as risk estimate tools, impacting a patient's quality of life, and reducing the likelihood of suffering. The tools used in radiology may recommend clinical practice adaptations, such as avoiding an unnecessary surgery or procedure, thus altering the experience and risks and outcomes for patients.

Strong and predictable funding for NIH is crucial to ensure continued advancements in biomedical research discoveries, including those in radiology. ACR is grateful that NIH has received longstanding, bipartisan support from the subcommittee. ACR thanks the subcommittee for the continued support of biomedical research, and we look forward to working together to ensure breakthroughs and discoveries in radiology and other areas of medicine are possible. On behalf of ACR, we urge you to continue your strong support of NIH funding and appreciate your consideration of least $50.9 billion in FY 2024.

[This statement was submitted by Dr. William T. Thorwarth, MD, Chief Executive Officer, American College of Radiology.]

PREPARED STATEMENT OF THE AMERICAN COLLEGE OF SURGEONS

Chairman Baldwin, Ranking Member Capito, and members of the subcommittee, on behalf of the more than 87,000 members of the American College of Surgeons (ACS), thank you for the opportunity to submit written testimony addressing fiscal year (FY) 2024 appropriations. The ACS is a scientific and educational organization of surgeons that was founded in 1913 to raise the standards of surgical practice and improve the quality of care for all surgical patients. The ACS is dedicated to the ethical and competent practice of surgery. Its achievements have significantly influenced the course of scientific surgery in America and have established it as an important advocate for all surgical patients.

The ACS respectfully requests your consideration of the following priorities as the subcommittee works through the annual appropriations process for FY 2024:

FULLY FUND THE MILITARY AND CIVILIAN PARTNERSHIP FOR THE TRAUMA READINESS GRANT PROGRAM (MISSION ZERO)

In 2016, the National Academies of Science, Engineering, and Medicine (NASEM) released a report titled, "A National Trauma Care System: Integrating Military and Civilian Trauma Systems to Achieve Zero Preventable Deaths After Injury." This report suggests that one in four military trauma deaths and one in five civilian trauma deaths could be prevented if advances in trauma care reach all injured patients. The report concludes that military and civilian integration is critical to saving lives both on the battlefield and at home, maintaining the Nation's readiness and homeland security.

The Pandemic and All Hazards Preparedness and Advancing Innovation (PAHPAI) Act (Public Law No:116–22) authorized the MISSION ZERO Act, which, based on the NASEM Report recommendations, established a grant program within the Administration for Strategic Preparedness and Response (ASPR) to cover the administrative costs of embedding military trauma professionals in civilian trauma centers. These military-civilian trauma care partnerships allow military trauma providers to gain exposure to treating critically injured patients and increase readiness for when these units are deployed, further advancing trauma care and providing greater patient access.

Ensuring access to trauma care requires many crucial components including trauma centers and appropriately trained trauma surgeons, physicians and nurses. By defraying the associated costs for the civilian hospital of embedding military surgeons, the military-civilian partnerships funded by the grant allow military surgeons to gain skill and expertise treating critically injured patients in a civilian setting, thus increasing readiness for when these units are deployed. Just as military trauma providers learn from their civilian counterparts, the best practices learned on the battlefield are brought home to further advance trauma care and provide greater civilian access.

The ACS thanks Congress for providing $4 million in funding for the program in FY 2023. However, the ACS strongly urges Congress to fully fund the Military and Civilian Partnership for the Trauma Readiness Grant Program at the authorized amount of $11.5 million for FY 2024. Building on previous funding will allow for continued implementation of military-civilian trauma partnerships, preserve lessons

learned from the battlefield, translate those lessons to civilian care, and ensure that service members maintain their readiness to deploy in the future.

CANCER PREVENTION RESEARCH

The ACS Cancer Programs, including the Commission on Cancer, are dedicated to improving survival and quality of life for cancer patients through advocacy on issues pertaining to prevention and research. Past congressional support for federally funded cancer research has been the foundation for progress made in the battle against this disease. To continue this momentum, the ACS supports the following funding levels for FY 2024:

National Institutes of Health (NIH)

The ACS strongly supports robust annual funding growth for NIH to ensure that the agency can continue its meaningful work advancing medical and public health research and urges Congress to fund the NIH at $50.924 billion.

In addition, the ACS supports continued funding for the Advanced Research Projects Agency for Health of at least $1.5 billion, that supplements, and does not supplant, the essential funding of NIH.

The National Cancer Institute (NCI)

The NCI is experiencing a demand for research funding that is far beyond that of any other Institute or Center (IC) at NIH. Between FY2013 and FY2022, the number of research grant applications to NCI rose by 45%, compared to just 20% at all other ICs. That is good news because it shows how much excitement there is in cancer research, however, at its current funding level, NCI is unable to keep up with demand; only about one out of seven applications receives funding. Therefore, the ACS encourages Congress to fund the NCI at $9.98 billion.

Centers for Disease Control and Prevention (CDC) Cancer Prevention and Control Programs

Research is important, but so is prevention. About half of the 600,000 cancer deaths in the U.S. each year could be prevented through the application of existing cancer control initiatives. Sustained investment in the CDC Cancer Prevention and Control programs is critical to saving lives. The ACS urges Congress to appropriate $536.4 million for FY 2024.

FIREARM INJURY AND MORTALITY PREVENTION RESEARCH

According to the CDC, there were more than 48,000 firearm-related fatalities in 2021, a measured increase over previous years. The ACS believes that public health research can play a role in reducing the number of firearm-related injuries and deaths, just as it has for other public health issues.

Federally funded public health research has contributed to reductions in motor vehicle crashes, smoking, and Sudden Infant Death Syndrome. The ACS believes that a similar approach can provide necessary data to inform efforts to reduce firearm-related injuries and deaths. The ACS supports a total of $60 million-$35 million for the CDC and $25 million for the NIH to conduct public health research into firearm injury and mortality prevention.

NATIONAL HEALTH CARE WORKFORCE COMMISSION

Increasing evidence indicates critical health care workforce shortages across the country. One step Congress can take to address this crisis is to fully fund the National Health Care Workforce Commission. The Commission was established more than a decade ago as a multi-stakeholder body charged with developing a national health care workforce strategy, including reviewing current and projected health care workforce supply and demand and analyzing and recommending Federal policies affecting the workforce. Unfortunately, this body was never funded and therefore has not been able to begin its important work. The ACS supports funding the Commission at $3 million for FY 2024. Doing so will direct needed resources to address the Nation's workforce challenges and provide a new opportunity for direct stakeholder engagement.

Thank you for your consideration of our requests. Please contact Amelia Suermann at asuermann@facs.org if you have any questions or would like additional information.

Sincerely.

[This statement was submitted by Patricia L. Turner, MD, MBA, FACS, Executive Director and CEO, American College of Surgeons.]

PREPARED STATEMENT OF THE AMERICAN EDUCATIONAL RESEARCH ASSOCIATION

Chair Baldwin, Ranking Member Capito, and Members of the subcommittee, thank you for the opportunity to submit written testimony on behalf of the American Educational Research Association (AERA). AERA recommends that the Institute of Education Sciences (IES) within the Department of Education receive at least $900 million in fiscal year (FY) 2024, aligned with the request from the Friends of IES coalition, for which we are a leading member. In addition, AERA recommends $50.924 billion for foundational research within the National Institutes of Health (NIH) in FY 2024 with proportional increases for important research supported by the Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD) and the Office of Behavioral and Social Science Research (OBSSR).

AERA is the major national scientific association of 25,000 faculty, researchers, graduate students, and other distinguished professionals dedicated to advancing knowledge about education, encouraging scholarly inquiry related to education, and promoting the use of research to improve education and serve the public good.

INSTITUTE OF EDUCATION SCIENCES

IES is the independent and nonpartisan statistics, research, and evaluation arm of the U.S. Department of Education charged with supporting and disseminating rigorous scientific evidence on which to ground education policy and practice. The mission of IES is analogous to other prominent Federal research agencies such as the National Science Foundation and the National Institutes of Health.

Our members, as well as State and Federal policymakers and practitioners, rely on IES to provide reliable education statistics, support research to improve academic and non-academic outcomes, and develop evidence-based practices to inform instruction and support student learning at all educational levels.

Since 2002, the investment in IES has resulted in evidence-based interventions used in classrooms across the country. IES-funded work in literacy included the development and scaling up of Assessment to Instruction (A2i), an online tool that supports teachers on differentiated reading instruction and assessment for students in grades K–3. After demonstrating effectiveness in improving reading outcomes over the course of several IES grants, funding from the Small Business Innovation Research program helped to scale up A2i. In 2022, Scholastic acquired A2i to be included as part of its literacy platform, expanding the reach of this evidence-based program to 115,000 schools. This is only one example of how IES investment in foundational education research—in this case, determining whether individualized instruction improves literacy outcomes—leads to direct application to education practice.

The declines in scores on the 2022 National Assessment of Educational Progress (NAEP) math and reading assessments served as a call to action to accelerate learning. Programs within the Research, Development, and Dissemination and the Research in Special Education line items serve as critical resources for leveraging the success of evidence-based interventions and for supporting new opportunities for high-reward, quick-turnaround scalable solutions with the potential to develop transformative interventions in education.

We appreciate the increases to IES appropriations over the past few fiscal years. Yet, even with these increases, due to limited funding, IES was unable to launch National Center for Special Education Research competitions for research and training grant programs during FY 2022 beyond those supported through American Rescue Plan funds. In addition, several core National Center for Education Research competitions for research and training grants in FY 2023 were not run. We encourage the subcommittee to provide additional resources in the Research, Development, and Dissemination and Research in Special Education line items for IES to expand support for both emerging priorities and foundational research areas.

The Statistics line item supports National Center for Education Statistics (NCES) administrative data collections and longitudinal surveys, as well as participation by our Nation's students in important international assessments such as the Programme for International Student Assessment. Data from NCES, including from the Integrated Postsecondary Education Data System and the National Teacher and Principal Survey, are frequently cited and used to describe the condition of education in the United States. NCES also has an essential leadership role in implementing the Foundations of Evidence-based Policymaking Act, which directs Federal agencies to leverage data and evaluations to inform policy decisions.

In the 2022 report, A Vision and Roadmap for Education Statistics, the National Academies of Science, Engineering, and Medicine (NASEM) committee that examined NCES statistical work referenced the limited capacity that NCES has in both

funding and staff. Additional resources are essential to carry out several of the report's key recommendations, including developing a strategic plan, broadening outreach to data users to gather feedback on their needs, and establishing a joint statistical research program in partnership with IES. We strongly recommend providing sufficient funding for the Statistics line that would increase the capacity of NCES to maintain important longitudinal surveys alongside the continued investment in rapid data collection and reporting through the School Pulse Panel.

Alongside the important survey work NCES supports, States are increasingly seeking ways to determine the long-term impact of state policies, including in education, and they turn to information in their Statewide Longitudinal Data Systems (SLDS). The most recent SLDS grants are providing States the opportunity to partner in the development of meaningful measures-in this case, to pilot an NCES-developed indicator to measure poverty using school geocoded addresses as an alternative to using free-and-reduced price lunch eligibility. States participating in this pilot have provided feedback on this NCES initiative and have also noted strengthened data capacity and integrity within their data systems as a result.

To date, NCES has been unable to meet the state demand for SLDS grants. For the FY 2019 competition, 28 of 44 States that submitted applications received grants, although the average amount of grants was reduced by half compared with those awarded in FY 2015. Growing interest in using data from these systems, including an IES research competition encouraging the research use of these data for examining longitudinal impacts of state policies, show the importance of continuing investment in these data systems.

In A Vision and Roadmap for Education Statistics, the NASEM committee recommended that NCES strengthen state capacity to link data, adopt shared data standards, and provide actionable information to State and local education agencies to help improve student learning outcomes. Additional funding for SLDS would help enhance NCES technical assistance and ongoing efforts to promote best practices for state data governance structures and data interoperability, including through the voluntary Common Education Data Standards.

NATIONAL INSTITUTES OF HEALTH

AERA recommends $50.924 billion for foundational research funded by the National Institutes of Health (NIH) in fiscal year 2024 with proportional increases for the Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD) and the Office of Behavioral and Social Science Research (OBSSR). Funding provided for the Advanced Research Projects Agency-Health should supplement and not supplant appropriated funds for NIH foundational research.

NICHD supports research at the intersection of health and education, including ways to foster health literacy, potential influencers of family environments on child well-being and cognitive development, and interventions for students with learning disabilities who struggle with reading. Providing $1.877 billion for NICHD in FY 2024 will allow the institute to expand research to increase understanding of how best to support additional research on early language and motor development and to bolster the professional development of early career researchers.

OBSSR plays an important role in coordinating and co-funding behavioral and social science research across NIH that contributes to the understanding of influences on health and interventions to improve health outcomes. OBSSR has long recognized the interdependence of education and health in terms of prevention, intervention, and the health-risk consequences of a lack of or limited educational exposure. We recommend no less than the FY 2023 funding level for OBSSR, including a proportionate increase in its FY 2024 budget as provided to the NIH.

Thank you for the opportunity to submit written testimony in support of at least $900 million for IES and $50.924 billion for NIH foundational research in fiscal year 2024. AERA welcomes working with you and your subcommittee on strengthening investments in essential research, data, and statistics related to education and learning.

[This statement was submitted by Felice J. Levine, PhD, Executive Director, American Educational Research Association.]

PREPARED STATEMENT OF AMERICAN GERIATRICS SOCIETY

The American Geriatrics Society (AGS) greatly appreciates the opportunity to submit this testimony. The AGS is a national non-profit organization of nearly 6,000 geriatrics healthcare professionals and basic and clinical researchers dedicated to improving the health, independence, and quality of life of all older Americans. The

AGS believes in a just society—one where we all are supported by and able to contribute to communities and where ageism, ableism, classism, homophobia, racism, sexism, xenophobia, and other forms of bias and discrimination no longer impact healthcare access, quality, and outcomes for older adults and their caregivers. As the subcommittee works on its fiscal year (FY) 2024 Labor, Health and Human Services, and Related Agencies Appropriations Bill, we ask that you prioritize funding for the geriatrics education and training programs under Title VII of the Public Health Services (PHS) Act and for aging research within the National Institutes of Health (NIH) and National Institute on Aging (NIA).

We are appreciative of your ongoing support of the Title VII Geriatrics Health Professions Programs at the Health Resources and Services Agency (HRSA), which includes the Geriatrics Workforce Enhancement Program (GWEP) and Geriatrics Academic Career Award (GACA) program. However, the AGS believes it is urgent that we increase the educational and training opportunities in geriatrics and gerontology and ensure that HRSA receives the funding expansion necessary for these critically important programs for the care and health of older adults.

We ask that the Subcommittee consider the following funding levels for these programs in FY 2024:

—$82 million to support the GWEP and GACA program (PHS Act Title VII, Section 750 and 753 (a)).

—$50.924 billion for the National Institutes of Health's (NIH) foundational work and a minimum increase of $321 million for research on Alzheimer's disease and related dementias (ADRD) over the enacted FY 2023 level.

Sustained and enhanced Federal investment in these initiatives is essential to delivering high-quality, better coordinated, efficient, and cost-effective care to our older Americans whose numbers are projected to increase dramatically in the coming years. The number of people 65 and older is estimated to climb from 61.6 million today to more than 94.7 million by 2060, while those 85 and older is projected more than double from 7.1 million today to 19 million by 2060.[1] As our aging population grows, the prevalence of diseases disproportionately affecting older people-most notably Alzheimer's disease and related dementias (including vascular, Lewy body, and frontotemporal dementia)-and economic burden associated with these diseases will increase.

To ensure that our Nation is prepared to meet the unique healthcare needs of this rapidly growing population, we request that Congress provide additional investments necessary to expand and enhance the geriatrics workforce, an integral component of the primary care workforce, and foster groundbreaking medical research on aging.

PROGRAMS TO TRAIN GERIATRICS HEALTHCARE PROFESSIONALS

GWEP and GACA Program ($82 million)

Our healthcare workforce receives little, if any, training in geriatric principles,[2] leaving us ill-prepared to care for older adults as health needs evolve. With the severe shortage of geriatrics healthcare providers and academics with the expertise to train these providers, the AGS believes it is urgent that we increase the number of educational and training opportunities in geriatrics and gerontology. By 2025, there will only be approximately one geriatrician for every 3,000 older adults that require geriatrics care, leaving thousands without access to these services by 2025.[3] There are similar shortages of health professionals specializing in geriatrics across other disciplines. Additionally, rural populations have more limited access to primary care than residents of urban areas, and are generally older, have a higher incidence of poor health, and face greater barriers to receiving care such as transportation and internet access. The requested increase in funding levels would help to

[1] U.S. Census Bureau International Programs Center. International Database (IDB). Accessed May 1, 2023. https://www.census.gov/data-tools/demo/idb/#/pop?COUNTRY_YEAR=2023&COUNTRY_YR_ANIM=2023&FIPS_SINGLE=US&FIPS=US&popPages=BYAGE&POP_YEARS=2023,2060&menu=popViz&ageGroup=O.

[2] Only 3 percent of medical students take even one class in geriatric medicine and fewer than 1 percent of RNs, pharmacists, physician assistances and physical therapists are certified in geriatrics or gerontology. Yet estimates are that by 2030, 3.5 million additional health care professionals and direct-care workers will be needed to care for older adults. 2018 Issue Brief, Eldercare Workforce Alliance, Available at https://eldercareworkforce.org/wp-content/uploads/2018/03/GWEP_OnePager_v2.pdf.

[3] U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis. National and Regional Projects of Supply and Demand for Geriatricians: 2013–2025. Published April 2017. Accessed May 1, 2023. https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/geriatrics-report-51817.pdf.

expand the critically important GWEPs and GACAs commensurate with the increasing need.

The GWEP is currently the only Federal program designed to increase the number of providers, in a variety of disciplines, with the skills and training to care for older adults. The GWEP awardees educate and engage the broader frontline workforce, including the caregiving workforce and family caregivers, and focus on opportunities to improve the quality of care delivered to older adults, particularly in underserved and rural areas. Due to the GWEPs' partnerships with primary care and community-based organizations, they are uniquely positioned to rapidly address the needs of older adults and their caregivers. The GWEP was launched in 2015 by HRSA with 44 3-year grants provided to awardees in 29 States. In 2019, HRSA funded a second cohort of 48 GWEPs across 35 States and two territories (Guam and Puerto Rico) and provided extension grants to 15 former GWEP awardees. Additional funding would allow 80 GWEPs at $950,000 per program, enabling every State to have a GWEP and more rural and underserved areas of the country to have access to geriatrics training and expertise.

The GACA program is an essential complement to the GWEP. GACAs ensure we can equip early-career clinician educators to become leaders in geriatrics education and research. It is the only Federal program designed to increase the number of faculty with geriatrics expertise in a variety of disciplines. The program was eliminated in 2015 through a consolidation of several training programs. However, the program was reestablished in November 2018 and most recently, HRSA funded 26 GACAs for 4 years through June 30, 2027. Additional funding would allow 60 GACAs at $100,000 per award, ensuring we have a larger and more geographically diverse pipeline of geriatrics research and training expertise with the incentives and resources needed to grow the field.

As demonstrated during the COVID–19 public health emergency, GWEPs and GACAs are critical in providing assistance for proactive public health planning with their geriatrics' expertise and knowledge of long-term care and can help ensure States and local governments have improved plans for older adults in disaster preparedness for future pandemics and natural disasters. As the U.S. population rapidly ages, access to a well-trained workforce and appropriate care for medically complex older adults is imperative to maintaining the health and quality of life for this growing segment of the Nation's population.

To address these issues, we urge the subcommittee to provide a FY 2024 appropriation of $82 million for the GWEP and GACA program. This increase in funding over FY 2023 levels would help ensure that HRSA receives the funding necessary to carry these critically important programs forward. Additional funding will also allow HRSA to expand the number of GWEPs and GACAs and move towards closing the current geographic and demographic gaps in geriatrics workforce training. Given the increasing diversity among older people [4] and rapid growth of the older population,[1] the need for a diverse workforce as well as training in geriatrics and gerontology will continue to increase. The infrastructure of care in the U.S. needs substantial investments so that access to long-term services and supports is expanded while the healthcare workforce is adequately supported and prepared to care for us all as we age.

RESEARCH FUNDING INITIATIVES

NIH/NIA ($50.924 billion for base spending and a minimum increase of $321 million for Alzheimer's disease and related dementias research)

The institutes that make up NIH, specifically the National Institute on Aging (NIA), lead the National scientific effort to understand the nature of aging and extend the healthy, active years of life. As a member of the Friends of the NIA (FoNIA)—a broad-based coalition of aging, disease, research, and patient groups committed to advancing medical research that affects millions of older Americans-the AGS urges you to include at least $50.924 billion for base funding and a minimum increase of $321 million for research on ADRD over the enacted FY 2023 level.

Healthcare costs associated with age-related diseases are significant and rising. By 2060, for example, the number of people age 65 and older affected by Alzheimer's

[4] Matthews KA, Xu W, Gaglioti AH, et al. Racial and Ethnic Estimates of Alzheimer's Disease and Related Dementias in the United States (2015–2060) in Adults Aged>=65 Years. Alzheimers Dement. 2019;15(1):17–24. doi:10.1016/j.jalz.2018.06.3063.

disease is estimated to reach 13.85 million cases[5]—more than double the estimated 6.7 million in 2023—and is projected to cost $1 trillion in 2050 which does not include the current $339.5 billion in unpaid caregiving by family and friends.[6] Further, chronic diseases related to aging, such as diabetes, heart disease, and cancer continue to afflict 80 percent of people age 65 and older.[7] Forty percent of Medicare beneficiaries have four or more chronic conditions and account for 78 percent of Medicare expenditures.[8] Continued and increased Federal investments in scientific research will ensure that the NIH and NIA have the resources to conduct groundbreaking research, foster the development of research and clinical scientists, provide research resources, and communicate information about aging and advances in research on aging. Breakthroughs from NIH research can not only delay the onset of costly age-related diseases but also can save trillions of dollars by the middle of the current century.

Additionally, the AGS urges you to ensure that any funding for the Advanced Research Projects Agency for Health (ARPA–H) does not come at the cost of the existing NIH institutes and centers. We believe that a meaningful increase in NIH-wide funding, in combination with aging and increase in prevalence of diseases, will be vital to sustain the research needed to make progress in addressing chronic disease and ADRD that disproportionately affect older people.

Strong support such as yours will help ensure that every older American is able to receive high-quality care. We greatly appreciate the subcommittee for the opportunity to submit this testimony.

PREPARED STATEMENT OF THE AMERICAN INSTITUTE OF BIOLOGICAL SCIENCES

The American Institute of Biological Sciences (AIBS) appreciates the opportunity to provide testimony in support of fiscal year (FY) 2024 appropriations for the National Institutes of Health (NIH). We encourage Congress to provide NIH with at least $51 billion in FY 2024.

AIBS is a scientific association dedicated to promoting informed decision-making that advances biological research and education for the benefit of science and society. AIBS works to ensure that the public, legislators, funders, and the community of biologists have access to information that can guide informed decision-making.

Biological research, including biomedical research, is in our National interest. It advances our understanding of the living world and provides solutions to important problems. Increasing our knowledge of how genes, cells, tissues, organisms, and ecosystems function is vitally important to efforts to improve the human condition. Food security, medicine and public health, national security, economic growth, and sound environmental management are all informed by the biological sciences. Notably, biological research helps to sustain biodiversity and healthy ecosystems that underpin the livelihoods of communities.

Federal investment in scientific research and development (R&D) fuels innovation and creates jobs. Biological research funded by NIH and other Federal agencies helps solve national challenges, such as the need to track and combat emerging diseases, improve human health and well-being, enhance food security, and advance the bioeconomy. The translation of biological knowledge into formal and informal education programs fosters the development of the scientifically and technically skilled workforce needed by employers. Data show that employers continue to seek workers with scientific and technical skills. Science and engineering employment in the United States has grown more rapidly-at an annual growth rate of 4 percent-compared to the 2 percent annual growth rate for the U.S. workforce overall. In fact, the U.S. STEM workforce constitutes 23 percent of the total U.S. workforce and is comprised of more than 36 million people in diverse occupations that require STEM knowledge and expertise.

The loss of biological diversity and the concomitant negative implications for human health and well-being are of significant concern. As the human population

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[5] Rajan KB, Weuve J, Barnes LL, McAninch EA, Wilson RS, Evans DA. Population estimate of people with clinical AD and mild cognitive impairment in the United States (2020–2060). Alzheimers Dement. 2021;17(12):1966–1975. doi:10.1002/alz.12362.

[6] Alzheimer's Association. 2023 Alzheimer's Disease Facts and Figures. Alzheimers Dement. 2023;19(4):1–98. doi:10.1002/alz.13016.

[7] National Prevention Council. Healthy Aging in Action: Advancing the National Prevention Strategy. Published November 2016. Accessed May 1, 2023. https://www.cdc.gov/aging/pdf/healthy-aging-in-action508.pdf [page 11].

[8] Centers for Medicare and Medicaid Services. Chronic Conditions Charts: 2018. Updated December 1, 2021. Accessed May 1, 2023. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Chartbook__Charts.

grows and people increasingly come into contact with new environments and species migrating into new habitats, the risk of disease exposure increases. Human health is inextricably linked to the health of other species in our shared environment. One Health (https://www.cdc.gov/onehealth/index.html), an approach that recognizes that the health of people is closely connected to the health of animals and our shared environment, is increasingly being recognized as an effective approach to address health issues at the human-animal-environment interface, including zoonotic diseases, antimicrobial resistance, vector-borne diseases, and environmental contamination. Increased research investments are needed to improve our understanding of the linkage between biodiversity and human health as well as the impacts of climate change on human health and well-being.

NIH is the largest public funder of biomedical research in the world. Research supported by NIH has improved public health, increased average life expectancy by 6 years in the last 5 decades, and resulted in effective treatments for illness and disability. NIH awards more than 60,000 competitive grants each year that support the work of over 300,000 scientists at more than 2,500 U.S. institutions, including universities, medical centers, independent research institutions, and companies.

NIH helps drive economic growth. In FY 2021, NIH extramural funding generated an estimated $94.2 billion in economic output—or $2.60 of economic activity for every $1 of research funding—and supported more than 550,000 jobs nationwide. NIH investments in research also stimulate increased private investment. A $1 increase in public basic research stimulates an estimated additional $8.38 of industry R&D investment in a particular research area after 8 years. The NIH's Human Genome Project has resulted in an economic growth of almost $1 trillion—a 178-fold return on investment—at a cost of only $2 per year for each U.S. resident. Furthermore, for every $100 million NIH spends on research, it generates 76 patents, which create opportunities for $598 million in further research and development.

In addition to supporting critical biomedical research advancements, NIH supports recruitment and training of our next generation of researchers. In 2022, NIH grants directly supported the training of more than 5,500 post-doctoral fellows through training grants as well as many other students through extramural research grants. Support for undergraduate and graduate students is critically important to our research enterprise. Students learn science by doing science, and NIH programs engage students in the research process.

Unfortunately, Federal research and development investments are shrinking as a share of the U.S. economy. The U.S. is still the largest performer of research and development globally, but our share of worldwide scientific activity has declined considerably over the past two decades, while countries in East and Southeast Asia, especially China, have been rapidly increasing their investments in science. According to the National Science Board, the annual increase of China's R&D, averaging 10.6 percent annually between 2010 and 2019, continues to outpace that of the United States, with an annual average of 5.4 percent from 2010 to 2019.

Funding for NIH, has not kept pace with the demand for research grants. Despite the large number of highly competitive and potentially transformative grant proposals submitted to NIH, 79% of applications were rejected in 2022.

To remain at the global forefront of innovation and to fully realize the benefits of NIH-supported research, the U.S. government must make bold and sustained investments in NIH. Unpredictability in funding disrupts research programs, creates uncertainty in the research community, and stalls the development of the evidence-based science that could lead to new treatments or cures for maladies affecting our world.

Funding NIH at $51 billion, an increase of 7 percent over the FY 2023 enacted level, will enable the agency to support research in a number of important priority areas, including combatting the lasting effects of the COVID–19 pandemic, tackling the opioid epidemic, eradicating HIV in the United States, expanding mental health research, addressing health disparities and inequities, and investigating the human health impacts of climate change. Enacting robust funding increases will allow NIH to ramp up efforts to bolster the Nation's pandemic preparedness so that we are in a stronger position to respond to future outbreaks. The requested funding will also allow the agency to continue supporting the Next Generation Researchers Initiative, which enables researchers to initiate and sustain independent research careers and also helps to grow and diversify the biomedical research workforce.

CONCLUSION

Previous investments in NIH have advanced the potential of medical research, supported current and new scientists, and enabled the discoveries of critical

diagnostics and therapies, including the unprecedented pace of development of COVID–19 vaccines.

Providing the NIH with a base budget of at least $51 billion in FY 2024 is necessary to undo the harmful effects of recent stagnant funding that slowed American scientific discovery. The requested funding will grow and sustain the U.S. bioeconomy and enable NIH to accelerate work on important initiatives at the frontiers of science and medicine. Importantly, these increases will advance research on infectious disease emergence and transmission, prevent future pandemics, and fill gaps in our knowledge about the spread and evolution of biological threats.

We also ask that any additional funding to support the new Advanced Research Projects Agency for Health (ARPA–H) should supplement, not supplant, our $51 billion recommendation for NIH's base budget. The new agency charged with supporting transformative high-risk, high-reward research must complement, and not interfere with, NIH's commitment to funding basic research. Safeguards must be put in place to ensure that investments made in ARPA–H does not detract from the investigator-initiated research funded by NIH institutes and centers.

Please continue supporting increased investments in our Nation's scientific and medical research capacity. Thank you for your thoughtful consideration of this request and for your prior efforts on behalf of the National Institutes of Health.

[This statement was submitted by Jyotsna Pandey, Ph.D., Public Policy Director, American Institute of Biological Sciences.]

PREPARED STATEMENT OF THE AMERICAN LIBRARY ASSOCIATION

The American Library Association (ALA) urges the subcommittee to include in its FY24 appropriations $20 million for technical assistance to improve library and museum facilities to be administered by the Institute of Museum and Library Services (IMLS) under its Program Administration line.

Public libraries nationwide have billions of dollars in capital needs for construction and renovation. The American Library Association's 2021 data brief found more than $8 billion in estimated needs across nine States and the District of Columbia which have recent statewide facilities assessments. Extrapolated to the National population, the Nationwide needs would be $32 billion. Such an extrapolation is necessary because more than 40 States have no recent data about the condition of public library facilities in the state.

Many public libraries struggle to identify funding sources in the face of these tremendous capital needs, particularly since the dedicated Federal contribution ended more than 25 years ago. Currently, less than 1% of public libraries' capital funding nationally is from Federal sources, with 71% coming from local governments, 8% from State governments, and 20% from private funding. Given this reliance on local revenue sources, funding capital improvements in rural and underserved communities can be particularly difficult.

These improvements are needed so libraries can deliver crucial services that advance literacy and learning to everyone in their communities in facilities that are safe, modern, and accessible to all. To mention a few examples of these needs:

In Alabama, the Gadsden Public Library needs to install climate control to protect its archive of hundreds of family files, thousands of City-related documents, and countless historic photographs, negatives, slides, VHS and cassette tapes, and Super 8 movie reels.

In Texas, the Richland Hills Public Library has sought funding for an outreach vehicle. Currently, library staff use their personal vehicles to deliver library materials to homebound patrons, including the city's large senior population.

In Connecticut, 45 percent of the State's public libraries are not wheelchair accessible.

To address needs like these in libraries nationwide, we ask for support for libraries in conducting facilities condition assessments, facilities master planning, and data collection about capital needs. To do so, we ask the subcommittee to provide programmatic funding to IMLS as part of its Program Administration line, for allocation with priority for rural and underserved communities and facilities that pose a severe health or safety threat.

In summation, ALA asks that the subcommittee provide $20 million for Technical Assistance to Improve Library and Museum Facilities in FY 2024 to be administered by IMLS as part of its Program Administration line. Thank you for your consideration, kmaher@alawash.org.

[This statement was submitted by Kevin L. Maher, Deputy Director, Public Policy & Advocacy, American Library Association.]

PREPARED STATEMENT OF THE AMERICAN LIBRARY ASSOCIATION

The American Library Association (ALA) urges the subcommittee to include in its FY24 appropriations $232 million for programs under the Library Services and Technology Act (LSTA) administered by the Institute of Museum and Library Services (IMLS).

Libraries serve a vital role in communities across the country by providing an ever-expanding range of services, including many on-line services making today's technology-focused libraries 24-hour enterprises offering much more than they did 20 years ago. Libraries connect rural communities to a 21st Century economy...support child and adult literacy development...foster small business and entrepreneurship growth...assist students with homework needs...ensure veterans have access to benefits...connect blind and print disabled individuals with educational material...provide equitable services to underserved communities. For many, the local library is the only no-fee resource available.

LSTA funding at the authorized level of $232 million will ensure continued resources are available to libraries in every State. Current funding for LSTA at $211 million remains below its FY 2010 funding level of $213 million and its authorized level of $232 million (with a separate authorization of $24.5 million for the Laura Bush 21st Century Librarian Program).

The following examples demonstrate how LSTA funding strengthens communities:

—*Early Learning and Literacy*.—Libraries promote a range of literacies, offering family story times, access to new learning technologies and training for caregivers about the importance of early literacy and how to nurture pre-reading skills at home. The West Hartford (CT) Public Library received an LSTA grant for its Come Learn With Me: Moving Beyond Storytime" program for parent and child engagement, supporting children's literacy and communication skills to better prepare them for school.

—*Jobs and Careers*.—Libraries support patrons at all stages of their working lives, offering workforce development services, including high school or career certifications, resume and job application assistance, learning new career skills, and career and technical education programs. LSTA grants to the State Library of North Carolina support the Wilson County Public Library virtual reality lab encouraging students to explore high-tech careers and certification.

—*Small Businesses*.—Entrepreneurs use libraries to develop business plans, research emerging markets, or use 3–D printers and other technologies in the library for prototype development. Libraries propel new and expanding businesses. An LSTA Strengthening Communities grant at the Wilcox County Library (AL) is helping residents learn the skills to run small home-based or online businesses. The classes trained residents to produce products or services that could be used to better themselves economically.

—*Internet Access and Skills*.—Libraries are hubs for digital literacy and 21st century skills building. For the 24 million U.S. households lacking broadband internet service at home, the library is often the only place for access to computers and the internet. With LSTA funding, the Kenosha (WI) Public Library is able to offer its Digital Consumers to Digital Entrepreneurs program, a 6–8 week coding camp for area students. The grant allowed one-on-one assistance to students, small classes, and mentorships while encouraging them to explore careers in technology and computer science.

—*Access to Government Information and Services*.—Libraries enable access to a wealth of local, State, and Federal Government information. Librarians provide access to government services such as taxes, census, citizenship, unemployment, and voting. The Veterans Resource Center at the Tulare (CA) Public Library is made possible with LSTA support. The center helps veterans learn new skills, prepare for testing, translate military skills to civilian life, develop resumes and interview skills, and search for jobs.

—*Access for People with Disabilities*.—Libraries support people with print disabilities by providing content that is accessible in both print and digital forms. Through a network of state libraries for the blind, libraries share accessible copies to ensure that library users have the broadest content available. With LSTA support, the Maine State Library provides a variety of programs and services for residents with disabilities. This grant supports books in braille, large print materials, and recorded format along with playback equipment.

—*Access for Rural Residents*.—For some residents living in rural areas or smaller towns, a trip to the local library may not be so easy. The Nampa (ID)Public Library used an LSTA grant to make a bookmobile a reality. Nampa is now operating a bookmobile that travels to its many, often rural, communities and ensure local, rural, residents who cannot get to the library will still have regular

access to books and materials, Wi-Fi, laptops, 3D printers, robots as well as services for job seekers.

The bulk of LSTA funds are distributed to each State through the Institute of Museum and Library Services (IMLS) according to a population-based grant formula with a mandatory ⅓ state match. Priorities for use of LSTA funds are determined at the state level—not federal. Libraries have used LSTA funding for a broad range of diverse and innovative programs that profoundly touch and better the lives of tens of millions of Americans in every State in the Nation. LSTA is truly a local decision-making success story and a shining example of how a small Federal investment can be efficiently and reliably leveraged into dramatic State and local social and economic results.

Accordingly, ALA asks that the subcommittee provide $232 million for LSTA in FY 2024 to ensure that all Americans continue to have access to important resources at their local library.

ALA understands the tight fiscal constraints on the subcommittee, and we appreciate its continued dedicated support of LSTA. Thank you for your commitment to sustaining and strengthening our communities and our Nation by supporting America's libraries, kmaher@alawash.org.

[This statement was submitted by Kevin L. Maher, Deputy Director, Public Policy & Advocacy, American Library Association.]

PREPARED STATEMENT OF THE AMERICAN LIBRARY ASSOCIATION

The American Library Association (ALA) urges the subcommittee to include in its Fiscal Year (FY) 2024 appropriations bill at least $50 million for Innovative Approaches to Literacy (IAL) administered by the Department of Education (DOE).

The 2019 National Assessment of Educational Progress reading assessment illustrates the urgent need for the early literacy skills development offered by school librarians. The Assessment showed that only 35 percent of fourth grade students, 34 percent of eighth grade students, and 37 percent of 12th grade students performed at or above proficient for literacy. Access to high-quality literacy programming and resources remains a critical component of childhood literacy development. For American families living in poverty, the lack of access to quality reading materials and adequate learning facilities is prohibitive, fostering chronic disadvantages for already underserved youth. Without critical literacy support from programs like IAL, students often fall behind in school and struggle to achieve their full potential.

Innovative Approaches to Literacy is the only Federal program providing dedicated support to school libraries. Authorized in the Every Students Succeeds Act (ESSA), IAL provides competitive awards to school libraries as well as national not-for-profit organizations, including partnerships that reach families outside of local educational agencies (LEAs), to support children and families in high-need, underserved communities. By providing age-appropriate books, supporting parental engagement programs, and reinforcing professional development, the IAL program helps to support literacy skills to ensure that children enter school ready to learn and best positioned for success.

Since its inception in FY 2012, more than 200 IAL grants have been awarded to national non-profit organizations and school districts across every region of the U.S., delivering critical literacy resources in underserved communities. The IAL program is designed to provide the kind of support children and families need. Some examples of IAL grant activities include:

—The Yakama Nation Tribal School in Washington joined community partners for an IAL grant in 2021. Their Reading Through Mirrors & Windows IAL grant targets 14 schools with a large percentage of Native American and Hispanic students and will support literacy programs for educators, students, and parents designed to improve literacy skills. The grant will promote book distribution, mobile libraries, out-of-school time literacy activities, reader/writer theaters, and read-a-loud events. The 3-year grant has established laudable goals for the schools to achieve each year.

—An IAL grant was awarded to Tuscaloosa (AL) City Schools, a midsize school district serving 10,500 K–12 students in 20 locations. This collaborative grant with school libraries will provide a learning environment that is racially, ethnically, culturally, disability status and linguistically responsive. The grant allows the district to implement the Alabama Literacy Act to improve reading proficiency of public-school K–3 students. The district will be able to provide early literacy services and distribute high-quality books on a regular basis to children from low-income communities. Tuscaloosa schools have set goals that include a minimum of 85 percent of librarians will receive literacy training; 100

percent of participating schools will develop, improve, or expand their K–12 literacy plan; a 4 percent increase over baseline; and 100 percent of students will receive personal books and/or access to online books.

A strong learning environment begins with literacy skills in early childhood. A study by McKinsey & Company found that students taking formative assessments in spring 2021 lost the equivalent of 4 months of learning in reading on average, but the unfinished learning was especially for students of color and those from low-income households. Without immediate and sustained interventions, researchers estimate that pandemic-related unfinished learning could reduce lifetime earnings for K–12 students by an average of $49,000 to $61,000.

The American Academy of Pediatrics reports that children introduced to early reading and literacy support tend to read earlier and excel in school compared to children who lack the same access to books and literacy activities. Early literacy mastery is a strong indicator of future success in school and in life. Unfortunately, more than one in three American children start kindergarten without foundational skills to learn to read.

Recent studies and articles demonstrate the challenges facing our youngest students. One article notes that early reading skills in Virginia are at a 20-year low while 60 percent of high-poverty students in Boston are at high-risk for reading problems. Goldstein, Dana (2022, March 8) New York Times. Another article stated that more than one in three children who started school during the pandemic need 'intensive' reading help. Sparks, Sarah (2022, February 16) Education Week.

Providing books and access to childhood literacy programs for such children is essential as they learn to read and in turn this access is crucial to their—and our Nation's—economic futures. IAL is an important literacy support program that is urgently needed to address reading decline. IAL grants have been awarded during the life of the program to almost every State in the Nation. Schools across the country have received grants, including Dillingham (AK), Cutler-Orosi Joint Unified School District (CA), Chatham City Public School System, Ypsilanti (MI), Stringtown Public Schools (OK), Shelby County Board of Education (TN), as well as many others.

For families living in poverty, access to reading materials is severely limited. Children in these households have fewer books in their homes than their peers, which hinders their ability to prepare for school and to stay on track. IAL helps bridge that gap. Accordingly, we urge the subcommittee to foster this work by continuing to invest at least $50 million in IAL.

ALA asks for a modest, but critical, Federal investment of $50 million in the FY 2024 Innovative Approaches to Literacy (IAL) program, authorized under Every Student Succeeds Act. IAL provides competitive awards to high-need school libraries and national not-for-profit organizations (including partnerships that reach families outside of local educational agencies) to put books into the hands of children and their families. Increased funding will ensure more students in more States will receive urgently needed literacy development support.

ALA understands the tight fiscal constraints on the subcommittee, and we appreciate its continued dedicated support of IAL. Thank you for your commitment to sustaining and strengthening our communities and our Nation by supporting America's school libraries.

[This statement was submitted by Kevin L. Maher, Deputy Director, Public Policy & Advocacy, American Library Association.]

PREPARED STATEMENT OF THE AMERICAN LIVER FOUNDATION

SUMMARY OF FISCAL YEAR 2024 APPROPRIATIONS REQUEST

Request $1,500,000 in programmatic funding through the U.S. Department of Health & Human Services for a National Academies Study on Nonalcoholic Fatty Liver Disease (NAFLD).

Dear Chairwoman Baldwin, Ranking Member Capito, and distinguished members of the subcommittee,

Thank you for the opportunity to submit testimony on behalf of the American Liver Foundation (ALF) and the liver disease community. We extend our thanks for the significant investments in HHS, particularly CDC and the emerging Chronic Disease Education and Awareness program, provided over recent years. Please maintain this commitment and further enhance support for public health programs as you work with your colleagues on appropriations for FY 2024. We hope this Com-

mittee and Congress will continue to invest resources in key areas that will improve health, including efforts around disease prevention, screening, and treatment.

We also seek to ask for programmatic funding through HHS to fund a study on nonalcoholic fatty liver disease (NAFLD) through the National Academies of Sciences, Engineering, and Medicine. Below are details about our work and our requests. We truly hope you can make this request a reality to help us in our first step toward combating this "silent" disease affecting 80–100 million individuals in the U.S., most of whom are unaware they even have it. Thank you, again, for your time and consideration.

ABOUT THE FOUNDATION

Founded in 1976, ALF is the Nation's largest patient advocacy organization for people with liver disease. ALF reaches more than 4 million individuals each year with health information, education, and support services via its national office and an active online presence that leverages a robust multi-channel digital platform. Recognized as a trusted voice for liver disease patients, ALF also operates a national toll-free helpline (1–800–GO–LIVER), educates patients, policymakers, and the public, while also providing grants to early-career researchers to help find a cure for all liver diseases. For more than 45 years, ALF has been turning patients into survivors. For more information about ALF, please visit www.liverfoundation.org.

FATTY LIVER DISEASE

Nonalcoholic Fatty Liver Disease (NAFLD)

The liver is one of the body's largest organs, performing hundreds of functions daily including, the removal of harmful substances from the blood, digestion of fat, and storing of energy. NAFLD is caused by excess fat buildup in the liver, has few or no symptoms, and is the most common cause of liver disease worldwide affecting 1 billion people. According to some sources, NAFLD affects 80–100 million people in the U.S., most unaware they even have it. The disease disproportionately affects communities of color. It is not caused by heavy alcohol use (alcohol-associated liver disease). Risk factors include being overweight/obese, type 2 diabetes/insulin resistance, high cholesterol/triglyceride levels, one or more traits of metabolic syndrome (traits and medical conditions linked to overweight/obesity), and older age. Research estimates that NAFLD is present in up to 75% of overweight people and in more than 90% of people with severe obesity.

Nonalcoholic steatohepatitis (NASH)

Among those with NAFLD, about 25% (studies estimate about 9–15 million) are diagnosed with Nonalcoholic steatohepatitis (NASH), which is a dangerously progressive form of NAFLD in which patients have inflammation of the liver and liver damage, in addition to excess fat. NASH is expected to become the leading cause of liver transplantation in the U.S. in the next 2 years.

How Children are Affected by Nonalcoholic Fatty Liver Disease (NAFLD)

NAFLD has become the most common form of childhood liver disease in the U.S., more than doubling over the past 20 years, partly because of the increase in childhood obesity. Studies estimate that 5% to 10% of children have NAFLD.

PATIENT PERSPECTIVES

Shawanna—"In March of 2020, I saw my primary care physician for routine bloodwork. My physician called the next day informing me of elevated liver enzymes, and the need to repeat my labs. My doctor informed me she was calling a hepatologist on my behalf because she was deeply concerned and wanted me to be seen by a hepatologist ASAP. The next few months were very emotional for me and my family. I had multiple ultrasounds, MRIs, and ultimately a liver biopsy. In the end, I was diagnosed with NAFLD and NASH. Since there is no cure, the only advice I was given was diet and exercise. In 6 months, I lost 50 pounds and went from F3–F1 Fibrosis. Through researching my disease, I learned this disease is on the rise in children and adolescents, and because I am an educator, I became an advocate for our most vulnerable—our children. I started "Shawanna's Strut and Stroll for NAFLD" to raise awareness and money for research because I do not want anyone to go through what I experienced. The physical toll is difficult, but the mental/emotional aspect is equally draining because people have no idea how serious the disease is and how many people die because this disease is not taken seriously. We need help fighting this disease!!!"

Karl—"I was working in the medical profession 10 to fourteen-hour days while being on call 7 days a week. In December 2019, I got very sick and became very

lethargic and began sleeping all day and night. In February 2020, I was diagnosed with NASH with Stage 3 liver failure. Finding out that there was no specific treatment and the only option that may result in a positive outcome would be a liver transplant was devastating. Because of my medical background, I realized that for the rest of my life, I will be a prisoner of this horrible disease. Now I worry about my diet, a scratch that would not become infected, bleeding that takes longer than normal to clot, ensuring to cover my body with body lotion 3–4 times a day to prevent my skin from cracking and being susceptible to an infection, and most of all, the possibility that I am at significant risk in developing liver cancer is a part of my daily life. Increased research, education, and treatment options will be the key to decreasing the cost of the long-term treatment of this disease."

David—Six weeks. That's how quickly my mother, Geraldine, went from being diagnosed with NASH to leaving us forever. In October 2014 she passed away after a very brief and completely unexpected battle with late-stage NASH. They call NASH the "silent killer" and in Mom's case it was certainly true; she was never diagnosed with any form of liver disease at all before NASH. We had noticed some yellowing of her eyes and convinced her to go to the doctor about a month earlier, but it took time to get an appointment with a specialist, who checked her into a hospital upon the visit. I founded NASHAWARE.com to help raise awareness and educate others. If I can help even a few people, it will all be worth it. But I still want to do much more.

Benjamin—Right before I started medical school, my mom was diagnosed with liver inflammation. It took several years but she was ultimately diagnosed with Nonalcoholic steatohepatitis (NASH), a progressed form of Nonalcoholic fatty liver disease (NAFLD). NAFLD/NASH is manageable and—in many cases—can be reversed, so with the appropriate changes made to her diet and exercise, my mom was able to reverse her symptoms and is doing well today. Unfortunately, that is not the case for many Americans. NAFLD/NASH is a silent killer and often, people do not even know they have it.

Menchie—When I was diagnosed in 2012 with nonalcoholic fatty liver disease, my husband, Roger, was undergoing treatment of liver cancer. I shelved my NAFLD and focused on Roger's fight against liver cancer. Unfortunately, he lost his battle in December 2017. I learned there is no cure for NAFLD, but it could be reversed with a healthy diet, weight loss, and exercise. I am trying my best. Because what scares me more is the fatty liver turns into cancer. I saw how my husband underwent treatment. It's an everyday struggle. In memory of Roger and in the hope of spreading the mission of ALF, we formed our Liver Life Walk team and we named it Mabuhay Roger Garcia, We Love You.

Bruce—I am a liver disease patient that started out being diagnosed with NAFLD over 11 years ago. It was only caught because of what at the time were considered non-related issues (sleep apnea-now considered a co-morbidity and memory problems). Due to issues with the way liver disease is diagnosed and the lack of treatment(s), I have now progressed to NASH and a rare liver disease NRH (nodular regenerative hyperplasia). I want to help make sure that nobody else has to go through what I am still dealing with.

Our Request: We respectfully request that through the U.S. Department of Health & Human Services, programmatic funding of $1,500,000 is appropriated to fund a study on nonalcoholic fatty liver disease (NAFLD) through the National Academies of Sciences, Engineering, and Medicine. The recommendations and data that yield from this study will allow us and Congress to best address this growing disease and its impact on individuals and the U.S. health care system.

[This statement was submitted by Lorraine Stiehl, Chief Executive Officer, American Liver Foundation.]

PREPARED STATEMENT OF THE AMERICAN LUNG ASSOCIATION

SUMMARY OF FISCAL YEAR 2024 REQUESTS

$11.6 billion for the Centers of Disease Control and Prevention (CDC)

—National Center for Chronic Disease Prevention & Health Promotion (NCCDPHP)

Provide $3.75 billion for NCCDPHP

—Provide $310 million for CDC's Office of Smoking and Health (OSH)

—Provide $6 million for CDC's Chronic Disease Education and Awareness Program

—National Immunization Program at CDC's National Center for Immunization and Respiratory Diseases (NCIRD)

Provide $1.26 billion for NCIRD

—National Center for Environmental Health (NCEH)

Provide $322 million for NCEH

—Provide $110 million for CDC's Climate and Health Program

—Provide $40 million for CDC's National Asthma Control Program (NACP)

$51 billion for the National Institutes of Health (NIH)

$5 million for the Office of Climate Change and Health Equity (OCCHE) in the Office of the Secretary

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The country continues to face multipe threats to lung health concurrently. Barriers to affordable and quality healthcare, continued youth tobacco use, exposure to air pollution, and a respiratory virus that still claims thousands of lives weekly all highlight the continued need for a robust and well-funded public health infrastructure. The American Lung Association has consistently supported Federal investments in our Nation's public health and biomedical research activities by requesting significant funding for the Centers for Disease Control and Prevention. For the Nation to continue to combat ongoing challenges to public health and to prevent future health emergencies of communicable and non-communicable disease, we ask that CDC funding be increased to at least $11.6 billion for FY 2024. This funding must be in addition to, not in lieu of, any remaining emergency funds to respond to the COVID–19 pandemic.

The recent pandemic has also highlighted the importance of preventing and managing chronic lung conditions. Individuals living with certain lung diseases and people who smoke are among the most at risk for severe illness and death from COVID–19. The Lung Association recognizes the tremendous challenges Congress has faced in responding to the pandemic and appreciates all that it has done thus far. Continued investment in CDC programs that help people quit smoking; promote asthma control; support prevention and treatment of lung and other chronic diseases, including chronic obstructive pulmonary disorder (COPD) and lung cancer; and prepare for the health impacts created by a warming climate is vital.

The American Lung Association strongly supports substantial Federal investments in key health programs at CDC and NIH. For FY24, the Lung Association encourages Congress to take a balanced approach in its increases for these vital agencies and urges Congress to make significant investments in both public health and biomedical research.

Provide $11.6 billion for the Centers for Disease Control and Prevention (CDC): CDC continues to be faced with unique challenges and responsibilities, including preventing future public health emergencies, combating the youth e-cigarette epidemic, protecting the public from the health impacts of climate change, and managing and preventing chronic diseases such as asthma, COPD, and lung cancer. Consequently, the American Lung Association strongly supports the CDC Coalition's request of $11.6 billion for CDC for FY24 and sustained, robust and predictable funding moving forward annually for both cross-cutting initiatives, such as workforce and data modernization, and for the individual lines outlined below.

Provide $3.75 billion for National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP): As the pandemic has demonstrated, chronic diseases and infectious diseases are inextricably linked. Chronic diseases can be prevented and/or managed through supportive public health interventions, including tobacco prevention and cessation. Chronic diseases represent seven of the 10 leading causes of death, and account for 90% of the Nation's $3.8 trillion in annual health care costs. The American Lung Association strongly supports increasing the NCCDPHP budget to $3.75 billion. Such funding will allow NCCDPHP to fulfill its mission by expanding the current patchwork of existing programs to all jurisdictions nationwide.

Provide $310 million for CDC's Office of Smoking and Health (OSH): The American Lung Association is appreciative of the $5 million increase in funding for OSH in FY23 and asks for an additional $63.5 million for FY24. OSH is the lead Federal agency for tobacco prevention and control. One in four high school students continues to use at least one tobacco product. Smoking is the leading cause of preventable death and disease in the United States and costs the U.S. over $600 billion in healthcare costs and lost productivity annually. As such, support for tobacco cessation (quitting) and prevention activities is among the most effective and cost-effective investments in disease prevention. OSH works with State and local governments to prevent youth tobacco use and to promote evidence-based methods to help

smokers quit; for example, OSH's "Tips from Former Smokers" campaign has successfully prompted one million Americans to quit smoking. The additional funding will be used to continue to address the e-cigarette epidemic, to enhance the "Tips from Former Smokers" campaign so that it can be run year-round, to invest in youth prevention efforts and to work to eliminate health disparities among racial, ethnic, sexual, rural and socio-economic groups.

Provide $6 million for CDC's Chronic Disease Education and Awareness Program: Far too many individuals in the United States have or are at risk of potentially devastating chronic diseases without knowing. COPD is the sixth leading cause of death and disability in the United States. Approximately 16 million people in the United States have COPD, and millions more remain undiagnosed. Unfortunately, there are a myriad of chronic conditions like COPD that do not have stand-alone programs at CDC. Given these gaps, the Lung Association greatly appreciated the creation and funding of the Chronic Disease Education and Awareness competitive grant program at CDC in FY21 and the subsequent increases in FY22 and FY23. In FY24, the Lung Association asks for this program to receive $6 million to continue the momentum and allow CDC to expand its work with stakeholders to respond to chronic diseases that do not have stand-alone programs.

Provide $110 million for CDC's Climate and Health Program: CDC's Climate and Health Program is devoted entirely to identifying risks and developing effective responses to the health impacts of a changing climate, which include worsening air pollution; diseases that emerge in new areas; stronger and longer heat waves; and more frequent and severe droughts and wildfires. Communities across the country are already dealing with these challenges and it falls on health professionals to respond to the health impacts, like increases in asthma attacks, heat stroke, instances of tick-related illnesses and respiratory responses to mold. The Climate and Health Program creates a structure for identification, risk evaluation and intervention that States and cities can customize to meet their residents' needs. The Climate Ready States and Cities Initiative (CRSCI) housed within the program utilizes a five-step Building Resilience Against Climate Effects (BRACE) program to protect communities. The CRSCI program is a valuable tool for States, localities, Tribes and territories, but it has received insufficient funding. Funding constraints have led to cuts in funding for grantees, meaning that some jurisdictions no longer receive funding through this program. The American Lung Association supports a funding level of $110 million, which would allow CDC to fund every State and territory with adequate resources to provide education and adaptation efforts to respond to the impacts that are already occurring.

Provide $40 million for CDC's National Asthma Control Program (NACP): It is estimated that more than million Americans currently have asthma, of whom 5.5 million are children. The NACP tracks asthma prevalence, promotes asthma control and prevention and builds capacity in State programs. This program has been highly effective: asthma mortality rates have decreased overall despite the rate of asthma increasing. We thank Congress for the increase in funding of $3.5 million in FY23. At present, 23 States, Puerto Rico, and Houston, TX, receive funding, and additional entities are funded to collect detailed surveillance data so that public health interventions are more focused and effective. Additional funding to bring NACP's budget to $40 million in FY24 will allow CDC to increase the number of funded States during the 5-year new competitive award process this year, and also increase surveillance in States, including where pediatric asthma data are not available. Additional funding would also allow for the NACP to continue its efforts to develop public health interventions aimed at protecting people with asthma from wildfire smoke.

Provide $1.26 billion for the National Immunization Program at CDC's National Center for Immunization and Respiratory Diseases (NCIRD): The success of the Nation's vaccination programs has enabled many individuals to forget about the impact of many vaccine-preventable diseases, such as polio, that once wreaked havoc. The COVID–19 pandemic, in addition to a more recent measles outbreak, however, has provided a stark reminder of the need and significance of vaccines and a robust national vaccination program. The National Immunization Program must receive strong and sustained funding. The Lung Association asks for $1.26 billion for NCIRD to bolster the Nation's immunization infrastructure, to address any gaps in routine immunizations that may have emerged because of the pandemic, and to expand education efforts around vaccine hesitancy. The Lung Association also strongly supports the creation of the National Coronavirus and Other Respiratory Viruses Division within NCIRD.

Provide $51 billion for the National Institutes of Health (NIH): Research supported by NIH has been instrumental in the fight to identify the causes of and effective treatments for lung diseases. The Lung Association supports increased funding

for NIH research on the prevention, diagnosis, treatment and cures for tobacco use and all lung diseases including lung cancer, asthma, COPD, pulmonary fibrosis, influenza and tuberculosis. The Lung Association also supports robust funding increases for the individual institutes within NIH, recognizing the need for research funding increases to ensure the pace of research is maintained across NIH. Lastly, the Lung Association urges increased funding for cancer research in addition to the Cancer Moonshot, the All of Us Program and ARPH–H. Although lung cancer remains the leading cause of cancer deaths in the United States, the lung cancer survival rate has increased 33% in the past 10 years due to improvements in treatment. It is important that funding for cancer research increase concurrently in order to continue to make life-saving advancements.

Provide $5 million for the Office of Climate Change and Health Equity: The Office of Climate Change and Health Equity (OCCHE) within the Department of Health and Human Services was formed in 2021 to serve as a department-wide hub for examining how the agency can best coordinate responses to the growing health threats posed by a changing climate. Efforts under OCCHE help to train the health workforce to better respond to the health impacts—and health disparities—that a changing climate brings, as well as ready their systems and facilities to be resilient against climate impacts. In FY24, the Lung Association supports $5 million in funding for the Office of Climate Change and Health Equity to ensure health care facilities can assess and prepare communities for extreme weather and climate impacts.

With robust and sustained investment in health and continued focus on those who bear the greatest health burdens, the FY24 investments will help to reduce inequity and save lives.

Thank you for your consideration of our recommendations.

Sincerely.

[This statement was submitted by Harold P. Wimmer, President and CEO, American Lung Association.]

PREPARED STATEMENT OF THE AMERICAN MASSAGE THERAPY ASSOCIATION

The American Massage Therapy Association (AMTA) is pleased to submit a Statement for the record to express our appreciation for the Committee's efforts in recent years to ensure a stable source of funding for the National Institutes of Health (NIH), particularly congressional efforts to provide funding in the area of integrative and complementary non-opioid pain management therapies that include massage therapy. We also urge Congress to continue to support funding for pain management throughout NIH as well as the National Center for Complementary and Integrative Health (NCCIH), so that we can continue to develop better data on pain, and utilization of non-opioid alternatives in both the acute and chronic care settings.

Also, we encourage Congress to highlight the continuing need for the Centers for Medicare and Medicaid Services (CMS) to take appropriate steps to disseminate the final report of the May 2019 HHS Pain Management Task Force (PMTF). Massage therapy is specifically supported in the report, and is part of the HHS "Pain Management Toolbox" as an example of a treatment modality that should be considered as part of an overall integrative and collaborative care model to ensure optimal patient outcomes. https://www.hhs.gov/sites/default/files/pmtf-final-report-2019-05-23.pdf. Yet, almost 4 years after the release of the final report, there is still insufficient knowledge within the provider community about non-opioid pain management options.

Established in 1943 and numbering almost 100,00 members, AMTA works to advance the massage therapy profession through consistent licensing of massage therapists in all States, public education on the benefits of massage therapy, and support of research to advance knowledge about massage therapy. Massage therapists are currently licensed in 46 States and the District of Columbia.

Massage therapy is a well-established and evidence-supported integrative therapy that is effective for a wide variety of pain-related conditions:

—Massage therapy for pain management as an alternative to opioid use is a recognized supplemental benefit in Medicare Advantage plans,

—Massage is a covered benefit for our Nation's veterans and active-duty military personnel;

—Massage is supported by NCCIH for both acute and chronic pain, including low back pain, neck and shoulder pain, and side effects associated with certain cancers, as well as HIV/AIDS and fibromyalgia, and has been used in the NICU setting as an effective treatment for newborns born to mothers with substance abuse;

—Massage therapy is supported by major provider associations, including the American College of Physicians and The Joint Commission.
—Massage is currently utilized in acute care settings in hospitals and other institutions, such as the Mayo Clinic, M.D. Anderson Cancer Center, Duke Integrative Medicine, the Cleveland Clinic, and Memorial Sloan Kettering Cancer Center.

Despite the demonstrated value and efficacy of massage therapy through research, we know that more needs to be done. Research will continue to identify the optimal benefits of massage for particular demographic groups. And, we need to continue to improve our collective knowledge about the underlying mechanisms of pain, and how and why pain manifests differently for different patients.

For these reasons, we need to maintain a robust Federal research program at NIH and NCCIH dedicated to advancing massage therapy, and we need to continue to educate health providers about the benefits of massage and other integrative therapies to address pain management. We appreciate this Committee's interest and support for massage as a pain management therapy, and encourage continued support.

Thank you again for the opportunity to provide this statement.

[This statement was submitted by James Specker, Senior Director, American Massage Therapy Association, Government & Industry Relations.]

PREPARED STATEMENT OF THE AMERICAN PHYSICAL THERAPY ASSOCIATION

Dear Chair Baldwin, Ranking Member Capito, and Members of the Appropriations Committee:

The undersigned organizations representing more than 600,000 providers write to request a Federal appropriation to support the allied health workforce. Our organizations respectfully request a FY2024 programmatic appropriation of $8 million for the Health Resources and Services Administration allied health workforce program aimed at increasing educational opportunities in physical therapy, occupational therapy, respiratory therapy, audiology, and speech-language pathology for individuals who are underrepresented in such professions.

The PREVENT Pandemics Act, which passed as part of the Consolidated Appropriations Act of 2023, expanded the allied health workforce program within HRSA to increase educational opportunities for students from disadvantaged backgrounds or individuals who are underrepresented in our members' professions. Providing this appropriation will allow HRSA to provide scholarships and stipends to accredited higher education programs to recruit qualified individuals from underrepresented backgrounds, including persons with disabilities, students from economically disadvantaged backgrounds, and racial and ethnic minorities.

Supporting this critical workforce program will help strengthen and expand the comprehensive use of evidence-based strategies shown to increase the recruitment, enrollment, retention, and graduation of students from underrepresented and disadvantaged backgrounds. These strategies include outreach to the community, creating or expanding mentorship and tutoring programs, and providing scholarships and stipends to students.

The health care workforce is facing significant stresses, and the need to boost recruitment is critical now more than ever to improve access to high-quality care for rural and medically underserved populations.

We appreciate the opportunity to express our support for funding and implementation of this important health care workforce program. Should you have any questions, please contact Steve Kline with the American Physical Therapy Association at stevekline@apta.org. Thank for your time and consideration.

Sincerely,

American Academy of Audiology
American Association for Respiratory Care
American Occupational Therapy Association
American Physical Therapy Association
American Speech-Language-Hearing Association
National Rural Health Association

PREPARED STATEMENT OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION SERVICES

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.

We are grateful for this subcommittee's leadership in making bipartisan investments in mental health over the past several years, but more needs to be done. We must continue to address the human impact of the programs and why robust funding levels are 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 the demand for treatment for anxiety and depression remains high. Practitioners are seeing increased workloads 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 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 numbers of children seeking care for mental health emergencies. In addition, recent CDC data show that 45 percent of high school students feel consistently sad and hopeless, with teen girls and LGBTQ+ students showing disproportionate levels of concerning behaviors. All the 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 healthcare that we must turn the tide against.

We need investments in a diverse and robust mental health workforce to meet these challenges. Unfortunately, the U.S. continues to face a severe nationwide shortage of mental health care providers, including psychologists, with southern States having even less access to care.

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 (HHS), U.S. Department of Education, and U.S. Department of Labor.

Boosting Critical Research Funding:

APA Services endorses the Ad Hoc Group's request for 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. In addition, 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. NIMH delivered a report to Congress outlining a strategic framework to eliminate mental health disparities in youth by 2031. APA supports additional funding to help the institute reach that ambitious goal.

APA Services recommends at least $900 million for the Institute of Education Sciences (IES). This sum would enable IES to build on ongoing research and development activities to bolter education research and data infrastructure.

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 service demand. 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. In addition, 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 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 $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. In addition, 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. APA Services requests $10 million for CMS's Center for Medicaid and CHIP Services to support parity act enforcement within HHS.

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 are 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 the 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.

[This statement was submitted by Katherine B. McGuire, Chief Advocacy Officer, American Psychological Association Services, Inc.]

PREPARED STATEMENT OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION SERVICES, INC.

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We need investments in a diverse and robust mental health workforce to meet these challenges. Unfortunately, the U.S. continues to face a severe nationwide shortage of mental health care providers, including psychologists, with southern States having even less access to care.

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Health and Health Disparities on research in the populations most vulnerable to mental health disorders. NIMH delivered a report to Congress outlining a strategic framework to eliminate mental health disparities in youth by 2031. APA supports additional funding to help the institute reach that ambitious goal.

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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 $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. In addition, 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. APA Services requests $10 million for CMS's Center for Medicaid and CHIP Services to support parity act enforcement within HHS.

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 are 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 the 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.

[This statement was submitted by Katherine B. McGuire, Chief Advocacy Officer.]

PREPARED STATEMENT OF THE AMERICAN RED CROSS AND THE UNITED NATIONS FOUNDATION

Chair Tammy Baldwin, Ranking Member Shelley Moore Capito, and Members of the subcommittee, the American Red Cross and the United Nations Foundation appreciate the opportunity to submit testimony. We are grateful for the leadership that Congress has shown in funding CDC global health activities in prior years, and we urge Congress to protect and strengthen funding for the agency's global measles elimination activities for FY2024 at no less than $80 million, which is part of CDC's overall Global Immunization Division line.

COVID–19 PANDEMIC AND GLOBAL HEALTH SECURITY

COVID–19 has had an unprecedented impact on global immunization programs. From 2019 to 2021 the number of children receiving a first dose of measles containing vaccine (MCV1) decreased in all world regions, resulting in an overall drop in the global vaccination coverage rate from 86% to 81% over the period. It is estimated that more than 25 million children did not receive MCV1 through routine immunization, the highest increase in missed children since 2000. In addition, at least 61 million individuals did not receive MCV1 because of the COVID–19-related postponement of 18 preventative measles vaccination campaigns originally scheduled for implementation in 2020.

This growing immunity gap has set the stage for an increase in measles outbreaks and accompanying loss of life from an easily preventable disease. Because the measles virus is one of the most transmissible human diseases—with each infectious person capable of infecting as many as 18 unvaccinated individuals—a dramatic increase in measles outbreaks around the world is anticipated. Failing to close these immunity gaps will leave millions of children at risk and will compromise U.S. glob-

al health security by disrupting economies, trade, and country stability, as well as increasing the likelihood of the virus infecting U.S. communities. Global measles investments through the CDC Global Immunization Division will quickly close these global immunity gaps and strengthen surveillance systems. These investments will also help protect progress over the last decade in reducing maternal and child mortality and morbidity, as well as preserve and enhance country—and community-level immunization infrastructure that delivers other essential vaccines and medical interventions. With this context in mind, we respectfully provide the following justification for continued robust investment in CDC's global measles and rubella elimination efforts.

WHY MEASLES AND RUBELLA?

U.S. leadership has played a pivotal role in saving the lives of 56 million children between 2000 and 2021 through measles vaccination. Through the CDC's role in the Measles & Rubella Partnership, measles deaths have decreased by 83% since 2000. Measles is a highly contagious disease that can cause blindness, swelling of the brain, and death. Nine out of 10 people who are not immune to measles will contract the disease if they come in contact with a contagious person, and the measles virus can cause long-term damage to the immune system. Every day, roughly 351 children die of measles-related complications.

The rubella virus is a leading infectious cause of birth defects in the world despite availability of an affordable, effective vaccine since 1969. When rubella occurs early in a pregnancy, it can cause miscarriages, stillbirths, or a constellation of severe birth defects as part of congenital rubella syndrome (CRS) that can impact vision, hearing, heart health, overall development. Each year thousands of babies are born with CRS despite the vaccine preventable nature of the disease.

Since 2000, measles vaccines have been the single greatest contribution in reducing preventable child deaths globally. We have had safe and effective vaccines against both measles and rubella for over 50 years, but unfortunately vaccination rates globally stagnated for over a decade due to inadequate resources and now are decreasing due to COVID–19's impacts.

DOMESTIC IMPLICATIONS

The U.S. has maintained high rates of immunization and eliminated endemic measles and rubella in the early 2000s. However as seen in recent years, the virus continues to seek out and exploit local pockets of unvaccinated, vulnerable children. This happened recently in October 2022, during a measles outbreak in Ohio that infected 85 children, of whom 36 required hospitalizations. These outbreaks are costly for State and local health departments to detect and respond to and have economic productivity costs. For example, to respond to the measles outbreak in New York City in 2019, the NYC Department of Health spent over $6 million and dedicated more than 500 staff to halt the spread of the disease which began with a single imported cases from outside of the country.

THE MEASLES & RUBELLA PARTNERSHIP

The Measles & Rubella Partnership (M&RP)—which includes the American Red Cross, the Bill & Melinda Gates Foundation, Gavi the Vaccine Alliance, the US Centers Disease Control and Prevention, UNICEF, the United Nations Foundation, and WHO supports countries to prevent, identify, and respond to measles outbreaks through key interventions like surveillance, supplementary vaccination campaigns, and emergency response.

M&RP has achieved outstanding results by helping to vaccinate over 3.86 billion individuals in 88 countries since 2001, thereby contributing to saving an estimated 56 million children' lives over the past 20 years. In part due to M&RP, global measles mortality has dropped 83%, from an estimated 1,072,800 deaths in 2000 to an approximately 128,000 in 2021 (the latest year for which data is available), mostly children under the age of five.

THE ROLE OF CDC IN GLOBAL MEASLES MORTALITY REDUCTION

In 2021, thanks in part to U.S. funding through CDC, M&RP supported the vaccination of approximately 150 million children 18 countries. Funding for CDC permitted the provision of technical support to Ministries of Health that included: (1) planning, monitoring, and evaluating large-scale measles vaccination campaigns; (2) conducting epidemiological investigations and laboratory surveillance of measles outbreaks; (3) CDC's Global Measles Reference Laboratory serving as the leading worldwide reference laboratory for measles and rubella; and (4) conducting oper-

ations research to guide cost-effective and high-quality measles and rubella elimination programs.

The CDC Global Immunization Division, through which the M&RP receives funding, has been highly effective and we strongly support fully funding this work. All the programs funded through the Global Immunization Division budget line also help to build stronger health systems. As was seen during the response to COVID–19, resources like the Global Measles and Rubella Laboratory Network can be repurposed to quickly respond to other critical health issues. By building the capacity for measles and rubella resources the U.S. is also building capacity for future disease response efforts.

CONCLUSION

Since FY2001, Congress has generously provided funding to protect children and their families from the threat of measles and rubella in developing countries, thereby also protecting the U.S. population from the threat of measles importations. U.S. government funding for global measles and rubella efforts, however, has remained level since FY2010 at $50 million, which due to inflation has significantly eroded its purchasing power. Furthermore, the COVID–19 pandemic has gravely disrupted immunization systems around the world, leaving millions of children vulnerable to measles and other vaccine-preventable diseases. We must quickly increase vaccination coverage rates by reaching unvaccinated populations, to prevent the devastation of future measles outbreaks.

Because of these factors, for FY2024 the American Red Cross and United Nations Foundation respectfully request an increase of $30 million to raise the funding level to $80 million, as part of the overall funding for the entire Global Immunization Division account in FY2024. This investment will allow the CDC to help countries to close the immunization gap created by COVID–19, strengthen global disease detection capacity, safeguard the progress made over the last decade to reduce maternal and child mortality, and protect Americans by preventing measles cases and deaths in the U.S. Thank you for the opportunity to submit testimony, and for your continued commitment to ending preventable death and disability from measles and rubella.

[This statement was submitted by Koby J. Langley, Senior Vice President, International Services and Service to the Armed Forces the American National Red Cross and Peter Yeo, Senior Vice President United Nations Foundation.]

PREPARED STATEMENT OF THE AMERICAN SOCIETY FOR MICROBIOLOGY

The American Society for Microbiology (ASM) is the one of the largest life science societies, composed of more than 30,000 scientists and health professionals. Our mission is to promote and advance the microbial sciences. ASM respectfully requests that Congress provide at least $50.924 billion for the National Institutes of Health (NIH) and $11.58 billion for the Centers for Disease Control and Prevention (CDC) in fiscal year (FY) 2024. Within the CDC budget, we request $175 million for the Advanced Molecular Detection (AMD) program in the National Center for Emerging and Zoonotic Infectious Diseases.

Continuing to Lead through a Strong Investment in the NIH

We thank Congress for its longstanding, bipartisan support for the NIH and for its commitment to basic, translational, and clinical microbial research funded through multiple Institutes and Centers, particularly through the National Institute of Allergy and Infectious Diseases (NIAID). We especially thank Chair Baldwin, Ranking Member Capito and members of the Senate Appropriations subcommittee on Labor, Health and Human Services, Education and Related Agencies for their unwavering support for the NIH and leadership over the past several years, during which they and their Senate counterparts have worked in a bipartisan manner to place the NIH budget back on the path of meaningful growth above inflation.

Thanks to a renewed commitment to NIH, researchers were able to pivot when SARS–CoV–2 emerged and the race to develop tests, vaccines and therapeutics commenced. Researchers built on decades of federally funded basic science and technological advances to develop safe and effective vaccines at record speed. Now as we move past the pandemic, we must maintain the momentum and continue to provide robust, sustained and predictable funding for the NIH. The U.S. continues to face threats—known and unknown—and sustaining our investments is the only way we will seize the unparalleled scientific opportunities in microbial research that lie before us, and the only way we will be equipped to address the demands that future infectious disease outbreaks will place on our society.

NIH Funding has Transformed the Microbial Sciences

Beyond the remarkable achievements in COVID–19 diagnostics, vaccines and therapeutics that NIH funding enabled, investments in microbial research led to great strides in protecting and improving human health as illustrated by the following advances:

—A young person diagnosed with Human Immunodeficiency Virus (HIV) today who receives treatment will have a near normal life expectancy. The AIDS death rate has dropped 80% from its peak in 1995.

—Routine childhood vaccinations prevent millions of cases of illness. An estimated $82 billion in costs will be saved and 20 million cases, including 42,000 early deaths, will be prevented for children vaccinated in 2009. The introduction of a vaccine for rotavirus-the most common cause of childhood diarrhea worldwide-has resulted in the prevention of up to 50,000 child hospitalizations per year.

—NIH research played a major role in the discovery of the hepatitis C virus, which affects millions of people in the U.S. and around the world. The discovery and fundamental research resulted in the development of drugs that can cure almost all infected individuals, and as a result, blood donor screening programs have decreased the incidence of transfusion-transmitted hepatitis to near zero.

—The NIH has been on the forefront of supporting microbiome research since 2007, with the Common Fund's Human Microbiome Project (HMP), which was formed to develop research resources to study of microbial communities and how they impact human health and disease. Microbiome research has increased over 40 times since the inception of the HMP, and the work engages over 20 NIH Institutes and Centers. This important research has had implications for our understanding of microbiome interactions in pregnancy and preterm birth, inflammatory bowel disease, and diabetes, among other topics.

Continued Progress Requires Sustained Funding and Support for Investigators

Even in the face of the promise and progress highlighted above, well known pathogens and pathogen resistance threaten our Nation's health with serious economic and social ramifications. Seasonal flu continues to cost the U.S. billions annually in direct medical costs and lost productivity due to illness and claims the lives of thousands of Americans each year. Through sustained funding to NIAID, scientists continue the quest for a universal flu vaccine. Antimicrobial resistance (AMR) is a daunting public health challenge and considered a global crisis by the World Health Organization, the G20 and the United Nations. Continued investment in research to better understand how microbes become resistant, and develop more precise clinical diagnostics, novel therapeutics and vaccines is greatly needed.

CDC's Indispensable Role in Preventing and Controlling Infectious Disease

The programs and activities supported by CDC are instrumental in protecting the health of the American people. We applaud the CDC Moving Forward initiative, which will enable the agency to focus more on readiness and response to the American public. In particular, we are pleased to see the Office of Laboratory Science and Safety elevated to report to the Office of the Director. ASM appreciates the extraordinary emergency funding Congress provided to the agency since early 2020 to meet the needs presented by the pandemic. However, had Congress provided necessary support for CDC and public health infrastructure over time, our country would have been in a better position to address the public health crisis more effectively from the start. With this in mind, we urge Congress in FY 2024 to build on the infrastructure that has been bolstered in recent years, including robust funding for the Data Modernization Initiative and the Prevention and Public Health Fund. With this in mind, we urge Congress in FY 2024 to build on the infrastructure that has been bolstered in recent years, including robust funding for the Data Modernization Initiative and the Prevention and Public Health Fund. CDC aids in surveillance, detection and prevention of global and domestic outbreaks from novel viruses to foodborne illness, to Ebola, to the measles, to seasonal flu. CDC is the Nation's expert resource and response center, coordinating communications and action, and serving as the laboratory reference center. As we learned during the pandemic, States, communities, and international partners rely on CDC for accurate information, direction, and resources to ensure they continue to be prepared in a crisis or outbreak.

Three areas that ASM would like to highlight under CDC are: (1) advanced molecular detection technology; (2) antimicrobial resistance; and (3) laboratory capacity.

—The Advanced Molecular Detection (AMD) program brings cutting edge genomic sequencing technology to the front lines of public health by harnessing the power of next-generation sequencing and high-performance computing with bioinformatics and epidemiology expertise to study pathogens. The program has

played an indispensable role by leading genomic surveillance efforts and sequencing of SARS-CoV–2 samples, especially aimed at getting in front of emerging variants. We thank Congress for passing the Tracking Pathogens Act in late 2022 that supports this program, for providing transformational funding for AMD in the American Rescue Plan Act, and for providing two consecutive years of meaningful increases in base funding. With a stronger base, the AMD program can continue to promote innovation, expand workforce development, sustain the newly established Pathogen Genomics Centers of Excellence and enter into productive partnerships with academic research institutions and state/local public health agencies. ASM requests $175 million for AMD in FY 2024.

—Multiple programs support antimicrobial resistance, one of the most daunting health challenges we face today. ASM requests funding for the Antibiotic Resistance Solutions Initiative at $400 million, the National Healthcare Safety Network at $100 million, and the Division of Global Health Protection at $842.8 million, which will ensure that we have the resources across multiple programs to address this urgent public health challenge.

—Support for laboratory capacity is paramount, and the Emerging and Zoonotic Infectious Disease labs are the world's reference labs. But maintaining labs costs more each year, from quality and safety initiatives to the cost of shipments and supplies, to recruiting and retaining specialized and highly trained staff. We urge you to consider additional funding for resources to this area, particularly as we consider ways to bolster lab capacity in times of public health emergency.

ASM looks forward to working with you to ensure that researchers and public health professionals have the resources they need to apply fundamental microbial science research to meet 21st Century challenges in public health promotion, the prevention, detection and treatment of infectious diseases, and the prevention of outbreaks.

[This statement was submitted by Allen Segal, Chief Advocacy Officer.]

PREPARED STATEMENT OF THE AMERICAN SOCIETY FOR NUTRITION

Dear Chairwoman Baldwin and Ranking Member Capito:

Thank you for the opportunity to provide testimony regarding Fiscal Year (FY) 2024 appropriations. The American Society for Nutrition (ASN) respectfully requests at least $50.924 billion dollars for the National Institutes of Health (NIH) and $215 million dollars for the Centers for Disease Control and Prevention/National Center for Health Statistics (CDC/NCHS) in FY 2024. ASN is dedicated to bringing together the world's top researchers to advance our knowledge and application of nutrition, and has more than 8,000 members working throughout academia, clinical practice, government, and industry.

NATIONAL INSTITUTES OF HEALTH (NIH)

The NIH is the Nation's premier sponsor of biomedical research and is the agency responsible for conducting and supporting the largest percentage of federally funded basic and clinical nutrition research with $3.273 billion in nutrition and obesity research in FY 2022. Nutrition research and training has been funded at approximately 5% of total NIH obligations since FY 2015, although some of the most promising nutrition-related research discoveries have been made possible by NIH support. NIH nutrition-related discoveries have impacted the way clinicians prevent and treat heart disease, cancer, diabetes and other chronic diseases. Yet according to the recently released NIH Nutrition Research Report 2020–2021, funding levels for NIH-supported nutrition research and training have been flat for many years. Recently, due to inflation and other factors, support for nutrition research has actually declined—all while healthcare costs and risk factors for diet-related diseases remain high. From 2020 to 2021, age-adjusted death rates rose 3.3% for heart disease, 5.9% for stroke, and 2.4% for diabetes.[1] With additional support for NIH, additional breakthroughs and discoveries to improve the health of all Americans and reduce the economic burden of diet-related diseases will be made possible.

Investment in biomedical research generates new knowledge, improved health, and leads to innovation and long-term economic growth. ASN recommends at least $50.924 billion for NIH base budget in FY 2024, a $3.465 billion increase over the comparable FY 2023 program level, would allow NIH to accelerate progress in the NIH Common Fund's Nutrition for Precision Health, powered by the All of Us Re-

[1] https://www.cdc.gov/nchs/products/databriefs/db456.htm.

search Program, and can include the President's budget request for the NIH Office of Nutrition Research to be funded at $121.3 million. $50.924 billion provides a five percent increase across all NIH institutes and centers.

A budget of $50.924 billion will allow NIH to provide adequate support for the NIH Common Fund's Nutrition for Precision Health, powered by the All of Us Research Program, while still providing much-needed increases to other parts of the portfolio.

ASN also specifically requests that at least $40 million be allocated to the Office of Nutrition Research (ONR) within the NIH. The ONR has a crucial role in advancing nutrition science to promote health and reduce the burden of diet-related diseases and nutrition health disparities. ASN strongly supports the administration's FY 2024 Budget Request for the NIH ONR of $121.3 million to advance nutrition science to support nutrition research. By centrally coordinating the implementation of the Strategic Plan for NIH Nutrition Research, the ONR can support cross-cutting NIH nutrition research developed in collaboration with Institutes and Centers that already fund nutrition research. This funding level will provide the ONR with a strong foundation and increased capacity to carry out the following examples:

—Establish Food as Medicine Networks or Centers of Excellence to conduct implementation science, intervention, and health quality research to inform the development of more impactful health care policy that improves public health, lowers insurance costs, and expands nutrition education and training among health care providers.

—Maintain the Nutrition Science Data and Biospecimen Resources Portal, which provides datasets, biospecimens, and data analysis tools and resources to support nutrition research.

—Supplement the Dietary Biomarker Development Consortium, which works to identify biomarkers that can serve as independent, objective markers of dietary intake and complement current dietary intake assessment methods.

—Support the Developmental Origins of Health and Disease program, to examine the role of diet, food environment, and related environmental exposures in order to answer key mechanistic questions about the developmental origins of some diseases, and ultimately lead to an optimized diet for the health of the parent and child.

—Develop specific initiatives to advance the goals of the National Strategy on Hunger, Nutrition, and Health.

Increased support for nutrition research will provide solutions ensuring nutrition security and access to healthy food to prevent diet-related health disparities and promote health equity for a variety of diet-related diseases and conditions, such as cardiovascular disease, obesity, diabetes, and cancer. The complexity of human nutrition demands that cutting-edge data science and system science methods be employed to move this field forward. NIH needs sustainable and predictable budget growth to fulfill the full potential of biomedical research, including nutrition research, aimed at improving the health and well-being of all Americans and global populations.

CENTERS FOR DISEASE CONTROL AND PREVENTION NATIONAL CENTER FOR HEALTH STATISTICS (CDC NCHS)

The National Center for Health Statistics, housed within the Centers for Disease Control and Prevention, is the Nation's principal health statistics agency. ASN recommends a FY 2024 funding level of $215 million dollars for NCHS to help ensure uninterrupted collection of vital health and nutrition statistics and help cover the costs needed for technology and information security maintenance and upgrades that are necessary to replace aging survey infrastructure. The U.S. is a leader in this area but NCHS has been flat funded for years, losing purchasing power while facing increased costs. A $215 million budget would allow NCHS to keep pace with necessary survey innovations and collect information needed to monitor nutrition, public health and health care without cutting back on any major surveys such as the National Health and Nutrition Examination Survey (NHANES).

The NCHS provides critical data on all aspects of our health care system, and it is responsible for monitoring the Nation's health and nutrition status through surveys such as the National Health and Nutrition Examination Survey (NHANES), that serve as a gold standard for data collection around the world. Nutrition and health data, largely collected through NHANES, are essential for tracking the nutrition, health and well-being of the American population, and are especially important for observing nutritional and health trends in our Nation's children. This is an invaluable source of data that has been and can continue to be used to address major health issues as they arise. The U.S. Department of Agriculture uses this data to

develop nutrition policies that guide multibillion-dollar Federal food assistance programs, and nutrition researchers use this valuable data as well.

Nutrition monitoring conducted by the Department of Health and Human Services in partnership with the U.S. Department of Agriculture/Agricultural Research Service is a unique and critically important surveillance function in which dietary intake, nutritional status, and health status are evaluated in a rigorous and standardized manner. Nutrition monitoring is an inherently governmental function and findings are essential for multiple government agencies, as well as the public and private sector. Nutrition monitoring is essential to track what Americans are eating, inform nutrition and dietary guidance policy, evaluate the effectiveness and efficiency of nutrition assistance programs, and study nutrition-related disease outcomes. Funds are needed to ensure the continuation of this critical surveillance of the Nation's nutritional status and the many benefits it provides.

Through learning both what Americans eat and how their diets directly affect their health, the NCHS is able to monitor the prevalence of obesity and other chronic diseases in the U.S. and track the performance of preventive interventions, as well as assess 'nutrients of concern' such as calcium, iron, folate, iodine, vitamin D, and other micronutrients which are consumed in inadequate amounts by many subsets of our population. Data such as these are critical to guide policy development in health and nutrition, including food safety, food labeling, food assistance, military rations and dietary guidance. For example, NHANES data are used to determine funding levels for programs such as the Supplemental Nutrition Assistance Program (SNAP) and the Women, Infants, and Children (WIC) clinics, which provide nourishment to low-income women and children. Additional support would enable collection of more data on underrepresented groups, such as pregnant and lactating women, and assessment of nutritional status indicators for nutrients on which we have no, or inadequate, information. As such, ASN recommends that Congress direct the secretaries of USDA and HHS and other agencies as needed to engage with the National Academies of Sciences, Engineering, and Medicine (NASEM) to conduct a comprehensive study of NHANES including opportunities to modernize the survey methodology.

Thank you for the opportunity to submit testimony regarding FY 2024 appropriations for the NIH and the CDC/NCHS. Please contact John E. Courtney, Ph.D., ASN Executive Officer, at 9211 Corporate Boulevard, Suite 300, Rockville, Maryland 20850, jcourtney@nutrition.org, if ASN may provide further assistance.

Sincerely.

[This statement was submitted by Martha A. Belury, PhD, RDN, 2022–2023 President, American Society for Nutrition.]

PREPARED STATEMENT OF THE AMERICAN SOCIETY OF HEMATOLOGY

The American Society of Hematology (ASH) represents more than 18,000 clinicians and scientists committed to the study and treatment of blood and blood-related diseases, including malignant disorders such as leukemia, lymphoma, and myeloma, as well as non-malignant conditions such as sickle cell disease (SCD), thalassemia, bone marrow failure, venous thromboembolism, and hemophilia.

NATIONAL INSTITUTES OF HEALTH

Hematology research, funded by many institutes at the National Institutes of Health (NIH), including the National Heart, Lung and Blood Institute (NHLBI), the National Cancer Institute (NCI), and the National Institute of Diabetes, Digestive and Kidney Diseases (NIDDK), has been an important component of Congress' investment in the Nation's health. NIH-funded research has led to tremendous advances in treatments for children and adults with blood cancers and other hematologic diseases and disorders. Hematology advances also help patients with other types of cancers, heart disease, and stroke. Basic research on blood has aided physicians who treat patients with heart disease, strokes, end-stage renal disease, cancer, and AIDS.

The field of hematology continues to evolve and move closer to conquering blood diseases thanks to novel technologies, mechanistic insights, and cutting-edge therapeutic strategies, which would not have been possible without Congress' investment in NIH. Groundbreaking scientific research highlighted at the December 2022 ASH Annual Meeting and Exposition, much of which was either funded by NIH or derived from NIH-funded research, presented information on advances in gene therapy, practice-changing discoveries in immunotherapies, and advances in patient care for a wide range of hematologic diseases and conditions. Moreover, the Society's reg-

ularly updated ASH Agenda for Hematology Research serves as a roadmap to prioritize research within the hematology field and includes recommendations for areas of additional Federal investment that will equip researchers to make truly practice-changing discoveries in hematology and other fields of medicine for years to come.

ASH thanks Congress for the robust bipartisan support that has resulted in nearly a decade of welcome and much needed funding increases for NIH. For fiscal year (FY) 2024, ASH joins nearly 400 organizations and institutions across the NIH stakeholder community to strongly support the Ad Hoc Group for Medical Research recommendation that NIH receive at least $50.924 billion for its foundational work, a $3.465 billion increase over the comparable FY 2023 program level, which would allow NIH's base budget to keep pace with the biomedical research and development price index (BRDPI) and allow meaningful growth of nearly five percent.

ASH also joins the community in strongly urging lawmakers to ensure that any funding for the new Advanced Research Projects Agency for Health (ARPA–H) supplement the recommendation for NIH's base budget, rather than supplant the essential foundational investment in the NIH. Continued investment in NIH's basic science and translational research and the resulting foundation it provides is necessary for ARPA–H to fulfill its promise as a biomedical research accelerator.

CENTERS FOR DISEASE CONTROL AND PREVENTION

The Society also recognizes the significant role of the Centers for Disease Control and Prevention (CDC) and its critical work on preventing and controlling clotting disorders such as venous thromboembolism, reducing complications from bleeding disorders such as hemophilia, and improving the care and treatment of individuals with SCD. With a close connection between hematology and maternal health, ASH also recommends that the hematologic perspective is included in cross-CDC discussions about maternal health, including how existing programs such as the Sickle Cell Data Collection program could be leveraged to close knowledge gaps related to maternal health.

SCD is an inherited, lifelong disorder affecting approximately 100,000 Americans. Individuals with the disease produce abnormal hemoglobin which results in their red blood cells becoming rigid and sickle-shaped, causing them to get stuck in blood vessels and block blood and oxygen flow to the body, which can cause severe pain, stroke, organ damage, and in some cases premature death. Though new approaches to managing SCD have led to improvements in diagnosis and supportive care, many people living with the disease are unable to access quality care and are limited by a lack of effective treatment options.

CDC, through its Sickle Cell Data Collection program, awards grants to States, academic institutions, and non-profit organizations to study long-term trends in diagnosis, treatment, and healthcare access for people with SCD in the U.S. Currently 11 States participate in the data collection program, with data being collected from multiple sources (e.g., newborn screening programs and Medicaid) to create individual health care utilizations profiles. Funding through the CDC Foundation has enabled Georgia and California to collect data since 2015; additional CDC Foundation funding, along with discretionary funding from CDC and the Department of Health and Human Services (HHS) and funding provided by Congress since FY 2021 has expanded data collection programs to include nine additional States (Alabama, Colorado, Indiana, Michigan, Minnesota, North Carolina, Tennessee, Virginia, and Wisconsin). These 11 States are estimated to include just over 35% of the U.S. SCD population.

ASH thanks Congress for the $6 million provided for the data collection program in FY 2023 and appreciates the administration's request for $6 million in FY 2024. This funding will allow CDC to maintain its current level of support in States currently participating in the program. However, the Society strongly recommends providing CDC with at least $10 million in FY 2024 for the Sickle Cell Data Collection program. This additional funding will allow the program to continue in the States currently participating and also to expand the program to include additional States, with the goal of covering the majority of the U.S. SCD population over the next 5 years. An increase in funding would also provide CDC with the opportunity to leverage lessons learned through its data modernization efforts to help improve technical aspects of the program and provide for more coordinated and timely data analysis.

Additionally, ASH supports the public health community's request for at least $11.581 billion in overall funding for the CDC in FY 2024. Strong funding for CDC is vital to supporting all of CDC's activities and programs, which are essential to protect the health of our communities.

HEALTH RESOURCES AND SERVICES ADMINISTRATION

ASH supports funding for the SCD programs within HRSA's Maternal and Child Health Bureau, including $8.205 million for the SCD Treatment Demonstration Program (SCDTDP) and at least $7 million for the SCD Newborn Screening Program, which is part of HRSA's Special Projects of Regional and National Significance (SPRANS) program. The grantees funded by these programs work to improve access to quality care for individuals living with SCD and sickle cell trait. The SCDTDP funds five geographically distributed regional SCD grants that support SCD providers to increase access to high quality, coordinated, comprehensive care for people with SCD, while the SCD Newborn Screening Program provides grants to support the comprehensive care for newborns diagnosed with SCD.

Finally, ASH joins many others in the physician community in supporting funding for HRSA's Supporting the Mental Health of the Health Professions Workforce program. Health care professionals have long experienced high levels of stress and burnout, and our members have shared that the COVID–19 pandemic only exacerbated these problems. Burnout has been shown to reduce job performance, increase turnover, and, in its most extreme instances, lead to mental health issues. This important program, authorized as part of provisions in the Dr. Lorna Breen Health Care Provider Protection Act, will provide funding to support the implementation of evidenced-based and evidence-informed programs, practices, and trainings with the goal of reducing burnout and promoting mental health and wellness among the health care workforce. ASH supports the administration's request for $25 million for the Supporting the Mental Health of the Health Professions Workforce program in FY 2024 and respectfully urges Congress to provide this funding in order to expand access to vital programs to address the growing mental health challenges facing our health care workforce.

Please contact ASH Senior Manager, Legislative Advocacy, Tracy Roades at troades@hematology.org, for further information concerning hematology research or ASH's FY 2024 requests.

PREPARED STATEMENT OF THE AMERICAN SOCIETY OF HUMAN GENETICS,

The American Society of Human Genetics (ASHG) thanks the subcommittee for its continued strong support and leadership in funding the National Institutes of Health (NIH). The $2.5 billion increase provided for NIH in Fiscal Year (FY) 2023 reinforces our Nation's commitment to the health and well-being of all Americans at a time when investing in biomedical research and scientific innovation is more important than ever. ASHG urges the subcommittee to appropriate at least $50.924 billion for NIH's base budget in FY 2024. This amount would allow NIH's base budget to keep pace with the biomedical research and development price index (BRDPI) and allow meaningful growth of five percent.

EXTRAORDINARY PROGRESS IN HUMAN GENETICS & GENOMICS RESEARCH

Federal funding for human genetics and genomics research is enabling new insights into the structure of, and variation in, the human genome, and leading to new discoveries in preventing, diagnosing, and treating disease. Advances in genomic sequencing, both in sequencing speed and cost reduction, have been leveraged to enhance the ability to detect and diagnose rare neurogenetic disorders, genetic predisposition to early-onset heart conditions, and rare conditions that predispose individuals to colorectal, endometrial, and other cancers.[1] Understanding the genomic contribution to disease enables improved diagnosis and treatment, subsequently reducing healthcare costs and improving well-being.[2] Continued Federal funding to support research exploring the genetic underpinning of cancer has led to better techniques for early detection and prevention of cancerous tumors, leading to increased survival,[3] and has created a national ecosystem for sharing and analyzing cancer data so that researchers can more efficiently collaborate, increasing the potential for new discoveries.[4]

Additionally, NIH funding for human genetics and genomics has directly unleashed the power of precision medicine to improve health and well-being. Due to

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[1] https://pubmed.ncbi.nlm.nih.gov/36459977/.

[2] Health NRC (US) and I of M (US) R on TGBR for. Impact on Health Care and Public Health. National Academies Press (US); 2010. Accessed March 28, 2023. https://www.ncbi.nlm.nih.gov/books/NBK209648/.

[3] https://acsjournals.onlinelibrary.wiley.com/doi/full/10.1002/cncr.34479; https://doi.org/10.1002/cncr.34479.

[4] https://www.cancer.gov/research/key-initiatives/moonshot-cancer-initiative.

critical investments like NIH's All of Us Research Program, a groundbreaking effort to collect and study data from over one million people, researchers and clinicians can now compare an individual's personal and family history to more accurately identify predisposition to disease. For example, heart disease is responsible for 1 in 5 deaths[5] in the United States, and it disproportionately affects individuals from racial and ethnic communities that have been historically underrepresented in medical research. There are now more than 200 research projects on heart disease and more than 15 peer-reviewed studies about heart disease that used the All of Us dataset. All of Us is building one of the largest, most diverse, and broadly accessible datasets for researchers, enabling studies addressing health disparities and investigating novel treatments for a range of conditions, including heart disease.[6]

Human genetics and genomics research is also delivering hope for the millions of people in the United States living with rare diseases. For example, decades of work funded by the NIH have led to the first FDA approved drug for treating progeria, a rare pediatric genetic disorder that causes accelerated aging and premature death in children.[7] This advancement was made possible by our understanding of human genetics and subsequent knowledge of exactly how a single gene mutation leads to disease. In addition, the NIH's Undiagnosed Diseases Network (UDN) was created to establish a nationwide network of researchers and clinicians who leverage advances in genomics tools and research to uncover the mechanisms underlying rare diseases and conditions, which collectively impact approximately 25 million Americans. Funding for the UDN has improved the ability for patients suffering from undiagnosed conditions to receive the clarity of a diagnosis and has contributed to major advances in therapies (e.g., gene and cell therapy) that can be used to treat both rare and common genetic diseases. Knowledge gained from the study of rare genetic diseases will also impact our approach to treating common diseases. Critically, these advances are driven by NIH's robust support for fundamental research to better understand disease mechanisms. The Consolidated Appropriations Act 2023 reaffirmed the importance of the UDN and ASHG supports its continuation as a priority program at the NIH.

GENETICS & GENOMICS: STRIVING FOR EQUITY AND RESEARCH COHORT DIVERSITY

Genetic science can advance health equity through the deliberate, meaningful inclusion and participation of individuals from diverse groups in human genetics and genomics research. While human beings are 99.9 percent identical in our genetic makeup, the variation in the remaining 0.1% can influence a person's risk of disease or how the body responds to medications, stress, or environmental factors. Polygenic-risk scores (PRS) are one way to provide insight into a person's risk for disease based on their genes. It is imperative for participation in genetics and genomics research to reflect humanity's diversity so that we can gain a fuller understanding of the genetics of health and disease, so all people can enjoy its benefits, and genetic discoveries can be equitably applied in healthcare.

While human genetics and genomics research has advanced biomedical research and improved the lives of patients, the field has historically failed to account for the rich diversity of patients that the research should be designed to serve. For example, because most individuals participating in genetics research are of European ancestry, PRS tools are more effective for assessing disease risk in people of European ancestry than for individuals with Hispanic, South Asian, East Asian or African ancestries.[8] Recently, scientists have taken a step to improve the accuracy of these genetic scores for a broader population by creating a new method called PRS–CSx.[9] This new approach incorporates population level differences in DNA patterns and further pushes this approach closer to being useful in clinical contexts. However, the lack of participation of underrepresented communities in human genetics and genomics research can largely be attributed to issues around scientific mistrust, miscommunication, and barriers that make it challenging for individuals to participate in this much needed research.

During the COVID–19 pandemic, NIH established the Community Engagement Alliance (CEAL) Initiative consisting of researchers, policy-makers, community-

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[5] https://www.cdc.gov/heartdisease/facts.htm.

[6] Lunt C, Mayo K, Master H, Growing a research ecosystem in the cloud: Early insights from the All of Us Research Program; (Abstract #PB3215). Presented at the annual meeting of the American Society of Human Genetics, October 27, 2022, in Los Angeles, California.

[7] https://www.fda.gov/news-events/press-announcements/fda-approves-first-treatment-hutchinsongilford-progeria-syndrome-and-some-progeroid-laminopathies.

[8] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9072305/.

[9] Ruan, Y. et al. Improving polygenic prediction in ancestrally diverse populations. Nat Genet 54, 573–580 (2022).

based organizations, faith-based organizations, and other relevant stakeholders to tackle scientific misinformation and build public trust in biomedical research and its advances among communities across our Nation.[10] Community engagement to foster sustainable partnerships and trust is also key for science when there is public hesitancy to participation in research, as is the case with human genetics and genomics research

ASHG was pleased to see that the Consolidated Appropriations Act 2023 included language urging the National Human Genome Research Institute (NHGRI) to build on these successes and establish a community engagement program to support efforts to increase the participation of individuals historically underrepresented and hesitant to participate in human genetics and genomics research.

BROAD DATA SHARING: ESSENTIAL FOR HUMAN GENETICS AND GENOMICS RESEARCH

The funding provided by the U.S. government to the NIH is instrumental in promoting the health and stability of the United States, and its benefits extend globally. Broad sharing of human genome data from NIH-funded research drives cutting-edge innovations worldwide and is essential for advancing science and maximizing the public's return on investment in biomedical research. The genetics and genomics research community is a leader in developing best practices for sharing data while protecting individuals' privacy. We strongly support policies including the Common Rule, the Genetic Information Nondiscrimination Act (GINA), the 21st Century Cures Act, the NIH Genomic Data Sharing Policy, and the Health Insurance Portability and Accountability Act (HIPAA), which together act to protect individuals from the inappropriate disclosure of data for non-research purposes.[11] As Congress continues its oversight of the Nation's research enterprise, we urge the Committee to recognize the privacy protections already established by Congress and NIH for genetic research data, and to ensure that broad data-sharing can continue to fuel scientific progress and maintain the United States' leadership and global competitiveness.

SUMMARY

ASHG joins the Ad Hoc Group for Medical Research in recommending at least a $50.924 billion base budget for NIH for FY 2024. This funding level would allow NIH's base budget to keep pace with inflation, specifically the biomedical research and development price index, and support crucial research on human genetics and genomics across all of the NIH's 27 Institutes and Centers.

The American Society of Human Genetics (ASHG), founded in 1948, is the primary professional membership organization for human genetics specialists worldwide. The Society's nearly 8,000 members include researchers, clinicians, genetic counselors, nurses, and others who have a special interest in the field of human genetics.

[This statement was submitted by Brendan Lee, MD, PhD, President, American Society of Human Genetics.]

PREPARED STATEMENT OF THE AMERICAN SOCIETY OF NEPHROLOGY

On behalf of the more than 37 million Americans living with kidney diseases, the American Society of Nephrology respectfully requests that in the Office of the Secretary of Health and Human Services (IOS), General Department Management, $25 million be included for KidneyX, a public-private partnership to accelerate innovation in the prevention, diagnosis, and treatment of kidney diseases, in the Fiscal Year (FY) 2024 Labor, Health and Human Services, Education and Related Agencies Appropriations bill.

More than 37 million people in the United States are living with kidney diseases, including more than 800,000 with kidney failure, a life-threatening condition for which there is no cure. Currently, there are two therapies available to manage kidney failure, a kidney transplant and dialysis, both of which remain conceptually the same since their development approximately 50 years ago. A kidney transplant is the best therapy for most people with kidney failure, yet a national organ shortage means than 12 Americans die every day while on the nearly 100,000-person long waitlist. Dialysis, the most common therapy for kidney failure, is an important tool to manage kidney failure, yet has survivability outcomes worse than all but the

[10] https://covid19community.nih.gov/about/who-we-are.

[11] American Society for Human Genetics. (2021). Perspectives: Research and Privacy [Fact sheet]. https://www.ashg.org/wp-content/uploads/2021/08/Factsheet-DataPrivacy.pdf.

deadliest cancers: more than 60 percent of people starting dialysis today will die within 5 years.

The status quo for treating and managing kidney diseases is also far too costly to taxpayers to continue without intervention. Medicare annually dedicates $150 billion, or 18 percent of Medicare spending, to the care of people with kidney diseases, including $50 billion, or 6 percent of Medicare spending, to manage kidney failure alone. Relative to other chronic diseases with comparable Federal spending and disease burden, people with kidney diseases have had a lack of innovation in the prevention, diagnosis, and treatment of kidney diseases, but hope is on the horizon: KidneyX is attracting a new generation of innovators and investors and transforming kidney care.

KidneyX is incentivizing innovators to fill unmet patient needs through a series of prize competitions, de-risking the commercialization process by fostering coordination among Federal agencies and creating a sense of urgency on behalf of patients and families. To date, KidneyX has provided funding to 67 innovators in 22 States and 40 congressional districts across 5 prize competitions for solutions ranging from patient-generated solutions that improve quality of life while living with kidney diseases to steps toward paradigm-shifting technologies such as a wearable or implantable artificial kidney and xenotransplantation. Further, KidneyX is delivering on its pledge to catalyze private markets to invest in the advancement of kidney care. For instance, investors contributed more than $300,000,000 to multiple winners of KidneyX's first prize competition, Redesign Dialysis.

FY 24 funding will continue to prioritize the progress of the Artificial Kidney Prize, which seeks to catalyze the development of the world's first artificial kidney, will build off of prior KidneyX competitions and recent advances in regenerative medicine, xenotransplantation, and patient-centered design. With $25,000,000 in funding, KidneyX can support additional innovators in the Artificial Kidney Prize competitions and run prizes in other priority areas in the treatment, prevention, and diagnosis of kidney diseases. Three such areas KidneyX is exploring include reducing the water usage in dialysis-globally, dialysis uses enough medically pure water to fill Lake Tahoe every year-increasing patient shared decision making in transplant care, and advancing predictive analytics in organ offer acceptance. On average, a transplant recipient is offered 15 kidneys without their knowledge before they receive a transplant, and 26% of all procured kidneys are discarded even though research shows that virtually all of these organs would have benefitted patients if they were accepted.

This year, KidneyX will announce winners of its current prize competition, the Artificial Kidney Prize Phase 2, which seeks to accelerate the development of an artificial kidney from the regenerative medicine, cellular engineering, tissue engineering, systems biology, and synthetic biology communities. Prior innovations awarded KidneyX prizes include those highlighted below:

—Applying advances in science and technology to improve current kidney failure therapies, such as nanomaterials to reduce infections in dialysis grafts and an innovative catheter which might exponentially reduce infections in the provision of dialysis, both seeded through the Redesign Dialysis Phase 1 and Redesign Dialysis Phase 2 prize competitions

—Patient generated solutions to better manage their care, such as clothing which provides health care staff easy access to dialysis ports without having to remove or scrunch up clothing, seeded through the Patient Innovator Challenge

—Groundbreaking technologies that may lead to a fully implantable or bioartificial kidney, such as an implantable silicon filter cartridge paired with a bioreactor with kidney cells that together provide continuous treatment without needing to be tethered to a dialysis machine, or a method to genetically engineer pig kidneys to make them perform life-sustaining functions when transplanted in humans, both seeded through the Artificial Kidney Prize competitions

A bipartisan achievement, KidneyX was first unveiled as a concept at the 2016 Obama White House Organ Summit and was launched in 2018, featuring as central pillar of Former President Donald J. Trump's 2019 Executive Order on Advancing American Kidney Health to increase innovation for people living with kidney diseases. KidneyX is a true public-private partnership: the private sector has already committed $25 million to KidneyX and to matching future Federal funding with additional private sector funding to achieve a program total of $250 million. KidneyX has received a total of $20 million since FY 20 in enacted appropriations. Since its inception, KidneyX has demonstrated the success of its public-private prize funding model, delivering on its mission of accelerating innovation in kidney care, attracting new innovators and investors to the kidney space, and broadening the availability

of novel ideas and capital to improve the lives of the 37 million Americans with kidney diseases.

In light of this strong track record, we respectfully request that the Labor-HHS subcommittee continue its commitment by appropriating $25 million in FY 2024 for KidneyX, catalyzing private sector investment in kidney health including to develop new treatment options for people with kidney diseases, such as the world's first artificial kidney. In addition, we also ask that you include the following language in the report accompanying your Committee's appropriations bill:

The Committee is aware that more than 37 million people in the United States are living with kidney diseases, and for more than 800,000 of those individuals, the diseases progress to kidney failure, a life-threatening condition without a cure. The Committee notes that kidney failure alone accounted for more than 6 percent of Medicare spending (approximately $50 billion) in CY 2020, yet patient choice in therapies for kidney failure remain restricted to core technology developed 50 years ago and that more than 60% of patients starting dialysis, the most common therapy for kidney failure, will die within 5 years.

The Committee requests that HHS prioritize funding for KidneyX as a bipartisan and market-based approach to accelerate innovation in kidney health in future budget requests.

Thank you for your consideration of this important request. Should you have questions or need additional information, do not hesitate to contact Zach Kribs, American Society of Nephrology Manager of Congressional Affairs, at zkribs@asn-online.org.

ABOUT THE AMERICAN SOCIETY OF NEPHROLOGY

Since 1966, ASN has been leading the fight to prevent, treat, and cure kidney diseases throughout the world by educating health professionals and scientists, advancing research and innovation, communicating new knowledge, and advocating for the highest quality care for patients. ASN has nearly 21,000 members representing 140 countries. For more information, visit www.asn-online.org and follow us on Facebook, Twitter, LinkedIn, and Instagram.

[This statement was submitted by Zach Kribs, American Society of Nephrology, Manager of Congressional Affairs.]

PREPARED STATEMENT OF THE AMERICAN SOCIETY OF NEPHROLOGY, THE AMERICAN SOCIETY OF PEDIATRIC NEPHROLOGY, AND THE NATIONAL KIDNEY FOUNDATION

On behalf of more than 37 million children, adolescents, and adults living with chronic kidney diseases (CKD) in the United States, the American Society of Nephrology, the American Society of Pediatric Nephrology, and the National Kidney Foundation request $50.924 billion for the National Institutes of Health base budget in Fiscal Year (FY) 2024, an increase of 7.3% that will provide real growth above biomedical research inflation, and request a robust proportional increase for the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) of no less than $168 million. Further, we request that Congress ensure there is a physician-scientist workforce ready to meet the current and future needs of the growing number of people with kidney diseases by including the kidney health research workforce in any policy making to address broader workforce shortages.

For more than 800,000 Americans, kidney diseases progress to kidney failure, a life-threatening condition for which there is no cure. Kidney failure is most commonly managed by in-center hemodialysis, a therapy that has changed little in the 50 years since its development and has a 5-year survival rate of less than 40 percent-worse than nearly all forms of cancer. While a kidney transplant is the optimal therapy for most patients with kidney failure, it is often inaccessible due to a shortage of organs and inequities in our Nation's transplant health system. Patients seeking a kidney transplant, face a nearly 90,000 person-long waitlist, and the wait can be as long as 10 years in some areas of the country. As a result, 12 Americans die every day waiting for a kidney.

Even as Congress has provided steady increases for the NIH over the past decade, NIH funding for kidney disease research has lagged far behind that of NIH overall; between fiscal years 2017 and 2021 NIH support for kidney research increased at half the rate of NIH funding increases. Increased investment in kidney health research will improve outcomes for people living with kidney diseases and reduce costs to the US health care system. Our organizations request that the committee maintain and increase investment in kidney disease research by providing $50.924 billion

for NIH in FY 2024 with an at least proportional increase for NIDDK of $168 million.

Improving Equity in the Diagnosis of Kidney Diseases

People with kidney diseases face stark racial and socioeconomic disparities in disease burden and access to care. For instance, Black Americans and Hispanic Americans are more than four and two times as likely than White Americans respectively to have kidney failure. Disparities in prevalence and outcomes are due to multiple factors including lack of access to care, social determinates of health, and systemic racism. Greater investment in research is needed to increase understanding about the underlying causes of disparities and generate interventions to address them.

Enabling a Strong Kidney Health Workforce

Most people with kidney diseases experience comorbidities such as cardiovascular disease (including heart attack and stroke), anemia, bone disease, hypertension, and diabetes, and face increased risk from communicable diseases, including COVID–19 which has increased hospitalization and mortality among this vulnerable population. Pediatric kidney disease patients are often more complex than adult patients, many are living with rare medical conditions with unique needs which must be better understood. A strong, demographically representative, and culturally competent workforce of physician-scientists is needed to meet the needs of adults and children living with kidney diseases, especially while they face deadly consequences of the COVID–19 pandemic in their daily lives. Our organizations request that the committee ensure NIDDK is providing adequate support for training the next generation of kidney health scientists by continuing to oversee NIDDK's implementation of the number of adult and pediatric training positions funded by the newly established NIDDK U2C grant mechanism compared to prior mechanisms, and by ensuring funding opportunities available to kidney health researchers continues to grow.

An estimated 10,370 to 12,939 nephrologists currently practice in the United States. From 2008 to 2020, the number of US nephrologists doubled, yet despite this growth only 52% of accredited nephrology fellowship programs filled all their positions through the National Resident Matching Program (NRMP) Medical Specialties Matching Program in the appointment year 2022 Match. These figures do not specifically address a shortage of physician scientists and other kidney health researchers who are essential for increasing innovation in kidney health care. Potential kidney health researchers are often dissuaded by a perceived lack of career stability and funding opportunities, especially compared to the cost education. With an increasing number of Americans living with kidney diseases and kidney failure, it is vital that a kidney health research workforce exists to address the needs of a growing number of people living with kidney diseases over the next decade. Ultimately, the leadership of Congress will be needed to fully address workforce challenges. ASN, ASPN and NKF would welcome the opportunity for partnership as any polices to address health workforce and research proposals are developed.

Greater investment in kidney research should be an urgent priority to slow disease progression, improve treatment, reduce morbidities, and improve patients' quality of life. Better understanding of kidney diseases and its progression in adults and children, combined with improved methods for detecting kidney diseases and a highly skilled workforce of physician-scientists, may even prevent irreversible kidney failure in the future. Thank you again for your leadership, and for your consideration of our request. Should you have any questions or wish to discuss kidney disease research in more detail, please contact Erika Miller with the American Society of Pediatric Nephrology at (202) 484–1100 or emiller@dc-crd.com; Zach Kribs with the American Society of Nephrology at (202) 618–6991 or zkribs@asn-online.org; or Lauren Drew with the National Kidney Foundation (NKF) at (973) 668–2996 or lauren.drew@kidney.org.

ABOUT THE AMERICAN SOCIETY OF NEPHROLOGY

Since 1966, ASN has been leading the fight to prevent, treat, and cure kidney diseases throughout the world by educating health professionals and scientists, advancing research and innovation, communicating new knowledge, and advocating for the highest quality care for patients. ASN has nearly 21,000 members representing 140 countries. For more information, visit www.asn-online.org and follow us on Facebook, Twitter, LinkedIn, and Instagram.

ABOUT THE AMERICAN SOCIETY OF PEDIATRIC NEPHROLOGY

Founded in 1969, the American Society of Pediatric Nephrology is a professional society composed of pediatric nephrologists whose goal is to promote optimal care for children with kidney disease and to disseminate advances in the clinical practice

and basic science of pediatric nephrology. ASPN currently has over 600 members, making it the primary representative of the Pediatric Nephrology community in North America.

ABOUT THE NATIONAL KIDNEY FOUNDATION

The National Kidney Foundation is the largest, most comprehensive, and long-standing patient-centric organization dedicated to the awareness, prevention, and treatment of kidney disease in the U.S. In addition, NKF has provided evidence-based clinical practice guidelines for all stages of chronic kidney disease (CKD), including transplantation since 1997 through the National Kidney Foundation Kidney Disease Outcomes Quality Initiative (KDOQI). For more information about NKF, visit www.kidney.org.

[This statement was submitted by Erika Miller, Washington Representative for the American Society of Pediatric Nephrology.]

PREPARED STATEMENT OF THE AMERICAN SOCIETY OF PLANT BIOLOGISTS

On behalf of the American Society of Plant Biologists (ASPB), we would like to thank the subcommittee for its support for the National Institutes of Health (NIH). ASPB and its members strongly believe that sustained investments in scientific research are a critical component of economic growth, job creation, and innovation for our Nation. ASPB supports continued robust funding for NIH in fiscal year (FY) 2024 and asks that the subcommittee encourage increased support for plant-related research relevant to health within the agency, including within the newly established Advanced Research Projects Agency for Health (ARPA–H) and through programs led by the Office of Nutrition Research.

ASPB, founded in 1924 as the American Society of Plant Physiologists, was established to promote the growth and development of plant biology, to encourage and publish research in plant biology, and to promote the interests and professional advancement of plant scientists in general. ASPB members educate, mentor, advise, and nurture future generations of plant biologists; they work to enhance understanding of plant biology and its impacts on public health and wellbeing, as well as science in general, in K–16 schools and among the general public; they advocate in support of plant biology research; work to convey the relevance and importance of plant biology; and they provide expertise in policy decisions world-wide. Overall, ASPB members, as representatives of the society, work to disseminate information and to excite future generations about plant sciences, especially through ASPB's advocacy, outreach activities, conferences, and publications.

PLANT BIOLOGY AND THE NATIONAL INSTITUTES OF HEALTH

Plant research makes many fundamental contributions to the study of human health, including the discovery and supply of plant-derived pharmaceuticals, nutraceuticals, and alternative medicines; the continued, sustainable development of better and more nutritious foods; and the understanding of basic biological principles that underpin improvements in public health and human nutrition. Plant science and many of our ASPB member research activities have enormous positive impacts on the NIH mission to pursue "fundamental knowledge about the nature and behavior of living systems and the application of that knowledge to extend healthy life and reduce the burdens of illness and disability." In general, plant research aims to improve the overall human condition-be it food, nutrition, medicine, clean air, or agriculture-and the benefits of plant science research readily extend across disciplines. In fact, plants are often the ideal model systems to advance our "fundamental knowledge about the nature and behavior of living systems" because they are, like humans, complex multi-cellular organisms yet afford ease of genetic manipulation, a lesser regulatory burden, and maintenance requirements that are less expensive and burdensome than those required for the use of animal systems.

Fundamental Biological Research

Many fundamental biological components and mechanisms are shared by plants and animals. Examples include but are not limited to genetic principles, cell division, host-pathogen interactions, organism-environment interactions, polar growth, DNA methylation and repair, innate immune signaling, and circadian (biological) rhythms. For example, fundamental hereditary laws, the basis of modern genetics, were derived from the study of garden peas. The phenomenon of RNA interference, which has application in gene therapies for human disease, was first discovered in plants. Plants also contributed to the development of revolutionary technologies like

gene editing (e.g., the CRISPR-Cas9 system), capable of precisely editing genomes for a multitude of benefits. These technologies are being deployed to produce more nutritious food and to sustainably increase production. Furthermore, many treatments and therapies are based on metabolites derived from plants. Nearly 120 pure compounds extracted from plants are used globally in medicine, hinting at the significant possibilities for future discoveries applicable to human health, agriculture, and manufacturing.[1] These important discoveries, among many others in science and technology, reflect the fact that some of the most important biological discoveries applicable to human physiology and medicine can find their origins in plant-related research endeavors.

Use-Inspired Research

In addition to their role in expanding our understanding of the basic mechanisms of biology, plants have been enormously beneficial in advancing use-inspired research aimed at developing breakthrough technologies, platforms, and solutions for health and medicine. The newly established Advanced Research Projects Agency for Health (ARPA–H) within NIH is a promising avenue for bringing new plant-based breakthroughs from idea to reality. The ARPA model for funding research has already proved to be an excellent fit for plant biology as shown by successful programs funded through the Defense Advanced Research Projects Agency (DARPA) and the Advanced Research Projects Agency—Energy (ARPA–E), and ASPB supports the inclusion of plant-related research within the ARPA–H portfolio.

Health and Nutrition

Plant research contributes to the continued, sustainable development of better and more nutritious foods and the understanding of basic biological principles that underpin improvements in public health and human nutrition. ASPB applauds the recent steps NIH has taken to advance the study of "Food is Medicine," notably through the development of an upcoming Common Fund program focused on multidisciplinary research aimed at reducing health disparities and preventing diet-related diseases through the consumption of nutritious foods.[2] Plant biologists contribute to building the scientific evidence base underlying Food is Medicine approaches to support their implementation in public health practice.

Good nutrition is fundamental for health beyond diet-related diseases. One example of how advances in plant biology have been applied to tackling nutritional deficiencies is golden rice, designed to address vitamin A deficiency and reduce blindness risk in vulnerable children. Golden rice was engineered to include additional genes that switch on production of beta-carotene, and a bowl of this golden rice can provide 60% of a child's daily requirement of vitamin A to prevent blindness. Because environmental degradation and climate change also have health impacts, it is important that significant advances have also been made in the production of crops capable of thriving with less water, fewer inputs, and under extreme weather conditions. ASPB supports the continuation of NIH's Climate Change and Health Initiative as a tool for making additional progress towards health, nutrient, and food security through innovations made in plant science.

Drug Discovery

Plants are fundamentally important as sources of both extant drugs and drug discovery leads. In fact, 60% of anti-cancer drugs in use within the last decade are of natural product origin-plants being a significant source. Plant biology is also contributing to the advancement of new agents for cancer immunotherapy, a newer treatment strategy that uses the body's own immune system to fight disease. Research funded by NIH has shown that nanoparticles containing cowpea mosaic virus—which infects legumes but is harmless to humans—can be injected into tumors to bait the immune system into attacking and destroying cancerous cells. Ongoing support from NIH is enabling researchers to determine the mechanisms behind the efficacy of these nanoparticles in attacking tumors, research that will, in turn, help fulfil the goals of the Cancer Moonshot Initiative to reduce cancer death rates.[3]

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[1] Page 19, Decadal Vision: https://plantsummit.files.wordpress.com/2013/07/plantsciencedecadalvision10-18-13.pdf.

[2] https://dpcpsi.nih.gov/sites/default/files/Day-1-155PM-ONR-Concept-Food-is-Medicine-Lynch-background-508.pdf.

[3] https://pubs.acs.org/doi/10.1021/acs.molpharmaceut.2c00058.

TRAINING THE NEXT GENERATION OF PLANT BIOLOGISTS

A strong and diverse plant scientist workforce is crucial for addressing the many challenges facing our world, and training opportunities funded by NIH are as important for this mission as research-focused efforts. ASPB supports the expansion of funding opportunities targeted towards graduate students and postdoctoral scholars, as well as improvement of policies that improve NIH's training ecosystem and quality of life for early-career plant biologists. Of particular importance is the need for NIH-funded fellowships to provide a living wage for recipients, especially in geographic areas with high costs of living.

CONCLUSION

Plants play unique and pivotal roles in nutrition and health, agriculture, and the food supply, as well as basic science discoveries directly or indirectly relevant to public health. Plant biology research integrates seamlessly and synergistically with many different disciplines and core missions at NIH. As such, ASPB asks the subcommittee to provide continued robust funding for all components of the NIH and direct the agency to support additional plant biology research to continue to pioneer new discoveries and new methods with applicability and relevance in biomedical research. Thank you for your consideration of ASPB's testimony. For more information about ASPB, please see www.aspb.org.

[This statement was submitted by Crispin Taylor, Ph.D., Chief Executive Officer, American Society of Plant Biologists.]

PREPARED STATEMENT OF THE AMERICAN SPEECH-LANGUAGE-HEARING ASSOCIATION

Chair Baldwin and Ranking Member Capito: The American Speech-Language-Hearing Association (ASHA) thanks you for the opportunity to submit testimony on the Fiscal Year (FY) 2024 Labor, Health and Human Services, Education and Related Agencies appropriations bill.

ASHA is the National professional, scientific, and credentialing association for 228,000 members and affiliates who are audiologists; speech-language pathologists; speech, language, and hearing scientists; audiology and speech-language pathology support personnel; and students. Audiologists specialize in preventing and assessing hearing and balance disorders as well as providing audiologic treatment, including hearing aids. Speech-language pathologists (SLPs) identify, assess, and treat speech, language, swallowing, and cognitive-communication disorders.

My name is Robert M. Augustine, PhD, CCC–SLP, ASHA's President for 2023. I offer ASHA's support for the following programmatic funding and language requests for the U.S. Department of Education (ED) and Health & Human Services (HHS):

—$16.2 billion for the Individuals with Disabilities Education Act (IDEA) Part B State Grants, $502.6 million for IDEA Part B Section 619 Preschool Grants, $932 million for IDEA Part C Infants and Toddlers with Disabilities, and $250 million for IDEA Part D section 662 personnel preparation grants within the Department of Education.

—$1 million for the establishment of a communication/speech disorders technical assistance center within ED.

—$10.7 million for the Centers for Disease Control and Prevention and $17.8 million for the Health Resources and Services Administration for Early Hearing Detection and Intervention programs within HHS.

—$8 million for the Health Resources and Services Administration (HRSA) allied health workforce program.

—$534 million for the National Institute on Deafness and Other Communications Disorders and $119 million for the National Institute on Disability, Independent Living, and Rehabilitation Research for communication sciences disorder research.

INDIVIDUALS WITH DISABILITIES EDUCATION ACT

Children and youth (ages 3–21) with disabilities receive special education and related services under IDEA Part B, and infants and toddlers (birth-2 years old) with disabilities and their families receive early intervention services under IDEA Part C. Congress must continue to make appropriate investments in IDEA to ensure children with disabilities receive the free appropriate public education (FAPE) they are entitled to under law.

The proposed IDEA funding increase would help school-based personnel better meet the needs of students with disabilities. This critical program serves more than

7.5 million children in our Nation's schools, including students with communication disorders.[1] Schools and districts continue to struggle with increased costs, personnel shortages, and learning gaps associated with the COVID–19 pandemic, all of which increase the caseloads and workloads of school-based audiologists and SLPs. This critical funding would help ensure students with disabilities receive the necessary services and supports to which they are entitled. ASHA supports the Administration's FY 2024 budget request for IDEA at the levels identified above to ensure students with disabilities can continue to access needed services.

COMMUNICATION/SPEECH DISORDER TECHNICAL ASSISTANCE (TA) CENTER

Speech-language pathology services are highly utilized by students served under IDEA.

According to ED's 44th Annual Report to Congress on the Implementation of IDEA, 2022, speech or language impairments represent the second most prevalent disability category of services provided under IDEA Part B: 35.8% of children ages 3–5, and 17.8% of students ages 6–21.[2] Establishing and funding a Communication/Speech Disorders TA Center would help school-based SLPs and educational audiologists better address the needs of the significant population of students receiving speech-language services. Such a Center would provide resources, guidance, and best practice pertaining to the assessment and treatment to habilitate the communication disorders; identify and develop free or low-cost evidence-based tools and model programs; gather evidence-based information and/or data related to speech-language pathology clinical and professional issues including delivery models, identification and utilization of appropriate workspaces, caseload, and workload management; and provide support and guidance on the utilization of Federal funding to support capacity to circumvent staffing shortages for speech-language providers.

Congress previously recognized the value of a Communication/Speech Disorders TA Center by including language in the report to last year's bill (H. Rept. 117–403) encouraging ED to offer technical assistance to support students with speech-language disorders within school settings. ASHA urges the Committee to further enhance this language by providing $1,000,000 for ED to formally establish and operate a TA center dedicated to communication/speech disorders.

EARLY HEARING DETECTION AND INTERVENTION ACT

The Early Hearing Detection and Intervention (EHDI) Act is one of the Nation's most important public health programs, offering early hearing screening and intervention to all newborns, infants, and young children in every State and territory. Since Congress first authorized EHDI in 2000, it has been instrumental in increasing newborn hearing screening rates from 46% to 98% in 2020.[3] Early detection of hearing loss, and resulting diagnosis and intervention, can dramatically improve a child's chances to succeed professionally, academically, and socially. ASHA appreciates the Committee's recognition of disparities in access to pediatric hearing health care by including language in H. Rept. 117–403 to encourage the Centers for Disease Control and Prevention (CDC) to expand its work to improve surveillance, ensure access to timely identification of congenital and acquired hearing loss, and enhance the connection to follow-up services, particularly among racial and ethnic minority populations.

ASHA also applauds Congress for enacting S. 4052, the Early Hearing Detection and Intervention Act (Public Law 117–241), which reauthorized the EHDI program for 5 years and requires the Government Accountability Office (GAO) to conduct a study assessing program performance and efforts to ensure that newborns, infants, and young children have access to timely hearing screening, and importantly, early interventions, particularly for medically underserved populations, including racial and ethnic minorities.

ASHA urges the subcommittee to provide identified levels of funding for newborn hearing screening authorized by the Early Hearing Detection and Intervention Act (Public Law 117–241) to ensure that all children with hearing loss receive timely screening, diagnosis, and intervention services, and include report language highlighting the importance of timely completion of the GAO study.

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[1] U.S. Department of Education. (n.d.). About IDEA. https://sites.ed.gov/idea/about-idea/.

[2] U.S. Department of Education, Office of Special Education and Rehabilitative Services, Office of Special Education Programs. (2022). 44th Annual Report to Congress on the Implementation of the Individuals with Disabilities Education Act, 2022. https://sites.ed.gov/idea/44th-annual-report-to-congress-on-idea.

[3] U.S. Centers for Disease Control and Prevention. (2022). 2020 Summary of Hearing Screening Among Total Occurrent Births. https://www.cdc.gov/ncbddd/hearingloss/2020-data/02-screen.html.

ALLIED HEALTH WORKFORCE DIVERSITY

Studies have demonstrated that patients who receive care from members of their own racial and ethnic background generally have better outcomes, and health professionals from underrepresented and minority backgrounds are more likely to practice in medically underserved areas.[4] ASHA appreciates the enactment of Section 2224 of the Consolidated Appropriations Act, 2023 (Public Law 117–328) to expand the allied health professional education program within HRSA to increase educational opportunities for audiology and speech-language pathology students from disadvantaged backgrounds and for individuals who are underrepresented in such professions. This program would provide grants to increase the participation and retention of diverse students in programs that train and educate audiologists and SLPs through scholarships and stipends, preparatory resources, and support to retain and successfully graduate students. ASHA urges the subcommittee to appropriate $8,000,000 to fund this program within HRSA.

CONCLUSION

Thank you for the opportunity to provide this testimony for the record. ASHA appreciates the subcommittee's past investments in these critical education and health programs and urges continued support at the recommended funding levels. These investments are crucial to ensuring audiologists and SLPs can meet the hearing, balance, speech, language, swallowing, and cognition-related needs of your constituents regardless of age or setting. If you or your staff have any questions, please contact Kevin Stutman, ASHA's associate director of Federal affairs, at kstutman@asha.org.

PREPARED STATEMENT OF THE AMERICAN THORACIC SOCIETY

FISCAL YEAR 2024 FUNDING RECOMMENDATIONS

[in millions $]

National Institutes of Health	$50,924.0
National Heart, Lung, and Blood Institute	$4,273.0
National Institute of Allergy and Infectious Diseases	$7,040.7
National Cancer Institute	$9,988.0
National Institute of Environmental Health Sciences	$980.7
National Institute on Minority Health and Health Disparities	$660.0
National Institute of Nursing Research	$210.0
Centers for Disease Control and Prevention	$11,581.0
National Institute for Occupational Safety and Health	$375.3
Asthma Programs	$40.0
Division of Tuberculosis Elimination	$225.0
Office on Smoking and Health	$310.0
Global Climate Change Program	$110.0
Chronic Disease Awareness Education Program	$6.0
National Center for Environmental Health	$420.85

NATIONAL INSTITUTES OF HEALTH (NIH) AND CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC)

The American Thoracic Society (ATS) is pleased to submit the following testimony regarding Fiscal Year (FY) 2024 Federal appropriations for the Labor, Health and Human Services, Education, and Related Agencies in support of vital work being conducted by the NIH and CDC. We ask you to provide at least $50.924 billion for NIH, not inclusive of other funds for the Advanced Research Projects Agency for Health or pandemic preparedness. We further request funding of at least $11.581 billion for the CDC to continue to support the essential public health programs supported by the agency.

AMERICAN THORACIC SOCIETY

ATS is the world's leading medical society dedicated to the advancement of global respiratory health through multidisciplinary collaboration, education, and advocacy.

[4] U.S. Government Accountability Office. (2009). Graduate Medical Education: Trends in Training and Student Debt, 09–438R. https://www.gao.gov/assets/gao-09-438r.pdf.

The Society's more than 16,000 members are focused on leading scientific discoveries, advancing professional development, impacting global health, and transforming patient care.

NATIONAL INSTITUTES OF HEALTH

National Heart, Lung, and Blood Institute.—As part of the FY24 funding, the ATS recommends Congress provide at least $4.273 billion for NHLBI. The Institute supports cutting edge research on a wide range of diseases that impact the lungs including COVID, asthma, COPD, sleep-disordered breathing, and a wide range of other respiratory conditions. Recognizing that COPD is a leading cause of death and disability, the NHLBI continues to make progress implementing the COPD National Action Plan that was developed as the first-ever blueprint for a multifaceted, unified fight against this disease. Dedicated funding is needed to implement the recommendations of the COPD National Action Plan.

National Institute of Allergy and Infectious Diseases.—NIAID is a world-leader in supporting research on infectious and allergy related conditions, including lung related infections and allergy and immune-related lung diseases. Sustained annual increases to the NIAID have allowed the institute to support a Phase 1 clinical trial testing a freeze-dried, temperature-stable experimental tuberculosis (TB) vaccine in healthy adults that revealed that it was safe and stimulated both antibodies and responses from the cellular arm of the immune system. This was the first clinical trial of any subunit TB vaccine candidate in a temperature-stable (thermostable) form.

National Cancer Institute.—Despite progress on many types of cancer, lung cancer remains a leading cause of cancer deaths in the U.S. and worldwide. In 2022, lung and bronchus cancer were estimated to represent 12.3% of all new cancer cases in the U.S. The ATS looks forward to continuing collaboration with the NCI on lung cancer related research initiatives, including increasing lung cancer screening utilization, lung nodule management, lung cancer prevention, and the interaction between COPD and lung cancer. The ATS also notes the urgent need for effective nicotine cessation interventions to help youth addicted to e-cigarettes and other nicotine products.

National Institute of Environmental Health Sciences.—NIEHS funded investigators examining wildfire smoke exposure during pregnancy in relation to adverse pregnancy outcomes including preterm birth and severe maternal morbidity found that wildfire smoke is linked to preterm birth, with more effects in socially vulnerable areas. They continue to link maternal and child health effects to wildfire smoke exposures, which has exceeded levels considered safe for hundreds of thousands of pregnancies over the past several years.

National Institute on Minority Health and Health Disparities.—The ATS shares the Administration's commitment to addressing health disparities and appreciates the NIMHD-led initiatives to close the health disparity gap. Additional funding is needed for NIHMD to work with the academic community to identify and overcome the persistent systemic barriers that prevent many Americans from benefiting from good health and good health care.

National Institute of Nursing Research.—The NINR is on the forefront of new innovations that impact how nurses are educated and how they practice. In fact, 80% of research-focused educational training grants at schools of nursing are funded by NINR. With this support, nurse scientists, often working collaboratively with other health professionals, are generating groundbreaking findings and leading translational research. The scope of this research encompasses a range of strategic imperatives such as health equity, social determinants of health, population health, health promotion, and new models of care.

NIH Sleep Research Plan.—In 2021, the National Center on Sleep Disorders Research released a Sleep Research Plan that aims to address sleep-related health disparities, facilitate clinical research on sleep and circadian rhythms, and advance the scientific understanding and health impacts of sleep deficiency and circadian misalignment. Congress must ensure that the NIH is provided with adequate resources to achieve the 2021 Sleep Research Plan.

CENTERS FOR DISEASE CONTROL AND PREVENTION

National Institute for Occupational Safety and Health.—NIOSH is a Federal leader in research on occupational health. NIOSH also provides support for respiratory masks and other occupational protective technologies, occupational health research training, and provides technical assistance in cases of workplace exposure outbreaks.

Asthma Program.—CDC's National Asthma Control Program (NACP) currently funds 25 state, territorial, and municipal partners to improve the reach, quality, effectiveness, and sustainability of asthma control services and to reduce asthma morbidity, mortality, and disparities by implementing evidence-based strategies through a 5-year cooperative agreement. Our request for $40 million in funding for the National Asthma Control Program would enable CDC to continue to fund these programs to combat the terrible human and economic burden caused by asthma.

Division of Tuberculosis Elimination.—The COVID response has diverted staff and funds from TB control funding, resulting in missed opportunities to control TB in the U.S. Additional funding is needed to restore local TB control programs and to restore TB Trials Consortium sites that are conducting vital TB clinical drug trials critical to halting the TB pandemic.

Office on Smoking and Health.—Smoking remains the leading cause of preventable disease, disability, and death in the U.S. The CDC is at the forefront of the Nation's efforts to reduce deaths and prevent chronic diseases that result from tobacco use.

Global Climate Change Program.—Climate change continues to impact public health in myriad ways, including, smoke from wildland fires, droughts, intense heat, floods, and increased vector borne disease. Additional research is necessary to design and tailor interventions that will reduce the impact of climate change on the incidence and severity of disease, for disadvantaged communities that may not have resources to mitigate the effects of climate change.

Chronic Disease Education Awareness Program.—CDC does not have an established program for major chronic diseases such as COPD as well as less prevalent chronic diseases. CDC has created a competitive grants program to fund public education efforts on important chronic diseases that CDC has not yet addressed. Funding is needed to expand grant opportunities for conditions such as COPD and other chronic respiratory diseases.

National Center for Environmental Health.—According to the CDC, over 25 million people, including over 5 million children, live with asthma in the United States. Asthma disproportionately impacts women and minority communities who bear the brunt of the disease. Individuals living in poverty, as measured by the Federal poverty line, are also likelier to suffer from asthma. The ATS looks forward to further collaborations with the NCEH in highlighting asthma as a priority health condition with evidence-based interventions, which can prevent the need for costly emergency department visits.

PREPARED STATEMENT OF THE AMERICAN TYPE CULTURE COLLECTION

Chair Baldwin, Ranking Member Moore Capito, and distinguished members of the Committee, thank you for the opportunity to comment on the National Institutes of Health (NIH) budget priorities for FY2024. I provide this testimony to express strong support for advancing global health, biodefense, clinical research, and biological resource management government programs and offer our continued collaboration.

The American Type Culture Collection (ATCC) is a non-profit organization founded in 1925 to provide the global scientific community with high-quality biomaterials, including cells, bacteria, viruses, and repository operations. Today, ATCC is the world's most diverse biological resource center, advancing global health initiatives within the U.S. government, academia, the pharmaceutical industry, and research foundations. We have assisted the government for over 50 years with frontline research and development (R&D), innovative solutions, and biological products, including during the recent COVID–19 pandemic, where ATCC was a critical provider of R&D services, reagents, detection and surveillance assays, and logistical support for the Federal response.

COVID–19 revealed weaknesses in our public health infrastructure and research systems, including inadequate resourcing and deficiencies in coordination required for a rapid response to national health security needs. Effectively preparing for, responding to, and recovering from complex infectious disease outbreaks, whether naturally occurring or intentionally introduced, requires an integrated approach between governments, academia, and the private sector. To better prepare for future global health challenges, this integrated approach should build and expand on trusted relationships, expertise, and resources that facilitate broad-spectrum, rapid response to emerging global health security issues.

Moreover, since the start of the COVID–19 pandemic and with new viral variants, requests for biomaterials have exploded exponentially, making it clear that more biomedical manufacturing space is required to support this surge in demand for bio-

materials. In January 2021, President Biden instituted the Pandemic Preparedness Plan, which defines the critical need for the Nation to ensure infrastructure for supply chains and manufacturing capabilities for essential response needs, including critical biological strains and reagents. While Regional Biocontainment Laboratories (RBLs) and their partners are key for public health, research, and advancing health care for patients, they do not currently focus on biomanufacturing. To address this gap, ATCC recognizes the need for a new facility to provide modern and reproducible large-scale biomaterial manufacturing capabilities focused on accelerating medical countermeasures for priority infectious disease pathogens.

ATCC is proud to have the relationships, expertise, and resources to serve the NIH. Still, we can and are eager to do more to serve the public health and research efforts across the NIH and other agencies, such as the Biomedical Advanced Research and Development Authority (BARDA) within the Department of Health and Human Services and Walter Reed Army Institute of Research (WRAIR) and Defense Threat Reduction Agency (DTRA) within the Department of Defense. Through our extensive work with NIH, academia, and private industry, ATCC provides rapid product development and worldwide supply chain logistics and management, complemented by innovative R&D services and subject matter expertise. We support clinical and epidemiological studies by providing high-quality downstream biospecimen processing, test materials/standards, and associated storage and distribution. ATCC applies its nearly 100 years of expertise in biological resource management by operating and managing government programs focused on new product development, organism characterization and authentication, and biological material storage and distribution.

At ATCC, we manage the Biodefense and Emerging Infections Resources (BEI Resources) for the National Institute of Allergy and Infectious Diseases (NIAID), among others, which has received more than 150 variants of COVID and propagated the virus to enable and support diagnostic, vaccine, and therapeutic development. BEI Resources provided more than 150,000 vials of SARS–CoV–2 and related coronavirus strains and reagents to over 3,200 researchers at 1,800 institutions in more than 75 countries from 2020–2023. In 2022, BEI Resources played a critical role in the ACTIV TRACE—Deep Sequencing Analysis Subgroup to harmonize the sequencing and analysis efforts for SARS–CoV–2.

We also manage the International Reagent Resource (IRR) program for the CDC, supporting the Nation's pandemic response by shipping over 80,000 reagents and test kits to the Nation's public health labs. In addition, our expertise supports the National Cancer Institute (NCI) and the Human Cancer Models Initiative (NCMI) to facilitate cancer research.

As a national resource for health and research excellence, we see the importance of infrastructure, coordination, and quick, reliable access to resources. Without updated physical infrastructure, scientists are blocked from advancing research and meeting current demands, which delays the development of therapies, vaccines, testing, and other innovations to advance health and improve patient outcomes. Additionally, coordination and data-sharing across research and biomanufacturing facilities avoid unnecessary redundancies and accelerate ways to use the knowledge gained to benefit public health. Therefore, we recommend that NIH and NIAID invest in updating and building a facility focused on biomanufacturing, new product development, and producing large quantities of research materials needed by the life science research community.

Removing barriers to unlock new scientific and health discoveries is vital to solving the world's biggest health challenges and preventing future pandemics. With more integration across government, academia, and private nonprofit partners, as well as investment in updated infrastructure and coordination, we believe NIH and the Department can enable this critical work. ATCC is ready and eager to partner in this endeavor. Thank you.

[This statement was submitted by Raymond Cypess, DVM, PhD, Chairman and CEO, American Type Culture Collection.]

PREPARED STATEMENT OF THE AMERICAN UROGYNECOLOGIC SOCIETY

The American Urogynecologic Society (AUGS) thanks the subcommittee for the opportunity to submit comments for the record regarding our Fiscal Year 2024 report language recommendations on lower urinary tract symptoms (LUTS) under the National Institute on Diabetes, Digestive and Kidney Diseases (NIDDK) and on pelvic organ prolapse (POP) under the Eunice Kennedy Shriver National Institute on Child Health and Human Development (NICHD). AUGS is a national medical soci-

ety whose mission is to promote the highest quality of care in female pelvic medicine and reconstructive surgery through excellence in education, research, and advocacy.

1. Lower Urinary Tract Symptoms

Lower Urinary Tract Symptoms (LUTS) refer to symptoms related to the storage and voiding of urine. Conditions associated with LUTS include overactive bladder, stress urinary incontinence and voiding dysfunction. According to the CDC, over half of people aged 65 and older living at home reported bladder and/or bowel incontinence.

Incontinence associated with LUTS takes an economic and emotional toll on individuals and has a significant financial impact on society. In the United States, direct and indirect costs of overactive bladder are estimated at $76 billion in 2015. By the year 2020, the costs of overactive bladder evaluation and treatment are projected to account for $82.6 billion of our healthcare expenditures, altogether making it a significant personal and public health burden. Stress urinary incontinence also poses an enormous financial burden in this country with over $12 billion spent annually on the condition.

Treatment efficacy varies widely and necessitates increased attention to how particular patient characteristics and symptoms may be used to guide treatment. However, there is an absence of knowledge in this area because there are not established clinical and patient genotypes and phenotypes in LUTS. Additionally, race and ethnic information is frequently not reported in research and often such cohorts are racially and ethnically homogenous. Current guidelines for treatment of LUTS rely on studies with cohorts of participants that do not represent the racial and ethnic distributions of communities. Research is needed that is inclusive of all racial and ethnic groups, characterizes LUTS clusters and studies their association to treatment responsiveness, and identifies biomarkers specific to individual phenotype profiles to help correlate symptoms and treatment outcomes.

For these reasons, the AUGS urges the subcommittee to adopt the following report language in the report accompanying the Fiscal Year 2024 Labor-HHS-Education appropriations bill that directs the NIDDK to conduct a workshop and prioritize research that will help develop a repository of patient genotypes and phenotypes for LUTS and will enable the identification of biomarkers to advance precision medicine approaches and improved treatment for conditions associated with LUTS.

NATIONAL INSTITUTE ON DIABETES, DIGESTIVE AND KIDNEY DISEASES

Lower Urinary Tract Symptoms—Lower urinary tract symptoms (LUTS) describe symptoms related to the storage and voiding of urine. Conditions associated with LUTS include overactive bladder, stress urinary incontinence, as well as neurogenic and non-neurogenic voiding dysfunction. According to the Centers for Disease Control and Prevention, over half of people aged 65 and older living at home reported bladder and/or bowel incontinence. The effectiveness of treatment for these conditions varies depending on patient characteristics and symptoms. Unfortunately, an established repository of patient genotypes and phenotypes for LUTS does not exist. Knowledge in this area would enable the identification of biomarkers to advance LUTS treatment. Therefore, the Committee urges the NIDDK to conduct a workshop and prioritize research that will lead to the development of a LUTS Precision Medicine Project focused on the characterization of LUTS clusters and their association to treatment responsiveness, identification of biomarkers, development of functional and physiologic assessment measures specific to individual phenotype profiles to objectively correlate symptoms and treatment outcomes. The Committee requests an update on a LUTS precision medicine project and on all research activities to advance LUTS prevention and treatment in the fiscal year 2025 Congressional Budget Justification.

2. Pelvic Organ Prolapse

Pelvic organ prolapse (POP) is a pelvic floor disorder that occurs when the pelvic floor muscles and connective tissue supporting pelvic organs (the bladder, uterus and cervix, vagina, and rectum) weaken or tear and can no longer support these organs. This causes one or more of the pelvic organs to fall downward into the vagina, like a hernia. Women may feel or see tissue coming out of the opening of their vagina as this condition advances.

POP is a common bothersome problem affecting quality of life, prompting 1 in 8 women in the United States to undergo surgical correction of POP. Surgical repair of prolapse is performed twice as commonly as incontinence surgery and constitutes the most common inpatient procedure performed in women older than 70 years. Worsening POP has been associated with deteriorating physical function, anxiety,

depression, fatigue, sleep disturbance, and social isolation. Treatment of POP requires significant health care resources; the annual cost of ambulatory care of pelvic floor disorders in the United States from 2005 to 2006 was almost $300 million. To date, treatment has been focused on the management of POP once symptomatic and information is lacking concerning potential therapies to prevent soft tissue injury and POP recurrence following surgical intervention. No effective preventative strategies exist against POP.

There are also significant racial and ethnic differences in barriers to treatment and care utilization for POP and in representation in POP research. Research is needed to assess preventative strategies and reduce the risk of subsequent POP and identify approaches to reduce the risk of POP recurrence.

For these reasons, the AUGS urges the subcommittee to adopt the following report language in the report accompanying the Fiscal Year 2024 Labor-HHS-Education appropriations bill that directs the NICHD to prioritize research activities that study pelvic floor disorders in minority populations.

EUNICE KENNEDY SHRIVER NATIONAL INSTITUTE ON CHILD HEALTH AND HUMAN DEVELOPMENT

Pelvic Organ Prolapse—Pelvic organ prolapse (POP) occurs when the pelvic floor muscles and connective tissue supporting the pelvic organs no longer support these organs, causing one or more of the pelvic organs to fall downward into the vagina. POP is a common problem, with 1 out of 8 women undergoing surgery for prolapse at some point in their life. Symptomatic POP is associated with urinary incontinence, depression, anxiety, sleep disturbance, sexual dysfunction, deteriorating physical function and diminished socialization. No effective preventative strategies for POP have been identified and the development of novel preventative strategies related to pregnancy is needed. Therefore, the Committee urges the NICHD to convene a workshop and prioritize prospective studies to assess peripartum, intrapartum, and postpartum preventative strategies for POP including ways to decrease pelvic floor trauma/denervation during delivery, with the goal of reducing the risk of subsequent POP and its complications. The Committee requests an update on this issue and on research activities to advance POP prevention and treatment in the fiscal year 2025 Congressional Budget Justification.

Your favorable consideration of these report language requests will positively impact knowledge and treatment for LUTS and POP and improve the lives of the millions of Americans affected by these devastating conditions.

PREPARED STATEMENT OF THE AMERICA'S POISON CENTERS

Chair Baldwin, Ranking Member Capito, and members of the Labor-Health and Human Services Appropriations subcommittee, my name is Carol DesLauriers and I am the President of America's Poison Centers, formerly known as the American Association of Poison Control Centers (AAPCC) and the Director of the Illinois Poison Center. As you may already know, Chair Baldwin's constituents are served by the Wisconsin Poison Center and Ranking Member Capito's constituents are served by the West Virginia Poison Center.

America's Poison Centers and our 55 poison control centers nationwide are extremely grateful for the subcommittee's longstanding, bipartisan support of the Poison Control Program line item within HRSA, which provides annual funding to the 55 poison control centers throughout the United States and U.S. Territories. In order to maintain the medical professionals and services necessary for the operation of our centers uninterrupted, we respectfully request $28.846 million for the Poison Control Program in fiscal year 2024, a $2 million increase over fiscal year 2023 enacted funding. This requested funding level, if approved, would remain approximately $2 million below the program's authorized level.

For over 70 years, poison control centers have been our Nation's primary defense against injury and death from poisonings. The Centers for Disease Control lists poisoning as the leading cause of injury-related death in America. The Poison Help hotline (1–800–222–1222) connects callers to their local poison center throughout the United States and U.S. Territories where they receive free, confidential, expert medical advice 24 hours a day, 365 days a year from toxicology specialists including nurses, pharmacists, and physicians. Poison control centers provide cost-effective, quality health care information to the general public and health care providers alike. We also provide vital health care education and awareness of opioid abuse and many other public health topics of importance to safeguard the public and our communities.

In 2021–2022, poison control centers managed more than 5 million human exposure cases and information requests, including those for opioid (including fentanyl), heroin addiction and abuse, edible marijuana exposure in children, adolescent and teen suicides and self-harm, and other challenging and complex cases affecting people of all ages in all 50 States and territories. Most cases were managed at home or the site of exposure, avoiding unnecessary and costly visits to emergency departments and dramatically reducing health care costs. Notably, every dollar invested in the poison center system saves $13.39 in medical costs and lost productivity for a total savings of approximately $1.8 billion each year. In short, keeping patients home when medically appropriate not only saves money, but it also alleviates unnecessary stress on patients.

CALL ROUTING ISSUE REPORT LANGUAGE REQUEST

America's Poison Centers also requests the subcommittee's assistance and partnership in addressing a longstanding issue that is of great concern to our poison centers and endangers the public we serve, namely, the proper routing of calls to poison control centers. In December 2019, Congress passed and the President signed the "Poison Center Network Enhancement Act," a 5-year program authorization bill that included a number of specific congressional priorities, including the proper routing of calls to poison control centers. The legislation specifically directed that "not later than 18 months after the date of enactment, the Secretary (of the Department of Health and Human Services) shall coordinate with the Chairman of the Federal Communications Commission...to ensure that communications with the National toll-free number are routed to the appropriate poison control center based on the physical location of the contact rather than the area code of the contact device."

Presently, calls to our 55 poison centers are routed based on the area code of the phone used rather than the caller's physical location. As a result, a growing percentage of calls from people in emergency—and often life-threatening—situations are being routed incorrectly to the wrong poison center. In 2022, 12 States and the District of Columbia had more than 10 percent of their calls misrouted. Some States are even higher. For example, over 29 percent of calls in Kansas were misdirected.

Congress provided HHS and the FCC 18 months from date of enactment (December 2019) to resolve this issue. Unfortunately, over the past three plus years, there has been little movement toward a solution and the problem of misrouted calls is only getting worse, putting lives at risk. For more than 3 years, America's Poison Centers, along with HRSA has attempted to engage Verizon, which is under contract by HHS and oversees the technical operation of the 1–800 Poison Control Hotline number. Verizon maintains that calls are being properly routed despite the data showing otherwise. After numerous meetings involving our centers, HRSA, FCC and Verizon, no Federal agency nor Verizon have been able to recommend or provide a solution to address the issue. As a result, on a daily basis, calls to poison control centers continue to be routed to centers multiple States away. I want to thank this committee for including language in the explanatory statement for the FY23 Labor HHS Appropriations bill directing HRSA to update the Committee within 30 days of enactment on the status of its work on misdirected calls.

To illustrate the urgency of this situation, I would like to give the subcommittee one example, which resulted in the death of a patient that should have been prevented: A call was made to a poison center regarding a patient bitten by a rattlesnake. The call was received not in the coverage area of the poison center where the bite occurred but by a center that has fewer snakes in its coverage area and as such, receives fewer snakebite calls. The center that received the call was located a half dozen States away from where the snakebite occurred. The initial poison center recommended that the symptomatic patient go immediately to the nearest hospital emergency department. The poison center in the state where the bite occurred received a call 1.5 hours later after the patient arrived at the hospital. The patient was hypotensive with extreme edema to the torso secondary to a bite on the inner thigh. The poison center recommended a large dose of antivenom, however, that hospital did not stock antivenom. As the patient got progressively worse, a transfer to a hospital with antivenom was arranged. The air ambulance could not transport the patient due to thunderstorms in the area. After a three-hour wait, the patient was transferred by ground ambulance to a trauma center due to the now life threatening effects the patient was experiencing. The patient was administered a large dose of antivenom upon arrival at the trauma center. Despite the antivenom, the patient died seven hours after arrival at the trauma center. If the correct poison center covering that area received the initial call, it would have referred the patient to the nearest hospital having antivenom. Poison centers track the antidote stocking and treatment capabilities of the hospitals in their respective coverage areas for this

very type of situation. With prompt administration of antivenom, this patient would likely have survived.

America's Poison Centers remain interested in working collaboratively with Verizon, HRSA, and the FCC towards a solution to this problem. Given the increasing severity of cases coming into poison centers, it is critically important that all communications with the National poison control toll-free number be routed, as directed by Congress, to the appropriate poison control center based on the physical location of the caller rather than the area code of the contact device.

Given the lack of progress on this issue for multiple years, we respectfully request the subcommittee include report language directing HHS to take all necessary steps to address the proper routing of calls based upon the physical location of the caller as directed in 2019. We stand ready and willing to work with HRSA and the FCC toward a workable solution.

Thank you again, Chair Baldwin and Ranking Member Capito, for your consideration of this and our funding request. America's Poison Centers is grateful for your leadership and looks forward to our continued work together serving the public health of all Americans.

[This statement was submitted by Dr. Carol DesLauriers, President, America's Poison Centers and Director, Illinois Poison Center.]

PREPARED STATEMENT OF THE ARTHRITIS FOUNDATION

On behalf of the more than 58 million adults and 300,000 children living with doctor-diagnosed arthritis in the United States, the Arthritis Foundation thanks Chairwoman Baldwin and Ranking Member Moore Capito for the opportunity to provide written testimony to the Appropriations subcommittee on Labor, Health and Human Services (HHS), and Education and Related Agencies for Fiscal Year 2024. We respectfully request: $60 million for the CDC Arthritis Program and $30 million for the Pediatric Subspecialty Loan Repayment Program administered by the Health Resources and Services Administration (HRSA).

CDC ARTHRITIS PROGRAM

Arthritis affects 1 in 4 Americans and is the leading cause of disability in the United States, according to the CDC. It limits the daily activities of over 23 million Americans and causes work limitations for 40 percent of the people with the disease. This translates to over $300 billion a year in direct and indirect costs. There is no cure for arthritis, and for some forms of arthritis like OA, there is no disease-modifying pharmaceutical therapy, making evidence-based self-management programs critical for managing the disease. The CDC is critical for the dissemination of evidence-based programs, data collection and disease surveillance, and public health research. The COVID–19 pandemic has exacerbated the challenges of disease management, making interventions like exercise programs more difficult to access and maintain. In FY 2024, Congress should increase CDC Arthritis Program funding to $60 million, which translates to roughly $1 for each American adult with doctor-diagnosed arthritis.

The CDC Arthritis Program is the only Federal program dedicated solely to arthritis. Today, the program provides grants to 13 States to support evidence-based disease management programs. The program aims to connect all Americans with arthritis to resources to help them manage their disease. Evidence-based programs like EnhanceFitness help keep older adults active, and have shown a 35 percent improvement in physical function, resulting in fewer hospitalizations and lower health costs compared to non-participants. In addition, Walk With Ease is an evidence-based group walking program that encourages people with arthritis to start walking and stay motivated to keep active. The program allows participants to meet a few times per week to receive health education on an arthritis or exercise-related topic followed by stretching activities, and a group walk. A recent CDC-funded randomized controlled trial found that the program can help reduce arthritis symptoms, reduce disability, and improve strength and balance.

Given the high prevalence and severity of this disease, the Arthritis Program is woefully under-funded compared to the investment in other chronic diseases. It is currently funded at $11 million, and due to either reduced funding or flat funding in recent years, the program has lost millions of dollars in purchasing power over the last decade.

With full funding of $60 million, the program would be able to:

—Provide funding to all 50 States to fully operationalize a National Arthritis Program. Today, the CDC Arthritis Program funds only 13 State programs around the country (AR, KS, MA, MN, MO, NH, NY, NC, OR, RI, UT, VA, and WA).

These programs play a vital role in the dissemination of proven strategies and programs, and all States should receive funding to operate an arthritis program;
—Expand national partnerships that are critical to promoting awareness, increasing primary provider referrals for non-pharmacologic management of chronic pain, and providing access to arthritis self-management and physical activity programs; and
—Invest in robust data and intervention and prevention research to better understand arthritis.

PEDIATRIC SUBSPECIALTY LOAN REPAYMENT PROGRAM

An estimated 300,000 children have arthritis, yet there are fewer than 450 board-certified practicing pediatric rheumatologists in the United States, mainly clustered in big cities and urban metro areas. Shockingly, seven States have no pediatric rheumatologists and five States have only one. Early diagnosis and treatment of arthritis is critical for disease management, and it can be difficult for providers untrained in pediatric rheumatology to diagnose arthritis.

The pediatric rheumatology workforce is stretched now more than ever due to the pandemic. Serious shortages are causing decreased access to care for young people, resulting in myriad complex challenges, including entire days of missed work and school for the child, siblings, and parents because of the length of time traveling to the nearest specialist; families deciding to move to a different state to be closer to a specialist; and having to travel by airplane to reach the closest specialist.

The Pediatric Subspecialty Loan Repayment Program (PSLRP) was funded for the first time in FY2022 and will make loan repayment available for pediatric subspecialists like pediatric rheumatologists to practice in underserved areas. Even with initial combined funding of $15 million across FY22 and FY23, the number of applications HRSA can fund will be severely limited, yet we anticipate demand will be high among pediatric subspecialists. We urge the inclusion of $30 million in the FY 2024 appropriations bill to build upon this important investment and address the ever-growing and critical pediatric workforce shortage.

We thank the subcommittee for its commitment to the health and wellbeing of all Americans. As you write the FY 2024 Labor-HHS-Education appropriations bill, we urge the inclusion of $60 million for the CDC Arthritis Program, and $30 million for the Pediatric Subspecialty Loan Repayment Program in order to continue investments that improve the lives of people with chronic diseases like arthritis. Please contact Anna Hyde, Vice President of Advocacy and Access, at ahyde@arthritis.org, with any questions.

PREPARED STATEMENT OF THE ASSOCIATION FOR CAREER AND TECHNICAL EDUCATION AND ADVANCE CTE

On behalf of the Association for Career and Technical Education (ACTE) and Advance CTE we are writing to respectfully request that the subcommittee increase funding for the Carl D. Perkins Career and Technical Education Act's (Perkins V) Basic State Grant program, administered by the U.S. Department of Education's Office of Career, Technical, and Adult Education, by $400 million—providing an overall amount of $1.83 billion in the forthcoming Fiscal Year 2024 (FY24) Labor, Health and Human Services, Education, and Related Agencies appropriations bill. It is vital that Congress continues to build upon the recent investments made in Perkins V in order to close a widening inflationary funding gap for this program, fully support the implementation of the law and the nearly 12 million secondary, postsecondary, and adult learners it serves across the Nation. At the same time, this investment is critical to the future, long-term success of recent investments Congress has made in our Nation's infrastructure and advanced manufacturing capacity that depend on robust State and local CTE system capacity.

As you are aware, the Biden Administration recently proposed $1.47 billion for this program in its FY24 budget request—a $43 million increase over FY23 enacted levels. As described throughout this testimony, the proposed increase for Perkins V State grants remains inadequate at the current economic moment of substantial and growing employer need for skilled talent and learner demand for CTE programs that provide on-ramps into these opportunities. Despite these foundational needs, the Administration has instead requested $215.4 million for Perkins V's CTE National Programs account—a $183 million increase over FY23 enacted levels. With these funds, which represents 15 percent of the total size of all Perkins V state formula grant funding, the Administration intends to expand its "Career Connected High Schools" initiative, a yet to be established competitive grant program which it has most recently estimated could support only 35 programs nationwide. Distrib-

uting funding in this manner would likely further exacerbate many longstanding inequities in our Nation as it would serve a limited number of students overall and unfairly favor funding for eligible entities that already have the capacity to write grants, while penalizing smaller and more rural districts and institutions.

Equally concerning, this proposal is duplicative of how Perkins V State grant funding is already used. For example, career guidance and academic counseling programs are an explicit use of state Perkins V funding (Sec. 124(b)(14)); they are a required component of local applications for Perkins V funding (Sec. 134(b)(3)(C)); and these activities are a required use of local Perkins V grants (Sec. 135(b)(5)(K)). Promoting learner attainment of credentials of value, postsecondary credits, and participation in work-based learning are comparably prioritized throughout current law and are clearly being implemented by States, school districts, and institutions as demonstrated in the recent publication of performance accountability data measuring State and local progress using these as measures of CTE program quality. While we share the Administration's enthusiasm for CTE and these specific programmatic elements, any proposed or actual additional funds for CTE in FY24 would be far more effectively used as part of Perkins V State grant program—an investment that reaches every State and Congressional district in the country and would increase learner access to the high-quality CTE programs supported by Perkins V formula dollars.

CTE at the secondary and postsecondary levels is an integral part of ensuring an equitable and efficient implementation of last year's bipartisan infrastructure legislation. According to the Brookings Institution, at least 17 million new workers will be needed for U.S. infrastructure jobs in the next decade, which is more than the entire current infrastructure workforce. To make good on Congress's promise to rebuild America's infrastructure, CTE will require robust funding to reskill the workforce in critical areas such as construction, transportation, housing, utilities, and telecommunications. CTE serves a critical role in preparing learners to enter in-demand sectors of the economy that have immediate and longer-term hiring needs. CTE also is central to efforts to reskill and upskill learners who have been displaced by economic forces outside of their control or who have been sitting outside of the labor market for one reason or another. Examining data from the last recession, the vast majority of new and replacement jobs went to individuals with more than a high school diploma, including 3.1 million jobs that went to those with associate degree or postsecondary certificates. CTE is the primary way many learners earn these in-demand credentials.

Just as all education programs have been hit hard by the pandemic, so have CTE programs. This has been exacerbated by the lack of dedicated CTE funding within any of the pandemic response bills. High-quality CTE programs provide opportunities for direct engagement between industry and learners and instructors, which often includes work-based learning experiences, and enable learners to earn credentials of value. Each of these activities are far more resource-intensive than traditional classroom-based education. Despite these needs, no pandemic aid package passed by Congress in response to the public health emergency included dedicated CTE funding. At a time of record inflation, CTE programs are disproportionately impacted by pandemic-related financial challenges because of the need to purchase and maintain industry-standard equipment required to provide learners with real-world experiences. Congress has an opportunity to provide much-needed resources to CTE programs as part of the FY24 appropriations process to begin to remedy some of these persistent challenges.

Expanding funding for CTE programs will create a brighter future for communities—leading to more career options for learners, better results for employers, and increased growth for our economy. Investing in CTE programs provides substantial benefits for not just the students enrolled, but for States and communities across the country. Every dollar spent on secondary CTE students in Washington state leads to $26 in lifetime earnings and employee benefits, while individuals who receive a certificate or degree from California Community Colleges almost double their earnings within 3 years. In Wisconsin, taxpayers receive $12.20 in return for every dollar invested in the technical college system. Oklahoma's economy reaps a net benefit of $3.5 billion annually from graduates of the CareerTech System.

CTE programs prepare students for careers in in-demand fields and provide an affordable pathway to both a family-sustaining career and financial independence. Health care occupations, many of which require an associate degree or industry credential, are projected to grow 14 percent by 2028—adding almost 2 million new jobs. Perkins V's State grants and the CTE programs it supports have already begun to respond to these labor market needs, with the highest learner enrollments in this Career Cluster during the most recent program year. Half of all STEM occupations, which offer students high-skilled, high-wage career opportunities, require less than

a bachelor's degree. There are currently about 30 million "good jobs"-jobs that pay a median income of $55,000 or more and require education below a bachelor's degree. CTE programs themselves can also be harnessed to respond to shortages in other fields, such as teaching, directly via "Grow Your Own" programs.

Additionally, the demand for workforce credentials is growing. The number of individuals earning certificates or associate degrees in CTE fields, such as manufacturing, health care, and STEM, rose 71 percent from 2002 to 2012. Students can pursue these valuable credentials at community and technical colleges for a fraction of the cost of tuition at other institutions: $3,860 on average for the 2021–2022 academic year. Highly-skilled workers deliver direct benefits to American employers through enhanced productivity and innovation.

CTE programs can serve even more learners and employers—but only if they receive more resources. According to the most recent Job Openings and Labor Turnover (JOLTS) Survey from the Bureau of Labor Statistics, the ratio of unemployed workers to job openings is 0.6, meaning that there are nearly two open jobs for every unemployed person. This tight labor market underscores the immense demand for skilled workers, especially as we continue to recover from the impacts of the pandemic and implement Federal investments in the Nation's infrastructure and advanced manufacturing capacity. CTE remains a critical component of the workforce pipeline for key industries that are needed to sustain the long-term economic growth that is central to the country's future.

However, learner demand for CTE programs, especially programs in in-demand sectors, is greater than supply. Additional resources are needed to build, expand and support high-quality CTE programs. And there's widespread support for CTE: 94 percent of parents approve of expanding access to CTE. However, a survey of school districts offering CTE found that the top barrier to offering CTE in high school was a lack of funding or the high cost of the programs. As our recent analysis demonstrates, funding for CTE State Grants remains more than $320 million below FY 2004 enacted levels when adjusted for inflation. While recent appropriations have represented initial down payments to meet increased need, a significant, robust investment in CTE programs is still needed to account for persistent underfunding, the lack of inflation-adjusted increases, and the overwhelming growth in demand for these programs from both learners and the wider American economy. Congress should build on the momentum from recent years and continue to strengthen the investment in CTE State Grants in FY24. And, Americans agree: 93 percent of voters support increasing the investment in skills training. Thank you for your thoughtful consideration of our request.

For more information or if you wish to discuss our request, please contact Advance CTE's policy advisor, Steve Voytek (svoytek@careertech.org) or ACTE's Government Relations Manager, Jimmy Koch (jkoch@acteonline.org).

PREPARED STATEMENT OF THE ASSOCIATION FOR CLINICAL ONCOLOGY

The Association for Clinical Oncology (ASCO), the world's leading professional organization representing over 45,000 oncology professionals, thanks this subcommittee for its 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 AND NATIONAL CANCER PLAN

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. 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 one out of every seven life-saving 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 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 new National Cancer Plan, including the Cancer Moonshot.

The Cancer Moonshot sets an ambitious goal of reducing the cancer death rate by at least 50% in 25 years, and the National Cancer Plan, released April 4, 2023, offers the roadmap for how to get there. The National Cancer Plan is an exciting proposal to accelerate scientific progress against the disease, maximize the potential of discovery and achieve the goal of the Cancer Moonshot initiative to "end cancer as we know it." The comprehensive plan details eight specific goals and sets forth strategies that rely on the resources of the Federal Government, academia, industry, and nonprofit organizations. The goals encompass the entire cancer continuum from cancer prevention and early detection through improved treatments, greater access to clinical trials, and better overall care delivery. The plan prioritizes eliminating health disparities as well as diversifying and strengthening the cancer care workforce. ASCO stands ready and eager to work with NCI and the entire cancer community to put this plan into action as soon as possible.

The National Cancer Plan builds on the groundwork established by the past several years of Moonshot investment. 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 a nearly $1.4 billion investment in 240 Cancer Moonshot projects across more than 70 cancer science initiatives. Funding for the Cancer Moonshot expires this fiscal year, and the National Cancer Plan provides clear goals and strategies for moving forward in the fight against cancer. Projects currently under way as part of Cancer Moonshot are included in the plan and strategically connected to other Federal and private cancer research efforts.

We urge Congress to sustain the momentum of the Cancer Moonshot by putting full support and funding behind the goals and strategies in the National Cancer Plan. With your support, the NCI can achieve its ambitious Moonshot goals of ending cancer as we know it today, meaningfully reducing the cancer death rate, and improving the experience of the people living with and surviving cancer, their families, and caregivers.

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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.

The NCI describes research as the backbone of the National Cancer Plan, including basic, translational, and clinical research. NIH and NCI funded translational research and clinical trials have already 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.

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 CDC's 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, there has only been a 6% increase over the past 13 years. 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 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 health 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 bipartisan 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. Please contact Katie Gifford at katie.gifford@asco.org with any questions.

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[This statement was submitted by Lori J. Pierce, MD, FASTRO, FASCO, Chair of the Board, Association for Clinical Oncology.]

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[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.

PREPARED STATEMENT OF THE ASSOCIATION FOR PROFESSIONALS IN INFECTION CONTROL AND EPIDEMIOLOGY

The Association for Professionals in Infection Control and Epidemiology (APIC) urge appropriators to prioritize investments in the following Federal programs:

LHHS Programs	Agency	FY 2024 Funding Request
National Healthcare Safety Network	CDC	$80 million
Bio-preparedness Workforce Pilot Program	HRSA	$50 million
Antibiotic Resistance Solutions Initiative	CDC	$400 million
Advanced Molecular Detection	CDC	$175 million

In recent years, healthcare facilities have experienced setbacks in their progress towards preventing healthcare-associated infections (HAIs) and antimicrobial-resistant infections. A 2021 CDC analysis found that, following years of consistent decline in HAI rates, U.S. hospitals witnessed a significant increase in four out of six types of HAIs in 2020.[1] A considerable number of these HAIs exhibit resistance to antibiotics. Moreover, the incidence and mortality rates of hospital-onset resistant infections involving seven pathogens rose by at least 15% between 2019 and 2020.[2]

The prevalence of antifungal-resistant threats has also escalated in recent years. Since 2016, the number of clinical cases of Candida auris has increased annually, with cases more than tripling from 2019 to 2021.[3] It is important to note, more than 1 in 3 patients with invasive Candida auris die.[4] Furthermore, this pathogen is easily spread within healthcare facilities such as hospitals and nursing homes, posing a significant risk to vulnerable populations. To date, 17 States have identified their first Candida auris case, and the threat continues to expand.[5]

As integral components of the Nation's public health infrastructure, these programs must be funded at levels demanded by the growing threat of existing and emerging infectious diseases. Moreover, these programs will be important to improve the quality of care delivered to Americans and crucial in preparing for the next public health emergency.

We urge you to invest $80 million in the National Healthcare Safety Network (NHSN). As the CDC's domestic tracking and response system, NHSN equips healthcare facilities, public health departments, and Federal agencies with accurate and actionable data to identify emerging and persistent threats, such as COVID–19, HAIs, and antibiotic resistant infections, as well as to deploy targeted infection prevention interventions. NHSN has played a key role in the reduction in various HAIs over the 5 years prior to the pandemic (18 to 42 percent).[6] CMS relies on NHSN data for public reporting and incentive payments for healthcare quality performance, with NHSN data contributing to at least $350 million in Federal savings.[7] By leveraging electronic health records and commercial infection control surveillance systems, NHSN innovates our existing healthcare data infrastructure while bolstering our public health data infrastructure. The stagnation in Federal funding over the last 10 years cannot sustain the exponential expansion of NHSN from 300 in 2005 to 38,000 healthcare facilities today—including hospitals, nursing homes, dialysis facilities, and ambulatory surgical centers (ASCs) across the country. An increased investment in NHSN would ensure CDC can provide adequate technical support to participants, modernize NHSN to produce faster data while reducing the administrative burden for healthcare facilities, and adapt NHSN to respond to the

[1] Centers for Disease Control and Prevention. (n.d.). The impact of COVID–19 response on healthcare-associated infections (HAIs) in acute care hospitals. https://www.cdc.gov/hai/data/portal/covid-impact-hai.html.

[2] Centers for Disease Control and Prevention. (n.d.). Antibiotic resistance and COVID–19. https://www.cdc.gov/drugresistance/covid19.html.

[3] Centers for Disease Control and Prevention. (2023, March 20). CDC reports concerning increase in Candida auris cases in U.S. healthcare facilities. https://www.cdc.gov/media/releases/2023/p0320-cauris.html.

[4] Centers for Disease Control and Prevention. Candida auris: Drug-resistant yeast. Retrieved from https://www.cdc.gov/fungal/candida-auris/c-auris-drug-resistant.html.

[5] Centers for Disease Control and Prevention. (2023, March 20). CDC reports concerning increase in Candida auris cases in U.S. healthcare facilities. https://www.cdc.gov/media/releases/2023/p0320-cauris.html.

[6] Centers for Disease Control and Prevention. (2021). National Healthcare Safety Network (NHSN) overview fact sheet. Retrieved from https://www.cdc.gov/nhsn/pdfs/NHSN-FactSheet-508.pdf.

[7] Centers for Disease Control and Prevention. (2021). National Healthcare Safety Network (NHSN) overview fact sheet. Retrieved from https://www.cdc.gov/nhsn/pdfs/NHSN-FactSheet-508.pdf.

current and future pandemics. Through greater NHSN participation, CDC can leverage the data needed to establish reliable national benchmarks, allowing healthcare facilities to measure the progress of their HAI and antimicrobial—resistant infection prevention efforts and ultimately optimize antibiotic prescribing practices and eliminate HAIs.

We urge you to invest $50 million in the Bio-preparedness Workforce Pilot Program. Workforce shortages coupled with lower pay and a lack of financial incentives for recruitment and retention persist among infectious disease (ID) professionals, including infection preventionists, infectious disease physicians, clinical microbiologists, nurses, pharmacists, physician assistants, and dentists. Despite deep gaps in the ID workforce, no Federal programs offered loan repayment for healthcare providers in these professions. A recent study of APIC survey data showed 40% of the IP workforce will enter retirement age within the next 10 years.[8] Prior to COVID–19, there were already concerns about the IP workforce, as 25% of acute care facilities listed at least one IP vacancy[9] and more than half of long-term care facilities experienced an IP leaving within 24 months.[10] In order to start filling gaps and prevent even further shortages of the ID workforce investments must be made now to encourage individuals to join these fields.

We urge you to invest $400 million in the Antibiotic Resistance Solutions Initiative (ARSI). Even with the accelerated development of new antibiotics, therapeutics, and vaccines, the growing trend in antibiotic resistance underscores the urgency for the U.S. to increase its investments in ARSI. Antibiotic resistance undermines medical breakthroughs in life-savings drugs by quickly making new antibiotics obsolete and threatening the success of cutting-edge treatments for cancer, organ transplants, and other medical conditions that can be complicated by infections. ARSI supports 50 State health departments, four large city health departments, and Puerto Rico to detect, respond, and contain antibiotic-resistant pathogens.[11] CDC bridges the gap in local laboratory capabilities and data-driven responses to antibiotic-resistant threats through ARSI's Antibiotic Resistance Lab Network, which equips the 55 States and localities with comprehensive lab capacity and facilitates coordination of activities through seven regional labs and the National Tuberculosis Molecular Surveillance Center.[12] Prior to the pandemic, the aggressive strategies of ARSI have reduced deaths and hospitalizations from antibiotic resistance (18 percent and 28 percent fewer since 2013, respectively).[13] Boosting investments in ARSI would further strengthen the Nation's epidemiology, laboratory, and diagnostics capacity to combat emerging antibiotic resistance.

We urge you to invest $175 million in the Advanced Molecular Detection (AMD) Initiative. AMD supports the integration of genomic sequencing with bioinformatics and epidemiology expertise to detect diseases faster, identify and respond to outbreaks sooner, and protect people from emerging and evolving disease threats. Through partnerships with State and local health departments, public health laboratories, and academic institutions, AMD increases access to the specialized technologies and expertise necessary to empower public health professionals at the frontlines to take action before disease-causing pathogens become more widespread. As the Nation responded to the COVID–19 pandemic, AMD was crucial to robustly tracking and combatting emerging variants of COVID–19 in real-time. An increased investment in AMD will better position the U.S. to respond more strategically to future pandemics and outbreaks.

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[8] Landers, T., Davis, J., Crist, K., & Malik, C. (2017). APIC MegaSurvey: methodology and overview. American Journal of Infection Control, 45, 584–588.

[9] Gilmartin, H., Reese, S. M., & Smathers, S. (2021). Recruitment and hiring practices in United States infection prevention and control departments: Results of a national survey. American Journal of Infection Control, 49(1), 70–74.

[10] Drake M, Nailon R, Fitzgerald T. Factors Associated with Infection Preventionist Turnover in Long-term Care Facilities. Am J Infect Control. Published online June 1, 2019. doi.org/10.1016/j.ajic.2019.04.150.

[11] Centers for Disease Control and Prevention. (2022, January 25). Antibiotic Resistance (AR) Lab Network. Retrieved from https://www.cdc.gov/drugresistance/solutions-initiative/ar-lab-network.html.

[12] Centers for Disease Control and Prevention. (2022, January 25). Antibiotic Resistance (AR) Lab Network. Retrieved from https://www.cdc.gov/drugresistance/solutions-initiative/ar-lab-network.html.

[13] Centers for Disease Control and Prevention. (2021). Antibiotic resistance threats in the United States, 2019. Retrieved from https://www.cdc.gov/drugresistance/pdf/threats-report/Prevention-Works-More-Action-Needed-508.pdf.

PREPARED STATEMENT OF THE ASSOCIATION OF AMERICAN CANCER INSTITUTES

The Association of American Cancer Institutes (AACI) represents 108 premier academic and freestanding cancer centers across the United States and Canada. As the subcommittee considers Fiscal Year (FY) 2024 funding, AACI appreciates the opportunity to submit this request for the Department of Health and Human Services budget.

AACI requests a $3.5 billion increase for the National Institutes of Health (NIH) bringing the recommended funding level to $51 billion in FY 2024. This proposed level of NIH funding would ensure that academic cancer centers can continue to discover and deliver potentially lifesaving new therapies for patients with cancer. AACI also requests at least $9.988 billion in FY 2024 for the National Cancer Institute (NCI), consistent with the needs outlined in the NCI's Professional Judgment Budget.

AACI CANCER CENTERS

AACI cancer centers are beacons of discovery, largely funded by the NIH and NCI. To ensure continued progress, these agencies rely on stable, predictable Federal funding to invest in groundbreaking cancer research.

AACI cancer centers develop and deliver state-of-the-art therapies and provide comprehensive care to patients—from prevention and screening through survivorship. These centers are at the forefront of the National effort to eradicate cancer, yet progress in cancer research does not follow a linear path. The pace of discovery and translation of basic research to novel therapies can be accelerated by appropriate and predictable investments in Federal funding for cancer centers. The NIH peer review system consists of two sequential levels of review. This rigorous process allows for a more objective evaluation, with members of the scientific research community assessing the merit of each project. This system ensures funding for high-quality research with the greatest benefit to society.[1]

PAYLINE

Uncertainty surrounding research project grants (R01s) and a decline in cancer center resources often drives promising scientists to explore opportunities abroad or outside of the biomedical research community. For many academic cancer centers, most NCI grant funds are used to sustain shared core resources that are essential to basic, translational, clinical, and population research, or to provide matching dollars that allow university departments to recruit new cancer researchers and support their early-career work. It is imperative that we enable America's scientists to master their craft.

We noted in FY 2021 that R01 grants for established and new investigators were being funded to the 11th percentile, up from the 8th percentile in FY 2019. In FY 2022, the grants were funded to the 12th percentile,[2] a slight increase. We request that Congress build on past successes by making a strong investment in the NCI in FY 2023. Steady increases from the FY 2023 12th percentile rate are essential to achieving the goal set by former NCI Director Dr. Norman E. Sharpless, to reach the 15th percentile by FY 2025. To continue in this direction, we are hopeful that Congress will adopt NCI Director Dr. Monica M. Bertagnolli's Professional Judgment Budget Proposal of $9.988 billion for FY 2024.

We are in the midst of what Dr. Sharpless has called a "golden age" of cancer research, with novel discoveries on the horizon. A failure to boost funding to the NCI could pose a real threat to the future of cancer research. Appropriate funding increases are essential to accelerating the pace of discovery.

CONCLUSION

Now is the time for Congress to invest in cancer research. According to the American Cancer Society, there will be an estimated 1.9 million new cancer cases diagnosed in the United States in 2023.[3] Fortunately, improvements in early detection, cancer staging, and surgical techniques, as well as the development of innovative therapies, have contributed to better outcomes for patients with cancer. We join our colleagues in the biomedical research community in recommending that the subcommittee recognize the NIH as a national priority by enacting a final FY 2024

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[1] https://www.cancer.gov/grants-training/apply-grant/peer-review.

[2] https://www.cancer.gov/grants-training/nci-bottom-line-blog/2023/nci-funds-more-research-grants-thanks-to-congress.

[3] 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.

spending package that includes $51 billion for the NIH and $9.988 billion for the NCI.

A robust Federal investment in NCI-Designated Cancer Centers and academic cancer centers will allow the cancer research community to continue accelerating progress against cancer. We must continue to build on this momentum or else we stand to lose an entire generation of potentially lifesaving research.

[This statement was submitted by Jennifer W. Pegher, Executive Director, Association of American Cancer Institutes.]

PREPARED STATEMENT OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES

The AAMC is a nonprofit association dedicated to improving the health of people everywhere through medical education, health care, medical research, and community collaborations. For FY 2024, the AAMC recommends the following for Federal priorities essential in assisting medical schools and teaching hospitals to fulfill their missions that benefit patients, communities, and the Nation: at least $50.924 billion for the National Institutes of Health (NIH), in addition to any funding for the Advanced Research Projects Agency for Health (ARPA–H); $500 million for the Agency for Healthcare Research and Quality (AHRQ); $1.51 billion for the Health Resources and Services Administration (HRSA) Title VII health professions and Title VIII nursing workforce development programs; $738 million for the Children's Hospitals Graduate Medical Education (CHGME) program; and at least $11.581 billion for the Centers for Disease Control and Prevention (CDC).

AAMC's members are all 157 U.S. medical schools accredited by the Liaison Committee on Medical Education; 13 accredited Canadian medical schools; approximately 400 teaching hospitals and health systems, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools and teaching hospitals and the millions of individuals across academic medicine, including more than 193,000 full-time faculty members, 96,000 medical students, 153,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences. Following a 2022 merger, the Alliance of Academic Health Centers and the Alliance of Academic Health Centers International broadened the AAMC's U.S. membership and expanded its reach to international academic health centers.

The AAMC appreciates the subcommittee's longstanding, bipartisan efforts to strengthen critical health programs. To enable the necessary support for the broad range of critical Federal priorities, the AAMC urges Congress to approve a funding allocation for discretionary spending, and, particularly, the Labor-HHS subcommittee that enables full investment in the priorities outlined below. To this end, the AAMC has joined more than 760 other organizations in urging congressional leaders to avoid deep cuts to nondefense programs like medical research in FY 2024 and beyond, and previously partnered with nearly 500 organizations in a March 31 letter reiterating the need for a robust funding allocation specifically for the Labor-HHS subcommittee. The AAMC also supports the president's proposal to supplement the annual HHS investments with mandatory funding to support ongoing pandemic preparedness.

National Institutes of Health. Congress's longstanding bipartisan support for medical research has contributed greatly to improving the health and well-being of all, and the AAMC thanks Congress for an eighth straight year of bipartisan support that resulted in the inclusion of $47.5 billion for medical research conducted and supported by the NIH in FY 2023. The foundation of knowledge built through NIH-funded research drives medical innovation that improves health through new and better diagnostics, improved prevention strategies, and more effective treatments. Over half of the life-saving research supported by the NIH takes place at medical schools and teaching hospitals, where scientists, clinicians, fellows, residents, medical students, and trainees work together to improve the lives of Americans through research. This unique and highly productive relationship lays the foundation for improved health and quality of life and strengthens the Nation's long-term economy. Additionally, the AAMC thanks the subcommittee for recognizing the importance of retaining the salary cap at Executive Level II of the Federal pay scale in FY 2023.

In FY 2024, the AAMC joins nearly 400 partners in supporting the Ad Hoc Group for Medical Research recommendation that Congress provide at least $50.924 billion for NIH's foundational work, which would represent an increase of $3.465 billion over the comparable FY 2023 funding level. This funding level would allow NIH's base budget to keep pace with the biomedical research and development price index (BRDPI) and allow meaningful growth of nearly 5% above inflation. Importantly,

the Ad Hoc Group strongly urges lawmakers to ensure that any additional funding the subcommittee opts to provide for ARPA–H supplements our $51 billion recommendation for NIH's base budget, rather than supplants the essential foundational investment in the NIH.

Securing a reliable, robust budget trajectory is key in positioning the agency—and the patients who rely on the research it funds—to capitalize on the full range of research in the biomedical, behavioral, social, and population-based sciences. We must continue to strengthen our Nation's research capacity, solidify our global leadership in research, ensure a research workforce that reflects the racial, gender, and geographic diversity of the population, and inspire a passion for science in current and future generations of researchers.

Agency for Healthcare Research and Quality. Complementing the medical research supported by NIH, AHRQ sponsors health services research designed to improve the quality of health care, decrease health care costs, and provide access to essential health care services by translating research into measurable improvements in the health care system. The AAMC joins the Friends of AHRQ in recommending at least $500 million in funding for AHRQ in FY 2024.

Health Professions Funding. The HRSA Title VII and Title VIII programs educate current and future providers to serve the Nation's ever-growing needs, while preparing for the health care demands of tomorrow. For decades, these programs have proven successful in recruiting, training, and supporting nurses, physicians, physician assistants, mental health providers, and other health professionals critical to addressing country's evolving health care needs. Studies have shown that HRSA Title VII programs like the Centers of Excellence (COE) and Health Careers Opportunity Program (HCOP) lead to increases in the number of students from rural and other underrepresented communities enrolling in health professions schools and training in rural settings. Despite their success and widespread interest, currently only 21 schools have HRSA HCOP grants and only 18 have HRSA COE grants—down from 80 HCOP programs and 34 COE programs in 2005 before the programs' Federal funding was cut substantially.

We appreciate that Congress has allocated modest increases for a handful of HRSA Title VII and Title VIII programs in recent years; however, funding for many programs, including the health and nursing workforce pathway programs, has been stagnant. The AAMC joins the Health Professions and Nursing Education Coalition (HPNEC) in recommending $1.51 billion for these critical workforce programs in FY 2024. Recognizing Federal budget constraints, the HPNEC recommendation for HRSA Title VII and Title VIII has not increased for 3 years. This proposed funding level will help address health workforce shortages in critical areas of need and shape the future health workforce at all stages of the continuum. The AAMC also supports the president's proposal for at least $25 million to fund the new HRSA Supporting the Mental Health of the Health Professions Workforce program, which received no funding in the FY 23 omnibus. Funding from the American Rescue Plan Act (ARPA, Public Law 117–2) allowed HRSA to support several programs to prevent burnout in the health care workforce and promote clinician well-being, but HRSA received far more high-quality applications than resources allowed the agency to support. Additionally, the newly proposed Health Care Workforce Innovation program has potential in promoting innovations to address pervasive workforce challenges.

AAMC also supports $738 million in FY 2024 for the HRSA CHGME program, which provides Federal graduate medical education support for children's hospitals to train the future primary care and specialty care pediatric workforce. Likewise, we encourage the subcommittee to provide robust funding to HRSA's Rural Residency Programs to expand training opportunities in rural areas. Another important HRSA program, the National Health Service Corps (NHSC), has also played a significant role in recruiting primary care physicians to federally designated Health Professions Shortage Areas (HPSAs) through scholarships and loan repayment options. The AAMC supports continued growth for the NHSC in FY 2024 appropriations, and we urge Congress to provide a level of funding for the NHSC that would fulfill the needs of current HPSAs.

Centers for Disease Control and Prevention. The AAMC joins the CDC Coalition in a recommendation of at least $11.581 billion for the CDC in FY 2024. In addition to ensuring a strong public health infrastructure and protecting Americans from public health threats and emergencies, CDC programs are crucial to reducing health care costs and improving health. Within that total, the AAMC supports the president's proposed $35 million for CDC-supported firearm safety research as well as the proposal to double firearm morbidity and mortality prevention research funding at the NIH to $25 million in FY 2024. The AAMC also supports $250 million for a new community violence intervention initiative at the CDC. Also within the CDC

total, the AAMC supports increased or new funding for: Data Modernization Initiative (DMI) ($340 million); Center for Forecasting and Outbreak Analysis (CFA) ($100 million); and Advanced Molecular Detection (AMD) program ($175 million).

Additional Programs. The AAMC also supports at least $474 million for the Hospital Preparedness Program within the Office of the Assistant Secretary for Preparedness and Response (ASPR), in addition to $40 million to continue the regional preparedness programs created to address emerging and other special pathogens, including funding for regional treatment centers, frontline providers, and the National Emerging Pathogen Training and Education Center (NETEC).

Once again, the AAMC appreciates the opportunity to submit this testimony and looks forward to working with the subcommittee as it prepares its FY 2024 spending bill.

PREPARED STATEMENT OF THE ASSOCIATION OF FARMWORKER OPPORTUNITY PROGRAMS

Chair Baldwin and Ranking Member Capito:

Thank you for the opportunity to present to you and your subcommittee the testimony of the Association of Farmworker Opportunity Programs (AFOP) in support of the Nation's 59-year commitment to providing eligible agricultural workers the opportunity to achieve the American Dream for themselves and their families. As you begin work on your fiscal year 2024 Labor-Health and Human Services-Education appropriations bill, AFOP encourages you to build on the foundations laid by the highly successful programs described below by adequately funding them in the coming fiscal year: National Farmworker Jobs Program (NFJP), United States Department of Labor (DOL) Employment and Training Administration ($114,600,000); and Susan Harwood Training Grants, DOL Occupational Safety and Health Administration ($13,787,000). Not only do these programs maximize the Federal Government's investment in them, but they also generate for employers the qualified and healthy workers essential to their growth. These programs also dramatically change peoples' lives for the better, often in rural areas, allowing them to enjoy economic success and participate more fully in our great nation. Thank you for supporting these very effective programs and the excellent results they bring for society's most vulnerable.

NATIONAL FARMWORKER JOBS PROGRAM

NFJP is the bedrock of the Nation's commitment to helping agricultural workers upgrade their skills in and outside agriculture, providing employers with what they increasingly say they need: hardworking, well-trained, skilled workers. Administered by DOL, NFJP provides funding through a competitive grant process to 54 community-based organizations and public agencies nationwide that assist workers and their families to attain greater economic stability. One of DOL's most successful employment training programs, NFJP helps agricultural workers acquire the new skills they need to start careers that offer higher wages and a more stable employment outlook. In addition to employment and training services, the program provides supportive services that help farmworkers retain and stabilize their current agriculture jobs, as well as enable them to participate in up-training and enter new careers. NFJP housing assistance helps meet a critical need for available quality agricultural worker housing and supports better economic outcomes for workers and their families. NFJP also facilitates the coordination of services through the American Job Center network for agricultural workers so they may access other services of the public workforce system.

The agricultural workers who come to NFJP seek training to secure and excel in the in-demand jobs employers say they find challenging to fill. In doing so, the workers establish the financial foundation that allows them and their families to escape the chronic unemployment and underemployment they continually face. Many NFJP participants enter construction, welding, healthcare, and commercial truck-driving. Others train for the solar/wind energy sector, culinary arts, and for positions such as machinists, electrical linemen, and a variety of careers in and outside of agriculture. To be eligible for NFJP, workers must be low-income, depend primarily on agricultural employment, and provide proof of American citizenship or work authorization. Additionally, male applicants must have registered with the Selective Service.

Agricultural workers are some of the hardest working individuals in this country, enduring tremendous physical and financial hardships in providing the produce Americans eat every day. Yet, agricultural workers remain among the Nation's most

vulnerable employees and job seekers, facing significant barriers to work advancement, including:

—The average agricultural worker family of four earns just $20,000 per year, well below the National poverty line.

—English-language fluency is a substantial challenge for many.

—More than half the children of migratory agricultural workers drop out of school, and, among all agricultural workers, the median highest grade completed is 9th grade.

—Due to poverty and their rural locations, most agricultural workers have extremely limited access to transportation.

Despite these barriers, NFJP continues to be one of the most successful Federal job training programs, exceeding each of DOL's performance goals. In 2021 alone, NFJP service organizations provided more than 18,000 agricultural workers with services, according to DOL. Extrapolating, NFJP providers have served over a million agricultural workers and their family members since the program's inception. Providing program funding this year at $114,600,000__the level set in last year's House-passed WOIA reauthorization bill (H. R. 7309)—would allow NFJP to train an even greater number of dependable, capable workers to take on the Nation's most challenging jobs. Also, consistent appropriations for youth agricultural workers (ages 14- to 24-years) will allow this cohort, so often overlooked and ignored by anti-poverty programs, to stay in school, and, if not in school, to avail themselves of crucial training to get a good job and establish themselves as productive and successful members of society.

AGRICULTURAL WORKER HEALTH & SAFETY

AFOP also supports appropriations for OSHA's Susan Harwood grant program, through which AFOP has augmented pesticide safety training with curricula to help workers recognize and avoid the dangers of heat stress so common in the fields. In supporting this funding, you can arm the Nation's agricultural workers with the knowledge they need to keep themselves safe on the job. The NFJP network of 248 trainers in 32 States trains agricultural workers on how to protect against pesticide poisoning. Trainers then follow up with agricultural workers to assess knowledge gained and retained, and changes in labor practice. Since 1995, more than 654,000 agricultural workers have become certified as trained in safety precautions, and hundreds of thousands of family members, children, and community agencies have also received safety training. The network collaborates with universities, community organizations, local governments, and businesses to maximize its unparalleled access to agricultural workers and their families. By reaching agricultural workers with safety training, the network's trainers offer access to other services and create a ripple effect of positive impact__improving the quality of life for agricultural workers and their families__which is what NFJP organizations do best.

Thank you for supporting these worthy programs. AFOP stands ready to assist you in any way as you proceed with your very important work.

[This statement was submitted by Daniel J. Sheehan, Executive Director, Association of Farmworker Opportunity Programs.]

PREPARED STATEMENT OF THE ASSOCIATION OF INDEPENDENT RESEARCH INSTITUTES

The Association of Independent Research Institutes (AIRI) thanks the Subcommittee for its long-standing and bipartisan leadership in support of the National Institutes of Health (NIH). We continue to believe that science and innovation are essential if we are to improve our Nation's health, sustain our leadership in medical research, and remain competitive in today's global information and innovation-based economy. AIRI urges the subcommittee to provide NIH with at least $51 billion in base funding in fiscal year (FY) 2024. AIRI also commends Congress for continuing to reject harmful policies such as reducing support for facilities and administrative (F&A) costs or investigator salary support on NIH grants. In addition, AIRI looks forward to working with Congress and the Biden Administration to explore how the newly established Advanced Research Project Agency for Health (ARPA–H) can support high-risk, high-reward research to accelerate the pace of biomedical innovation as the agency begins to launch programs in 2023. As the promise of ARPA–H rests on the foundational research that is supported by NIH's base budget, AIRI urges the subcommittee to ensure that any additional funding provided for ARPA–H supplements, and does not supplant, the NIH's base budget funding.

AIRI is a national organization of more than 80 independent, non-profit research institutes that perform basic and clinical research in the biological and behavioral

sciences. AIRI institutes vary in size, with budgets ranging from a few million to hundreds of millions of dollars. Each AIRI member institution is governed by its own independent Board of Directors, which allows our members to focus on discovery-based research while remaining structurally nimble and capable of adjusting their research programs to emerging areas of inquiry. Investigators at independent research institutes consistently exceed the success rates of the overall NIH grantee pool, and they receive nearly 10 percent of NIH's peer-reviewed, competitively awarded extramural grants.

AIRI thanks the subcommittee for providing an increase of $2.5 billion for NIH in the FY 2023 omnibus appropriations package, the agency's eighth consecutive funding increase. The subcommittee's support of NIH is strongly demonstrated by these much-needed funds for life-saving biomedical research. However, there is still much more to do. NIH is tackling vast, interdisciplinary problems such as cancer, Alzheimer's Disease, emerging infectious diseases, environmental health, and the opioid crisis, among others. As we emerge from the COVID–19 pandemic, now is not the time to pull back on needed investments in the Nation's biomedical research ecosystem. Continued budget certainty is needed for the agency to predictably fund new and ongoing grants and consider new initiatives necessary to improving human health and ensuring that we are prepared for the next public health crisis. To ensure cutting-edge research at independent research institutes is not disrupted, AIRI strongly supports a topline of $51 billion for NIH in FY 2024.

Like others in the biomedical and health research community, AIRI has followed the development of ARPA–H closely and is excited about the promise that the new agency holds to accelerate the pace of innovation while tackling some of the most persistent challenges in the health ecosystem. AIRI was pleased to see the launch of ARPA–H's first funding opportunity announcement this month and our member institutes are prepared to engage with the new agency to advance its mission. If successful, ARPA–H has the potential to address grand challenges in public health that were previously thought to be impossible to solve. However, we still do not fully understand many of the basic mechanisms underlying diseases and public health challenges facing the Nation today, such as cancer, Alzheimer's, and addiction, among others. Funding for fundamental research is still crucial to address these issues, and AIRI urges the subcommittee to ensure that basic research discovery funded by the NIH can adequately inform the transformative, applied research promised by ARPA–H. Only by ensuring robust funding for NIH's base budget and the foundational research it supports, can we put ARPA–H in the best possible position to succeed.

Not only is NIH research essential to advancing health, it also plays a key economic role in communities nationwide. Each year, NIH awards over 60,000 grants that directly support more than 300,000 researchers at more than 2,500 different institutions in every State and almost every congressional district. In FY 2022, NIH invested $36.68 billion, over 80 percent of its budget, in the biomedical research community. This investment directly and indirectly supported 568,585 jobs nationwide and generated $96.84 billion, or $2.64 for every $1 of NIH research funding, in new economic activity across the U.S.[1] In addition, for every $100 million of funding, NIH-supported research generates 76 patents. NIH-funded patents produce 20 percent more economic value than other U.S. patents and create opportunities for an estimated $598 million in further research and development. AIRI member institutes are particularly relevant in this effort to leverage NIH funding to spur economic growth, as they are located across the country, including in many smaller or less-populated States that do not have major academic research institutions. In many of these regions, independent research institutes are major employers and local economic engines, and they exemplify the positive impact of investing in research and science.

The NIH model for conducting biomedical research, which involves supporting scientists at independent research institutes, medical centers, and universities provides an effective approach to making fundamental discoveries in the laboratory that can be translated into medical advances that save lives. AIRI member institutions are private, stand-alone research centers that set their sights on the vast frontiers of medical science. However, AIRI member institutes are especially vulnerable to reductions in the NIH budget, as they do not have other reliable sources of revenue to make up the shortfall. Due to this reality, AIRI member institutes also face greater risks from proposals to reduce support for F&A costs or investigator salary

[1] NIH's funding information and economic impact data comes from United for Medical Research's 2023 Update on NIH's Role in Sustaining the U.S. Economy, https://https://unitedformedicalresearch.org/annual-economic-report/.

support on NIH grants. We urge the subcommittee to continue rejecting these harmful policies.

AIRI member institutes' flexibility and research-only missions provide an environment particularly conducive to creativity and innovation. Independent research institutes possess a unique versatility and culture that encourages them to share expertise, information, and equipment across research institutions, as well as neighboring universities. These collaborative activities help minimize bureaucracy and increase efficiency, allowing for fruitful partnerships in a variety of disciplines and industries. Also, unlike institutes of higher education, AIRI member institutes focus primarily on scientific inquiry and discovery, allowing them to respond quickly to the research needs of the Nation, as was demonstrated in the early days of the COVID–19 pandemic when many AIRI member institutes pivoted quickly to support essential research and discovery activities that contributed to the rapid development of vaccines and therapeutics.

AIRI deeply thanks the subcommittee for its important work dedicated to ensuring the health of the Nation, and we appreciate this opportunity to urge the subcommittee to continue the success of NIH by providing $51 billion for the NIH's base budget in FY 2024 and reaffirming that any additional funding for ARPA–H supplements the base budget funding to strengthen our Nation's investment in life-saving medical research.

Founded in 1962, AIRI is an association of independent, not-for-profit biomedical and behavioral research institutes whose mission is to enhance the ability of its members to improve human health and advance knowledge. We accomplish our mission through member networking, education, and involvement in the development of science policy.

PREPARED STATEMENT OF THE ASSOCIATION OF MINORITY HEALTH PROFESSIONS SCHOOLS, INC.

SUMMARY OF FISCAL YEAR 2024 RECOMMENDATIONS:

Health Resources and Services Administration:

—$1.51 billion for the Health Resources and Services Administration (HRSA) Title VII health professions and Title VIII nursing workforce development programs.
  —$47.42 million for HRSA's Minority Centers of Excellence
  —$47.95 million for HRSA's Health Careers Opportunity Program.
  —At least $2.31 million (FY 2023 level) for HRSA's Minority Faculty Loan Repayment Program
  —$67 million for HRSA's Scholarships for Disadvantaged Students (SDS).
  —$67 million for HRSA's Area Health Education Center (AHEC) Program

Centers for Disease Control and Prevention

—$74 million for the Racial and Ethnic Approaches to Community Health (REACH) Program

National Institutes of Health

—$50.92 billion for the National Institutes of Health
—$1 billion for the National Institute on Minority Health and Health Disparities (NIMHD).
  —$300 million for the Research Centers at Minority Institutions (RCMI)
  —$200 million in new, annual research funding dedicated specifically targeted at enabling historically black health professions schools to support research that reverses health status disparities among minority Americans.
  —$50 million for the NIMHD's Research Endowment Program (REP)
—$100 million for NIH's Extramural Research Facilities program

Office of the Secretary

—At least $74.84 million (FY 2023 level) for the Office of Minority Health at the Department of Health and Human Services.
—$5 billion in new funding designated for Historically Black Health Professions Institutions for the improvement and development of health care infrastructure.

Department of Education

—At least $100.78 million (FY 2023 level) for the Strengthening Historically Black Graduate Institutions (HBGI) Program.

Chairwoman Baldwin, Ranking Member Capito, and distinguished members of the subcommittee, thank you for the opportunity to submit testimony and thank you for your leadership in addressing challenges facing the health workforce, health disparities, and medically underserved communities. I am Dr. Johnnie Early, Dean and Professor at The Florida A&M University, College of Pharmacy and Pharmaceutical Sciences, Institute of Public Health and the Chair of the Association of Minority Health Professions Schools (AMHPS), which was established in 1976 to promote a national minority health agenda by addressing the needs of the health workforce and improving health status in medically underserved communities. Our funding recommendations are robust and we realize ambitious, however there have rightfully been discussion concerning the devastating effect of the pandemic on people of color and the need to address this effect for any future pandemic. To be as clear we can be, there must be more robust investment on minority health and disparities. To achieve this, we know that it will require the steadfast leadership of health equity champions. We stand ready to work with you and your colleagues to facilitate these efforts.

AMHPS is comprised of the 12 historically black medical, dental, pharmacy, and veterinary schools in the United States. The members are two schools of dentistry at Howard University and Meharry Medical College; four schools of medicine, at Charles R. Drew University, Howard University, Meharry Medical College, and Morehouse School of Medicine; five schools of pharmacy, at Florida A&M University, Howard University, Texas Southern University, Hampton University, and Xavier University; and one school of veterinary medicine, at Tuskegee University. Today, the association assists its member institutions in the expansion and enhancement of educational opportunities in the health professions for minorities and disadvantaged students and disadvantaged people. AMHPS continuously adheres to is founding call and honors its threefold mission to improve the health status of blacks and other minorities; improve the representation of blacks and other minorities in the health professions; strengthen our institutions and programs and to strengthen other programs throughout the Nation, which in turn will improve the role of minorities in the provision of health care.

Health disparities across racial and ethnic groups in the U. S. have been well documented over the last several decades and have remained remarkably persistent despite the changes in many facets of the society over that period. Moreover, the benefits of increasing diversity in the health professions to reduce such disparities have been studied at length, are based on empirical data, and are well understood by the medical community. Examples of these benefits include:

—Minority physicians are more likely to practice in medically underserved areas and care for patients regardless of their ability to pay.
—Minority physicians are more likely to choose primary care practices.
—Evidence suggests that improving cross-cultural communication between doctors and patients and providing patients with access to a diverse group of doctors improve adherence, satisfaction and health outcomes.
—There is evidence that the intellectual, cultural sensitivity, competency, and civic development of students is enhanced by learning in a diverse educational environment.
—A diverse health workforce encourages a greater number of minorities to enroll in clinical trials designed to alleviate health disparities.

Ironically, because of their mission focus the financial models of historically black health professions schools are uniquely disadvantaged compared to most of their peer institutions. Unlike subspecialty-oriented, research-intensive institutions—with higher margin clinical services, an integrated hospital system, substantial research enterprises, sizeable endowments, and a critical mass of wealthy donors—these institutions are faced with an unprecedented set of adverse factors that challenge their financial viability.

Last year, President Biden signed the John Lewis NIMHD Research Endowment Revitalization Act to revitalize this important initiative and Congress designated $12.00 million for the Research Endowment Program in FY 2023. This reinvigoration will allow minority-serving institutions to participate in this competitive opportunity to build their research endowments in a manner consistent with the statutory goal of assisting them in achieving a research endowment that is comparable to the endowments of other schools in their health professions discipline. The NIMHD Research Endowment Program (REP) allows academic institutions to build research infrastructure and recruit, train, and maintain a diverse faculty and student body. Additional robust funding in FY 2024 would allow active and former NIMHD Centers of Excellence to continue their historic focus on research to close the gap between the burden of illness and premature mortality experienced more commonly by com-

munities of color, as well as other medically underserved populations. To ensure successful implementation, we are asking for the Committee to allocate robust funding to NIMHD for this program, building on the $12 million that was allocated in FY 2023.

Congress has provided for additional GME Medicare positions in recent years, which will make a significant impact addressing health workforce shortages. Congress specified four categories of hospitals eligible for additional GME positions: hospitals located in rural areas; hospitals currently training over their caps; hospitals located in States with new medical schools; and hospitals serving Health Professional Shortage Areas [HPSAs]. To improve the ability of the GME program to address shortages in some of the most underserved communities, AMHPS recommends priority consideration of future position distribution within the HPSA category to teaching hospitals associated with Historically Black Medical Schools. Historically Black Medical Schools and their teaching hospitals have been under-resourced, while serving the most vulnerable and in-need communities. Priority consideration of such hospitals will align with the goals of the GME program and ensure health workforce shortages are being appropriately addressed in the most underserved communities throughout the U.S.

Chairwoman Baldwin, unfortunately, over the past several years funding for diversity-focused programs has deteriorated in varying degrees. Absent a monumental overall investment, the financial position and academic viability of historically black health professions schools will deteriorate rapidly. Thank you all again for the opportunity to share the priorities of the Association of Minority Health Professions Schools.

[This statement was submitted by Johnnie L Early II, PhD, RPh, Fellow NPhA, Chair, Association of Minority Health Professions Schools, Inc.]

PREPARED STATEMENT OF THE ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS

On behalf of the Association of State and Territorial Health Officials (ASTHO), I respectfully submit this testimony on 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 3 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.

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

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.

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 5-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 com-

munity 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.

[This statement was submitted by Anne Zink, MD, FACEP, President, Association of State and Territorial Health Officials.]

PREPARED STATEMENT OF THE ASSOCIATION OF UNIVERSITY CENTERS ON DISABILITIES

Testimony prepared for the subcommittee on Labor, Health and Human Services, Education and Related Agencies. This testimony primarily addresses three programs in the U.S. Department of Health and Human Services, including: (1) University Centers for Excellence in Developmental Disabilities: Administration on Community Living (ACL); (2) Leadership Education in Neurodevelopmental Disabilities: Health Resources and Services Administration (HRSA); and (3) Intellectual and Developmental Disability Research Centers: National Institutes of Health, National Institute for Child Health and Human Development (NICHD).

THE ASSOCIATION OF UNIVERSITY CENTERS ON DISABILITIES

The Association of University Centers on Disabilities (AUCD) is a membership organization that supports and promotes a national network of university-based interdisciplinary programs. Network members consist of 143 centers, including 67 University Centers for Excellence in Developmental Disabilities (UCEDD), 60 Leadership Education in Neurodevelopmental Disabilities (LEND) programs; and 16 Eunice Kennedy Shriver Intellectual and Developmental Disability Research Centers (IDDRC). AUCD's mission is to advance policies and practices that improve the health, education, social, and economic well-being of all people with developmental and other disabilities, their families, and their communities by supporting our members in research, education, health, and service activities that achieve our vision. AUCD's network of programs are located in every State and territory and are all part of universities or university medical centers. AUCD's programs excel in basic and applied research, training, information dissemination, creation of model demonstration programs, systemic reform, and policy analysis. Given that these programs work collaboratively, innovations from one program can be rapidly implemented in communities throughout the country. AUCD's programs serve as a bridge between the university and the community, bringing together the resources of both to build the capacity of communities to support individuals with developmental and other disabilities and achieve meaningful systemic change.

UNIVERSITY CENTERS FOR EXCELLENCE IN DEVELOPMENTAL DISABILITIES

The UCEDDs are interdisciplinary centers authorized in the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (DD Act) (Section 156 of Public Law 106–402, Subtitle D). The UCEDDs are located in every State and territory, with some States having multiple UCEDDs to serve the unique needs of the state. The funding from the DD Act supports the basic operating costs for each UCEDD. Each UCEDD leverages the core funding from the DD Act to secure additional funding to meet the needs identified by constituents within each State and territory and carry out the purpose of the DD Act. The purpose of the DD Act is to assure that individuals with developmental disabilities and their families help design and have access to individualized and community services and supports that promote self-determination, independence, productivity, and integration and inclusion in all facets of community life, through culturally responsive programs. The UCEDDs provide training, technical assistance, service, research, and information dissemination to people with developmental disabilities, their families, State and local government agencies, and providers. The UCEDDs have directly improved services and supports in the States and territories in early intervention, healthcare, public health, community-based services, education, employment, housing, assistive technology, emergency response, and transportation.

LEADERSHIP EDUCATION IN NEURODEVELOPMENTAL DISABILITIES (LEND) PROGRAMS

The LEND programs are authorized in The Autism Collaboration, Accountability, Research, Education and Support Act (Autism CARES Act) (Public Law 116–60). The LEND programs are located in 44 States, with an additional six States and three territories reached through program partnerships, (without additional Federal or state aid). LEND programs operate within universities and collaborate with university hospitals and/or academic health centers to provide advanced interdisciplinary training to enhance the leadership skills and clinical expertise of professionals to identify, assess, and provide care to individuals who have or are at increased likelihood of developing autism and other neurodevelopmental or related disabilities. The LEND programs are effective workforce development programs.

These professionals provide culturally and linguistically relevant and family-centered care. The LEND programs are committed to improving health equity in underserved populations. In Fiscal Year (FY) 2022, 29.8 percent of trainees in the LEND programs were from underrepresented racial groups, and 9.4 percent were Hispanic or Latino. LEND programs also include self-advocates with disabilities and family members as trainees and faculty to further enhance their leadership and advocacy skills as part of an interdisciplinary care team. They also offer an invaluable perspective based on their lived experience.

EUNICE KENNEDY SHRIVER INTELLECTUAL AND DEVELOPMENTAL DISABILITY RESEARCH CENTERS

The Intellectual and Developmental Disabilities Research Centers (IDDRCs) were established in 1963 as "centers of excellence" for research in intellectual and developmental disabilities. The IDDRC's represent the Nation's first and foremost sustained effort to prevent and treat disabilities through biomedical and behavioral research. The network of IDDRCs with AUCD membership consists of 15 Centers with current P30 core grant funding from NICHD. Each IDDRC supports 40 -100 research projects on an annual basis that seek to advance the understanding of chromosomal conditions and biochemical processes as they relate to brain function and intellectual and/or developmental disabilities. IDDRCs contribute to the development and implementation of evidence-based practices by evaluating the effectiveness of biological, biochemical, and behavioral interventions; developing assistive technologies; and advancing prenatal diagnosis and newborn screening. They also provide invaluable research, training, mentoring, and support to emerging leaders in clinical and research science.

FISCAL YEAR 2024 APPROPRIATIONS REQUESTS AND JUSTIFICATION

AUCD requests that Congress appropriate $47,173 million for the UCEDDs for FY 2024 within the Administration for Community Living (ACL) in the Labor-HHS-Education appropriations bill.

The increased funding will ensure that the UCEDDs continue to implement the purpose and requirements of the DD Act and can respond to the increased demand for training and technical assistance. In Fiscal Year 2022, the UCEDDs and LEND programs (frequently located in UCEDDs) reached 2.3 million people through community training and technical assistance activities and the UCEDDs and LENDs trained over 5,000 professionals that work with people with developmental and other disabilities. The funding provided to the UCEDDs also funds the UCEDD Resource Center, which provides technical assistance to increase the UCEDDs' impact. In FY 2022, every UCEDD requested technical assistance. The UCEDD Resource Center responded to 537 requests for technical assistance. The Center also disseminated 50 new products and 7 recurring products to the UCEDDs.

AUCD requests that Congress appropriate $58,344 million for Autism and other Developmental Disabilities for FY 2024 and of this amount appropriate $40,000 million for LENDs (in report language) within Health Resources and Services Administration (HRSA) in the Labor-HHS-Education appropriations bill.

Approximately one in 68 children in the United States has been identified with autism. Diagnosis can be difficult and needs to be made by well-trained professionals. On average, most children are not identified and diagnosed until after age four, even though diagnosis as early as age two is possible. It is well-established that the public health and healthcare systems lack sufficient providers trained in systems thinking and interdisciplinary practices to meet the needs of children with autism, who often have multiple co-occurring conditions. Furthermore, significant racial and ethnic disparities exist in the diagnosis and recognition of autism as well

as in access to care. The LEND programs are effective workforce programs that seek to meet these documented needs.

The increased funding for the Autism and Developmental Disabilities program will support research, training programs, and state systems to improve access to and the quality of systems of care for individuals with autism and other neurodevelopmental and related disabilities. The increased funding specifically for the LEND programs will allow the programs to address significant disparities in evaluation, diagnosis, and treatment, including for individuals from underserved communities. The funding will also support the LENDs to recruit and support more autistic adults as faculty advocates and trainees, with an emphasis on expanding the LEND curriculum to include and address adult life needs.

AUCD requests that Congress appropriate $1.877 billion for the NICHD within the National Institutes of Health (NIH). AUCD additionally requests a proportional increase of 7.3 percent for IDDRCs within the NICHD in the Labor-HHS-Education appropriations bill.

This increased level of funding for NICHD is essential to building upon the cutting-edge research and collaboration of the IDDRC network to better understand the neural and biomolecular underpinnings of intellectual and/or developmental disabilities to better inform treatments and interventions. While NICHD has seen annual funding increases, the IDDRC grant budget has remained flat for several years. Its successes are many. Scientific advances by the IDDRC network are identifying specific genes causing life-threatening conditions and are developing interventions to preserve health and function in the earliest stages of life.

OTHER PROGRAMS THAT SUPPORT AND SERVE CHILDREN AND ADULTS WITH DISABILITIES

AUCD supports the President's proposed budget increases for many other programs that support and serve people with disabilities, such as the proposed increase of $150 billion for Medicaid home and community-based services and for the programs funded under the Individuals with Disabilities Education Improvement Act. In addition, we specifically support the President's budget request or significant increases for:

—Transition Programs for Students with Intellectual Disabilities (TPSID) and related technical assistance centers (NCC and NDTAC) to promote college programs for students with intellectual disabilities;

—Projects of National Significance (PNS), innovative demonstration projects to monitor progress on key policy priorities for people with I/DD;

—Assistive Technology Act (AT) programs, provide critical funding to ensure people with disabilities can access and acquire the assistive technology devices and services they need to live, work, and attend school in their communities.

—The National Institute on Disability Independent Living and Rehabilitation Research (NIDILRR), the Federal Government's primary disability research organization, which funds programs that generate new knowledge and promote its effective use to strengthen individual and community capacity for inclusion; and

—The National Center on Birth Defects and Developmental Disabilities (NCBDDD) strives to advance the health and well-being of people with disabilities by preventing birth defects, promoting better understanding of developmental disabilities, and improving the health of people with disabilities.

AUCD and AUCD's member centers frequently secure grants from these programs. For example, the PNS fund three national long-term data collection projects that help policymakers, service providers, and people with developmental disabilities and their families to make the most informed policy and individual decisions related to healthcare and employment. All three of the National longitudinal studies are conducted by AUCD's members. The studies include a study of the evolution of integration and inclusion of people with developmental disabilities in society and more than 20 years of studies about community integration and employment for people with developmental disabilities.

PREPARED STATEMENT OF THE ASSOCIATION OF UNIVERSITY PROGRAMS IN OCCUPATIONAL HEALTH AND SAFETY

On behalf of the Association of University Programs in Occupational Health and Safety (AUPOHS), we respectfully request that the Fiscal Year 2024 Labor, Health, and Human Services Appropriations bill include at least $375,300,000 for the National Institute for Occupational Safety and Health (NIOSH), within the Centers for Disease Control and Prevention, including no less than $33,000,000 for the Edu-

cation and Research Centers (ERCs), $30,000,000 for the Agriculture, Forestry, and Fishing (AgFF) Program, and a $1,000,000 increase over the FY23 level for the Total Worker Health(r) (TWH) Program.

As you know, far too many Americans still lose their lives on the job. In 2021, a worker died every 101 minutes from injuries they got on the job (BLS 2021). This includes our first responders, who can be struck and killed by drivers while helping victims of a roadside traffic accident; our construction workers, who may fall from an inadequately guarded roof edge; our farmers who may be engulfed in flowing grain; and our shop owners and employees who may be asked to work late nights without proper security and become victims of violence. Although it is harder to measure, we also estimate that an additional 145 people die every day in the US from work-related disease. In addition to work-related deaths, we also have a high burden of nonfatal workplace injury and illness. Annually, 2.8 million workers are seriously injured on the job and one-third of those injured workers require time off to recover before they return to work. This costs the Nation's businesses more than $1 billion a week on serious, nonfatal workplace injuries (Liberty Mutual 2022) and causes great harm to workers and their families.

In addition to continuing to address a wide range of known hazards such as exposures to harmful substances and workplace injuries, there is a critical need to address the changing work environment and its impact on health and wellbeing. The American workforce is facing new challenges that impact productivity and the ability to recruit and retain employees. These include understaffing and burnout among healthcare workers, long-term care workers, and teachers; high suicide rates among construction workers and farmers; and the unanticipated impacts of new technologies. Workplaces are also facing challenges produced by a multigenerational workforce, reduced job security, high turnover, irregular work hours, and shift work.

NIOSH is the primary Federal agency focused on studying worker safety and health, and empowering employers and workers to create safe and healthy workplaces. Working in partnership with industry, universities, scientific and professional communities, and local, State, and Federal Government, NIOSH translates research into practice to prevent work-related illness and injury and promote worker health and wellbeing. NIOSH research leads to actions and policies that reduce workplace hazards contributing to cancer, chronic disease, hearing loss, and injury. A recent focus of NIOSH is to identify industries and work conditions that have helped fuel the National epidemics of suicide and opioid overdose. Understanding how the conditions of work can impact mental health and burnout is needed in order to develop and implement programs and policies to bolster workers' mental health. NIOSH is also the Federal agency charged with certifying and approving Personal Protective Equipment (PPE), including the masks that are necessary to protect U.S. workers from inhalation exposures to chemical and biological agents, including viruses. Recently, NIOSH accelerated the approval process for establishing the safety and quality of new masks and other PPE. Additionally, NIOSH continues to fund and promote critical research for a changing workforce and work practices, an important service for employers and employees in the face of emerging workforce needs. NIOSH has, for example, deployed teams across the country in response to industry requests for assistance, including to address the mental health crisis among health care workers. NIOSH contributes key leadership and expertise, providing Federal guidance and decision tools for multiple industries including construction, manufacturing, food and agriculture, mass transit, transportation and trucking, restaurants and bars, childcare facilities, and schools, including recent guidance for businesses to safely return to work and/or expand operations.

The NIOSH-supported extramural Centers, including the Education and Research Centers (ERCs), Centers in the Agriculture, Forestry, and Fishing (AgFF) Program, and the Total Worker Health(r) (TWH) Centers of Excellence, have responded to emerging workplace threats and supported NIOSH to rapidly respond to the needs and safety of the Nation's workforce. These Centers have been proactive in providing resources, employer assistance, over 100,000 hours of outreach training, and pragmatic research that drive timely improvements in our Nation's response to emerging occupational safety and health issues. The work the Centers have undertaken underscores the need for increased funding for NIOSH. As workplaces rapidly evolve, changes continue to present new health and safety risks to workers, which need to be addressed promptly through occupational health and safety research and training.

The 18 university based ERCs provide local, regional, and national resources for all those in need of occupational health and safety assistance. Collectively, the ERCs provide graduate- and post-graduate level education and research training in multiple occupational health and safety disciplines. The ERCs prepare a workforce of occupational safety and health professionals to every Federal Region in the U.S.

who are trained to identify and mitigate vulnerabilities to our workforce, including increasing our readiness to respond to chemical, biological, radiological, or nuclear attacks. Occupational health and safety professionals work with emergency response teams to minimize disaster losses, as exemplified by their lead role in minimizing hazards among workers involved in clean-up and restoration of the extreme devastation caused by Hurricanes Ian, Harvey, Irma, and Maria in Texas, Florida, Puerto Rico, and the U.S. Virgin Islands.

NIOSH also leads the research and outreach efforts on the Nation's most dangerous worksites that often impact lives in rural parts of America. The NIOSH AgFF Program was established by Congress in 1990 (PL 101–517) in response to evidence that agricultural, forestry, and fishing workers suffer substantially higher rates of occupational injury and illness than other workers. Agricultural workers are more than six times more likely to die on the job than other workers, averaging 566 fatalities per year; nearly 5 per 100 agricultural workers incur recordable nonfatal injuries each year. Our food security depends on a healthy agricultural workforce. Today, the NIOSH AgFF initiative includes 11 regional Agricultural Centers and one national Children's Farm Safety and Health Center. The AgFF program is the only substantive Federal effort to ensure safe working conditions in this vital production sector. The program also conducts research and outreach to ensure the safety of our Nation's 86,000 workers in forestry and logging, an industry with a fatality rate more than 30 times higher than that of all our Nation's workers. The AgFF Centers have had a significant impact on protecting safety and health of agricultural workers. For example, increased use of rollover protective structures and seatbelts on tractors has reduced overturn-related deaths. Partnering with fishing communities, the AgFF Centers developed comfortable lifejackets to wear at work, which have increased chances of survival in the event of a fall overboard. The lifesaving, cost-effective work of the AgFF program is not replicated by any other agency. The majority of AgFF workers are self-employed farmers, ranchers, and fishermen and thus exempt from State and Federal OSHA protections, so NIOSH and the AgFF Centers fill a critical role in training and education in these high-risk sectors.

NIOSH also supports 10 Total Worker Health (TWH) Centers of Excellence that conduct multidisciplinary research and test practical solutions to emerging challenges that impact the safety, health, wellbeing, and productivity of the American workforce. The TWH Centers conduct solutions-focused research in partnership with employers and employees and partner with government, business, labor, and communities to improve the health and productivity of the workforce. The TWH Centers' research, education, and outreach activities occur in workplaces, such as hospitals, factories, offices, construction sites, and small businesses, resulting in immediate and measurable improvements in health and safety. These Centers have assisted employers and employees to address changing workforce needs following the pandemic, including addressing the impact on mental health, stress, burnout, and resiliency of essential workers. The TWH Centers are an investment in the American economy, helping valued employees return home safe and healthy at the end of a productive workday.

While funding for the ERC, AgFF, and TWH Centers is crucially important to maintain resources, staff, and long-term capacity in occupational safety and health research at the State and regional level, the overall NIOSH funding level is also critical. The requested NIOSH topline funding level supports NIOSH intramural research, including the NIOSH personal protective equipment program, which develops and monitors N95s and advanced respiratory protection systems; disaster response research; mental health research; Per- and Polyfluoroalkyl Substance (PFAS) research; and research on substance use disorders related to work. Increased NIOSH topline funding also enables reinstating reduced extramural funding levels for innovative investigator-initiated awards.

We urge you to recognize the critical contribution of NIOSH to the health and productivity of our Nation's workforce by providing at least $375,300,000 for the National Institute for Occupational Safety and Health (NIOSH) in the Fiscal Year 2024 Labor, Health, and Human Services Appropriations bill. Thank you for the opportunity to submit testimony.

Prepared Statement of Kaleb Barber

I am Kaleb Barber, a Black man, a father, a first-generation college graduate, a former athlete, and now a graduate student. I have competed in sports my whole life, and that was the only way I thought I could get to and complete college. I did not know of any other extracurricular activities or experiences that would benefit me growing up because all I knew or cared about was sports. When I considered

coming to college, it was only to get a degree because it would make me better off than my parents. My father started college but didn't finish his degree, and my mother had my oldest half-brother when she was 15 and never attempted to go to college. I had my son the summer before my senior year of high school. I finished high school with a 2.21 GPA, with no idea why I was going to college besides the picture of me making more money than my parents so that I did not have to be poor. These identities are factors of why I am currently choosing to pursue my graduate degree in School Counseling and get my LPC license.

I often think back to my high school experience and how it played out in my decision to pursue a degree in school counseling. I had a child, wanted to go to college for sports, and had no idea what degree I wanted. Then there was the decision of where to go. Aside from saving money, I had yet to learn what I was doing and why I would choose one place over another. I then came to the idea of Emporia State University in Emporia, Kansas, and no, not because there was a program there that I liked or knew about because it was what I wanted to do for the future. I chose Emporia State because there was a person I went to high school with that was doing excellent in the event of track and field that I did, and I wanted him to take me under his wing so I could be as great as him. I only wanted to go to college to make money in the future and to succeed in my sport because that was the only way financially that existed for me in my head to attend college.

These were all things I wrestled with and thought about during my senior year to figure out what was in the future for me. Aside from making money in the long term, I realized I needed to figure out what I was doing or why I was doing it. What did my parents know about why to go to college besides making more money? What did I know about it besides what I learned from my parents? I only knew a few students getting scholarships outside of sports. Who else knew what I should do or why on Earth I should do this? Where were my counselors?

However, I think about how fortunate I was to have the support and opportunities I did have. My parents were divorced, but I did have both of them. I did have a son at a young age, but I had the support of my family. My blessings made me think about students coming from even lower-income families, ones with a single parent, ones with less support, ones who did not have the support to help them with a child, or ones whose environment was dangerous. I think about all the guys that look like me with a good head on their shoulders but do not have the knowledge to go to college. I want to be the one to help them on their path to whatever success is for them.

I was determined to use this new beginning when I arrived at Emporia State University. I had a son, and I had to make something of myself and put him in a better position than I was. On freshman enrollment day, I met a woman who was a part of TRIO Student Support Services. I do not remember anything she said besides that I was a first-generation and low-income student, and this was a resource that could help me navigate through college. I was all in, and this was the first place of support I found on campus. I often found myself in the office to talk when I was confused or had questions about navigating college. I remember going to the Student Support Services classes and learning all the things that could benefit me in college, such as career services, goal setting, GRIT, budgeting, and even taking personality tests that I still use the results of to this day. I appreciate all these lessons and how this was my introduction to college.

The following year things got even better. I was a walk-on for track and field in search of a scholarship, but it ended up that TRIO gave me my first scholarship, an opportunity to apply for an additional scholarship, and I even got to experience my first student leadership conference. I am still in contact with someone I networked with at this conference.

TRIO even gave me a few job opportunities as a program assistant for the Upward Bound summer program and then as their graduate assistant. My experience in TRIO greatly influenced my undergraduate experience, but everything that put TRIO in perspective was the opportunity to be a graduate assistant for Upward Bound. This position allows me to work with students from a background like mine. Working with Upward Bound students, I learned that I am still inexperienced and that TRIO introduced me to many new things. Showing high school students the opportunities in the world and explaining to them those experiences I never had will show them why they should look into their future.

Upward Bound was what I needed at their age, and this position has shown me what TRIO is genuinely about. TRIO put everything into perspective for me as it was the first support I received in college, and it has been with me on the whole journey of my college experience. This will be my last semester as a graduate assistant with the Upward Bound program but not my last semester in school. I recently learned that I received my final scholarship for the fall semester, the Rising MKN

Achiever Award, from the tri-state TRIO chapter. Since my program is online, I am applying for a position in Topeka, Kansas, to be closer to my son while I continue taking classes and completing my internship. This scholarship will help me pay for this next year to get closer to my goal of being a school counselor.

I look forward to working with students at an urban high school where I can assist those economically disadvantaged and will be the first in their families to receive a postsecondary education. It is so essential that all students have an equal opportunity for an education, no matter their skin color or financial means. Additionally, I would like to obtain my licensed professional counselor certification to have a private practice explicitly working with African American young adult males. This would be a safe space to assist them in feeling empowered and learning the skills necessary for positive mental health.

I have had quite the experience in this journey of figuring out what I want to do and growing into whom I want to be in college, but it has been an excellent path thinking back to all of the growth I have experienced from it. It has been a struggle for me to get where I am today, but with the support of my family and TRIO, I can give back and be the support I needed in high school; that is my purpose.

An African Proverb says, "It takes a village," and I want to be a part of that village that will help those students who need it the most.

[This statement was submitted by Kaleb Barber, Graduate Student, Emporia State University, TRIO Alum, Council for Opportunity in Education.]

PREPARED STATEMENT OF KATHERINE BENNETT, MD FACP

As the Director of Education of the Northwest Geriatrics Workforce Enhancement Center (NW GWEC) at the University of Washington (UW), past president of the National Association for Geriatric Education (NAGE), and a current Geriatrics Academic Career Award recipient, I am pleased to submit this statement for the record on behalf of myself, the NW GWEC, and NAGE recommending appropriations of at least $82 million in Fiscal Year 2024 to support geriatrics workforce training under the Geriatrics Workforce Enhancement Program (GWEP) and the Geriatrics Academic Career Award (GACA) program. Administered by the Health Resources and Services Administration (HRSA), both programs reach rural and underserved populations and address health inequities. We sincerely thank you for your past support of these programs. An appropriation at this level will build upon these programs that are vital to our Nation's older adults.

Think of an older adult in your life, such as your mother, your uncle, your neighbor. Would you prefer they receive care that manages just one health condition at a time such has high blood pressure and high cholesterol; or care that also focuses more comprehensively on helping them age in place, prevent falls, maintain brain health, and do what matters most to them? The latter is what we all want for ourselves as we age, and the Geriatric Workforce Enhancement Program aims to make sure that every older adult receives this type of care from a well-trained workforce. The GWEP and the GACA programs are the only federally funded programs designed to increase the number of health professionals with the skills and training to provide high quality, patient-centered, equitable, cost-saving care for older adults.

While the number of older adults in our country rapidly rises, the number of physicians who specialize in the care of older adults remains small, fewer than 7,000 geriatricians in the entire U.S. Most primary care team members (e.g., physicians, social workers, nurses, therapists, mental health providers) receive inadequate, if any, training in the care of older adults. Because the body changes as we age and because complexity and certain health conditions such as dementia are more common in older adults, this lack of training leads to poor health outcomes and avoidable health care costs such as hospitalizations and nursing home placement. The care of older adults requires special training. You, your friends, your family, and your constituents deserve to find high quality care anywhere you go, but this is not the current reality. The GWEP and the GACA programs are changing this through education and care transformation initiatives conducted in partnership with primary care practices and community agencies (e.g., Area Agencies on Aging), and by training future leaders in geriatrics.

There are currently 48 GWEPs, located in 35 States and 2 territories. The program's current funding makes it impossible to have at least one GWEP in every State or for current GWEPs to have enough funds to do an expanding body of work. This increased funding is urgently needed so that these programs can reach all areas of the country and effectively respond to the rapid growth in number and increasing health complexity of older adults.

The 48 current GWEPs have tremendous impact on their regions. During 2021–2022, GWEPs trained 69,518 health professions trainees/students/fellows, and 187,955 faculty and health professionals. GWEPs partner with health systems (including federally qualified health centers and Veteran's Affairs Medical Centers) and community-based organizations to have the greatest impact and optimize the community/health care linkages that are essential to older adults and their caregivers. GWEPs partnered with 262 health delivery sites to provide clinical training, with over 52 percent of these sites located in medically underserved communities. Every GWEP is focused on meeting the needs of rural and/or underserved populations, and GWEPs play an integral role in reducing health inequities.

The Northwest Geriatrics Workforce Enhancement Center (NW GWEC), University of Washington's GWEP, was established in 2015 and provides training and programs that enhance the lives of older adults and their caregivers in Washington and throughout the region. Our programs include Project ECHO-Geriatrics, a Primary Care Liaison Program based at the Area Agencies on Aging (AAA), a AAA Practicum for health professions trainees, and the Geriatrics Healthcare Lecture Series. Here are some examples of our successful reach.

—*Project ECHO-Geriatrics:* NW GWEC's Project ECHO—Geriatrics, or the Extension for Community Healthcare Outcomes, based on the evidence-based ECHO model, trains and mentors current and future primary care providers to provide specialty care to their own patients and reduce health disparities. Sessions involve virtual mentoring including teaching and consultations with an interprofessional geriatrics specialist panel. Since 2016, we have held more than 80 monthly sessions with 2000+ unique participants. Eighty brief lectures on geriatrics topics are also available online, free for any health professional and are used in the curriculum of primary care training programs. Sessions focus on key topics in the primary care of older adults such as dementia, depression, and fall prevention. Dr. Linares, faculty leader at a family medicine residency in Vancouver WA says that "it is a great resource, the multidisciplinary approach is invaluable, and we have used the feedback to improve the care of our patients."

—*Primary Care Liaison program:* Our GWEP partnered with several Area Agencies on Aging in WA to create a Primary Care Liaison program to connect primary care clinics to AAAs through outreach, engagement, and education as well as facilitating referrals. This program has increased primary care referrals to participating AAAs by over 5-fold. As you know, AAAs are the frontline contact with older adults in our communities and a foundation of the aging services network in the U.S.

The GACA program aims to train the next generation of leaders in geriatrics. There are currently 26 GACA awardees across 16 States representing a range of health professions disciplines (e.g., physicians, social workers, physical therapists). GACA awards support career development of future educators, leaders, and innovators in geriatrics and awardees also train interprofessional teams. For example, as a current GACA awardee, I partnered with my local Area Agency on Aging (AAA) to create a Project ECHO specifically to train AAA case managers in age-friendly care. I have also enrolled and trained more than 70 health professions students across 12 health professions (e.g., nursing, medicine, physical therapy, public health) in an Age-Friendly Healthcare Interprofessional Training Program. Their measured geriatrics and interprofessional team skills improved significantly with the program. GACA awardees throughout the country are reshaping the care of older adults through innovative projects such as reducing unsafe opioid prescribing in nursing homes, addressing food insecurity in older adults, and training certified nursing assistants in nursing homes.

Although GWEPs are preparing the healthcare workforce to meet the needs of older adults and their caregivers, not all States are benefiting: Only 35 States and two territories have a GWEP, and only 16 States have a GACA recipient. An increase in appropriations is essential to ensure that every State has at least one GWEP and that GWEP sites can meet the needs of older adults and the healthcare workforce. Additionally, increased appropriations can ensure that there are more GACA awardees to meet the Nation's current and future needs for transformative leaders in geriatric medicine. Believe me, you want a GWEP and a GACA in your state!

In summary, GWEPs and GACAs are essential to ensure that the healthcare workforce in this country can meet the needs of all of us as we age. Through our GWEPs, we have developed the knowledge and expertise to train interprofessional health care teams. Through our many partnerships and training activities, we have proved integral to the training and care delivery of the healthcare workforce. I thank you for your consideration of this request for appropriations and am grateful

for your past support of these programs that are revolutionizing healthcare of older adults and their caregivers and will ensure that all of us receive the care we want and deserve as we age.

PREPARED STATEMENT OF THE BIG CITIES HEALTH COALITION

On behalf of the Big Cities Health Coalition (BCHC), we respectfully request that the subcommittee provide the highest possible funding for the U.S. Centers for Disease Control and Prevention (CDC), central to protecting the public's health, for Fiscal Year 2024. Our key CDC programmatic priorities include those most critical to our members: immunization, epidemiology and laboratory capacity, public health data modernization, workforce, public health infrastructure and capacity, disease modeling and analytics, opioid overdose prevention, violence prevention, public health preparedness, and the social determinants of health.

BCHC is comprised of health officials leading 35 of the Nation's largest metropolitan health departments, who together serve more than 61 million, or about one in five, Americans. We thank you for your continued leadership and support for our Nation's public health workforce and systems. As the subcommittee members recognize, sustained annual funding is necessary to build public health capacity for the next pandemic, as well as the everyday work that helps keep communities as healthy and safe as possible.

CDC-Wide Activities—Local Health Departments: BCHC respectfully requests the continued inclusion of report language directing CDC to work with States to ensure Federal resources go to local communities and to track how funds are passed on to local health departments (LHDs).

National Immunization Program: We respectfully request $1.1 billion in FY2024 for the National Immunization Program. The CDC Immunization Program funds vaccine purchase and immunization program operations. Increased and sustained investment is needed to modernize immunization information systems (IIS), establish State-to-state IIS data sharing, increase and sustain a network of adult immunization providers reporting data into IIS, and engage with communities to build confidence and minimize disparities among people of color and those at heightened risk for acute outcomes from vaccine-preventable diseases.

Adult Vaccine Program: BCHC also supports the creation of a Vaccines for Adults program that is essential to further build and sustain a long-term network of adult immunization providers, reduce vaccination coverage disparities, improve outbreak control, and enhance and maintain vaccine infrastructure.

Epidemiology and Lab Capacity: We respectfully request $720 million in FY2024 for the Epidemiology and Lab Capacity (ELC) program. ELC provides critical support to and for epidemiologists and laboratory scientists who are instrumental in addressing various food, water, and vector-borne outbreaks, as well as funding improvements in health informatics. Despite ELC's vital role in responding to the pandemic, annual funding levels are not adequate to maintain public health preparedness or address routine challenges, particularly at the city or county level. An increase to ELC would enable increased support to LHDs to provide for their jurisdiction-specific needs, which should be sent directly to large, urban jurisdictions. Further, ELC dollars sent to the States should be better tracked through CDC reporting structures and shared publicly to increase transparency and accoutability.

Public Health Data Modernization Initiative (DMI): We respectfully request $340 million in FY2024 for the DMI that is working to create modern, interoperable, and real-time public health data and surveillance systems at the State, local, Tribal, and territorial levels. These efforts will ensure health officials across the country are prepared to address routine and emerging threats to their communities. COVID–19 exposed the gaps in our data systems, which Congress began to address by funding DMI through the CARES Act and American Rescue Plan Act. These dollars have been critical, and we are so appreciative of the support. The system, however, still requires long-term, sustained investment, not just to build capacity at the Federal and State level, but also in local jurisdictions, particularly our Nation's largest metro areas. Access to timely, accurate data at all levels is perhaps our most enduring public health challenge and additional investment is needed to continue to move this work forward.

Public Health Workforce: We respectfully request $106 million in FY2024 for CDC's public health workforce and career development programs. These funds support CDC's fellowship and training programs including the Public Health Associate Program and Epidemic Intelligence Service that extend the capacity of local and State health departments. Investments must be made to build and develop the pub-

lic health workforce, as well as attract and retain diverse candidates with varied skill sets. These pipeline programs are critical to expanding the workforce.

Public Health Infrastructure and Capacity: We respectfully request $1 billion in FY2024 to support an investment in public health infrastructure and capacity. Because public health is largely funded by condition, there has been little investment in cross-cutting capabilities that are critical for effective prevention and response infrastructure, such as policy development, communications, community engagement, and other organizational competencies. BCHC is grateful for the inclusion of funding in the FY2023 Omnibus, and we urge an ongoing investment to strenthen the public health system to avoid a funding cliff when the American Rescue Plan supplemental funding ends.

Center for Forecasting Epidemics and Outbreak Analytics: We respectfully request $100 million in FY2024 for the Forecasting Center to facilitate the use of data, modeling, and analytics to improve pandemic preparedness and response. With additional resources, CFA will also be able to enhance local and State capacity, enabling stakeholders at multiple levels to make more and better-informed decisions.

Opioid Overdose Prevention and Surveillance: We respectfully request $713 million in FY2024 for Opioid Overdose Prevention and Surveillance. Overdoses (ODs) are increasing across the Nation, erasing progress made inrecent years. CDC's funding to health departments through the Overdose Data to Action (OD2A) program is a critical resource for prevention of opioid and polysubstance use, as well as unintentional OD. Prevention efforts include harm reduction and linkage to care initiatives with a focus on highly impacted communities and reducing stigma. Increases in funding will allow CDC to fund more local communities, in addition to States, to address ODs in communities most at risk. Preventing ODs is a particularly local response that demands Federal resources, and we are so appreciative of those that have already been appropriated. LHDs also need to be able to use Federal funds to purchase Naloxone to prevent additional OD deaths. SAMHSA-funded purchasing is insufficient in supporting LHD distribution to stem the tide of overdoses. While CDC recently made a "one-time allowance" to support some purchase of naloxone, explicit Congressional authority for them to do so moving forward, would undoubtedly save many more lives.

Gun Violence Prevention Research: We respectfully request $35 million in FY2024 for Gun Violence Prevention Research. Firearm violence impacts the health and safety of all Americans and continues to be an acute issue in our Nation's largest cities. Significant gaps remain in our knowledge about how best to prevent gun violence.

Community and Youth Violence Prevention's Community Violence Intervention Initiative: We respectfully request $250 million in FY2024 for a Community Violence Intervention initiative to implement evidence-based community violence interventions locally. BCHC whole-heartedly supports an increased investment to scale up this initiative from $3 million and believes it is critically important to have CDC engaged in this effort in concert with the Department of Justice. Such an increase would allow the CDC to support actionable, proven community-driven public health strategies that can prevent and reduce violence in communities facing the highest burden of violence. Importantly, community violence is preventable, not inevitable, when we invest in a robust public health approach. A public health approach is highly collaborative and driven by local needs, bringing together community members most impacted by violence with different sectors-including health care, public health, schools, parks, housing, law enforcement, local businesses, faith-based institutions, and others-to collectively implement locally-informed strategies.

Public Health Emergency Preparedness Cooperative Agreements: We respectfully request $1 billion in FY2024 for the public health emergency preparedness (PHEP) grant program. PHEP provides funding to strengthen public health departments' capacity and capability to effectively respond to public health emergencies. PHEP funding awards have been cut by nearly 30% in the last two decades.

Our public health preparedness systems are stretched to the brink and will need increased, predictable base funding for years to rebuild and improve. Finally, we encourage the committee to include directive language to ensure these dollars reach the local level and to oppose combining CDC's three preparedness lines into one.

Social Determinants of Health: We respectfully request $100 million in FY2024 for the Social Determinants of Health (SDOH) program. Communities lack funding and tools to support cross-sector efforts and are limited in doing so by disease-specific Federal funding. Given appropriate funding and technical assistance, more communities could engage in opportunities to address SDOH and preventable inequities in health outcomes.

We thank the committee for the opportunity to share these important requests for CDC's FY2024 appropriations. Please do not hesitate to contact Chrissie Juliano (juliano@bigcitieshealth.org) if we can be of further assistance.

[This statement was submitted by Chrissie Juliano, Executive Director, Big Cities Health Coalition.]

PREPARED STATEMENT OF LEMARIOUS BROWNLEE

Every high school student wishes to attend college and further their education. However, not all students have the same resources and opportunities to accomplish this goal. TRIO programs can help in this situation. I joined the TRIO family when I was in the eighth grade. Since joining, I have gained a great support system behind me. The TRIO program is federally funded and provides academic support to low-income, first-generation, and disabled students. I participated in the TRIO program in high school, which proved to be a tremendous resource.

The program provided academic tutoring, college counseling, and financial support. The TRIO program assisted me in maintaining my academics, and the tutoring sessions assisted me in understanding challenging ideas that I had difficulty grasping in class. Furthermore, the TRIO program's college counseling was essential to me. The program helped me identify colleges that were a suitable fit for me and my academic objectives. They advised me on the application procedure and guided me through the essay section of the process.

Additionally, the TRIO program assisted me financially. The program informed me about scholarships and awards for which I qualified. They also helped me fill out financial assistance papers and gave me helpful advice on applying for student loans. I was also able to learn more about financial literacy with the program. I recall numerous times when the counselors and staff gave me advice that turned out to be valuable. Overall, the TRIO program was critical to my high school achievement and aided me in finding methods to attend college. I might not have been able to attend college if it hadn't been for the program's assistance. TRIO is a valuable resource for students who require academic aid and counseling. It gives scholars the skills to succeed academically and achieve their objectives.

[This statement was submitted by Lemarious Brownlee, Upward Bound Scholar, Coffeeville Upward Bound Program.]

PREPARED STATEMENT OF THE BUILD AMERICA'S SCHOOL INFRASTRUCTURE COALITION

Dear Chairwoman Baldwin and Ranking Member Collins,

On behalf of the undersigned national, State, and local organizations, we urge Congress to continue its investments in the Department of Education to support capacity building and technical assistance for school facilities. The COVID–19 pandemic expanded the understanding of the needs and challenges that school districts have in delivering healthy, safe, educationally suitable, energy efficient, resilient public school buildings and grounds. As a result, programs and funding for public school facilities have been included in key pieces of Federal legislation over the last 2 years, including the American Rescue Plan, the Infrastructure Investment and Jobs Act, the Inflation Reduction Act, and the FY23 appropriations bills. However, there is not a coherent approach to Federal programs that advance the quality and equity of our public school facilities including thousands of small rural school districts.

A June 2020 report from the Government Accountability Office (GAO) on the state of school infrastructure—the agency's first report on the subject since 1996—found that 54 percent of school districts across the country must replace or update major systems in more than half their buildings. The GAO report estimated that 4 in 10 districts need to update or replace Heating, Ventilation, and Air Conditioning (HVAC) systems in at least half of their school buildings, which it projects to affect 36,000 school buildings nationwide. Research shows that poorly functioning ventilation systems are a barrier to teaching and learning, and disproportionately experienced by students of color concentrated in high-poverty, segregated schools. The 2021 State of our Schools: America's PK–12 Public School Facilities report documented annual spending of $110 billion for our Nation's K–12 public school facilities operations, maintenance, and construction. However, based on the age, condition, and modern standards for these important buildings and grounds, the level of spending for K–12 facilities falls short by $85 billion every year, and this gap is greatest in low income, minority, and rural school districts.

Appropriate $50 million for school facilities state capacity building: BASIC requests that Congress appropriate $50 million to establish a program in the U.S. Department of Education that provides formula funding to State Education Agencies for States to assist LEAs with facilities data management, governance and decision making policy, planning, facilities training and technical assistance, and accountability. The state facilities capacity program should be modeled after the State energy program of the U.S Department of Energy. This funding would provide increased capacity to provide technical assistance and training to local school districts on the increasingly complex responsibilities of local districts for public school facilities planning and management.

Establish an Office of School Facilities within ED: Irrespective of an authorized program for direct grants, the U.S. Department of Education should have an Office of School Facilities Infrastructure to be responsible for coordination with other Federal agencies that have programs or responsibilities related to public school facilities, including the Department of Energy, the Environmental Protection Agency, Homeland Security-FEMA, the U.S. Department of Agriculture, and the U.S. Treasury. BASIC requests that Congress and the Administration establish a permanent office within USED with capacity to work with other Federal agencies on school facilities issues; provides input on how other U.S. Department of Education programs impact and are impacted by facilities condition, design, utilization, and location; staff the Green Ribbon Schools Awards program; manages the competitive facilities funding programs for States and charter schools, and for the National clearinghouse on school facilities. A total of $2 million should be set aside to reestablish the National Clearinghouse on School Facilities.

Plus Up Impact Aid School Construction: There has long been bipartisan support for the Impact Aid program but funding for infrastructure funding has been flat leveled for years. A new bipartisan effort should be made to plus-up school construction funding in this program.

For these reasons, BASIC urges Congress to make these investments that will help reduce extreme inequity in facilities, and leverage existing local, State, and Federal funding for school facilities.

Sincerely,

21st Century School Fund
AASA, The School Superintendents Association
Alberto Treves
American Industrial Hygiene Association
American Library Association
Association of School Business Officials International
Baltimore City Public Schools
BlueGreen Alliance
Californians for School Facilities
Carrier Corporation
Center for Green Schools at the U.S. Green Building Council
Children & Nature Network
Collaborative for High Performance Schools
Education Law Center
Education Market Association
Fast Growth School Coalition
Go Green Initiative
Green Building Initiative
Green Schools National Network, Inc.
Green Schoolyards America
Healthy Schools Campaign
Heart of America
Impact Fitness Foundation
International Union of Bricklayers and Allied Craftworkers
International Union of Painters and Allied Trades
Johnson Controls Inc.
National Association of Elementary School Principals
National Association of Energy Service Companies
National Association of Federally Impacted Schools
National Association of Secondary School Principals
National Council on School Facilities
National Education Association
National Rural Education Association
National Rural Education Association Consortium (NREAC)
North American Association for Environmental Education

Public Economics, Inc.
SafeTraces, Inc.
School Energy Coalition
School-Based Health Alliance
SMART California Sheet Metal Workers' Local 104
UndauntedK12

PREPARED STATEMENT OF CANDID

Nonprofits play a critical role in enriching our civil society and strengthening communities across the Nation. They are also an economic engine—nonprofits are the third-largest employer in the U.S., accounting for more than 12.5 million workers and 10% of the private workforce.

They not only provide essential services and programs for communities; they also provide the foundation for economic growth by offering child and senior care, educational supports, career development and adult education, and workforce development. For-profit businesses cannot find the skilled workers they need without a thriving nonprofit sector.

Although it plays a critical role in economic growth, the nonprofit sector is not able to access the timely wage and employment data available to every other industry. The Bureau of Labor Statistics provides nonprofit sector data only every 5 years, meaning that nonprofits are still extrapolating from 2017 data, without any comprehensive research that factors in the COVID–19 pandemic, inflation, technology advances or other factors affecting the current employment landscape.

According to the National Council of Nonprofits, "The labor market is active: more than 11 million jobs were posted in May 2020 and roughly 4.3 million workers quit or changed jobs that month, according to the Bureau of Labor Statistics. That agency does not specify nonprofit jobs, so nonprofits are forced to rely on anecdotal evidence to determine whether job applicants are taking work in the for-profit or governmental sectors, and which subsectors, if any, are close to their pre-pandemic employment levels."

By contrast, for-profit companies have access to quarterly wage and employment data that enables them to track real time employment totals and wage information, and benchmark their outcomes against larger trends, while helping policymakers understand challenges and craft responsive policy.

According to its mission statement in the 2020–2025 strategic plan, the BLS "measures labor market activity in the U.S. economy to support public and private decision making." This mission simply cannot be achieved with a blind spot for the economy's third-largest employer.

In addition to its fundamental unfairness, this system serves our sector and the American people extremely poorly. The nonprofit workforce is burnt out after addressing years of crisis-level need in their communities and are increasingly leaving the sector for more profitable, and less stressful, positions in other industries. This means longer wait times for necessary services, and a slowdown in the economic recovery as potential workers remain out of the labor force while waiting for family care or training.

It is essential that nonprofit leaders and policymakers have the data necessary to address the workforce crisis in the nonprofit sector, and develop sound strategies to support the sector into the future. This will ensure that essential services are available to our communities, and ensure that the economy is able to fully recover from the consequences of the pandemic.

Therefore, we strongly urge the subcommittee to support Senator Reed and Senator Whitehouse's FY24 program requests for $4 million to enable the Bureau of Labor Statistics to include nonprofit organizations as a distinct category of employer in its Quarterly Census of Employment and Wages and related reports.

The purpose of the QCEW is to provide "a quarterly count of employment and wages reported by employers covering more than 95 percent of U.S. jobs, available at the county, MSA, state and national levels by industry." This mission is incomplete without data on the third largest workforce in the country, and we ask you to help ensure that this request is included in the final bill.

The current lack of timely, accurate wage and employment data on the nonprofit sector is untenable and inadequate for a workforce representing the third largest payroll of any industry. Nonprofits and their partners have been requesting this data for years (2021 letter to Secretary Walsh, signed by 260 leaders and researchers), and the current workforce crisis makes this expansion of the QCEW a necessity. We urge you to support this request and ensure its inclusion in the final bill.

Thank you.

[This statement was submitted by Aleda Gagarin, Vice President of Influence, Candid.]

PREPARED STATEMENT OF CAST

Since 1984, CAST (originally the Center for Applied Special Technology) has worked tirelessly to ensure that our Nation is one where learning has no limits for any individual. We pioneered Universal Design for Learning (UDL), a framework for inclusive design of learning and training environments that harnesses technology and instructional practices to remove barriers to learning in digital as well as physical settings. UDL is now incorporated in key Federal education, career training, and workforce laws.[1] UDL provides principles and guidelines to support innovation and success by expanding and strengthening preschool to post-secondary education as well as career training opportunities, including access to Science, Technology, Engineering and Math (STEM) for all individuals across the Nation.

Our aim is to create a level playing field where all learners have equitable opportunities to succeed by expanding access and opportunity to education and employment for all individuals, including those historically marginalized due to race, language, income, or disability. UDL encourages the design of flexible learning environments that anticipate learner variability and provide alternative routes or paths to success. UDL acknowledges that variability across all learners is the norm rather than the exception and is a core lever of change to help make learning inclusive and transformative for everyone.

In support of its important portfolio of projects that include investments at the Federal level, in Fiscal Year (FY) 2024, CAST makes the following recommendations regarding key programs at the U.S. Department of Education: Fund education programs to sufficiently support States in their efforts to train personnel and educate all PreK–12 students. Key programs are:

(A) Elementary and Secondary Education

—Title I: $20.5 billion for students to access a quality education.

—Title II: $2.19 billion to support teacher professional learning and student access to literacy, evidence-based instruction and practices including UDL.

—Results for the Nation (LEARN): $194 million to improve English Language Arts.

Examples of UDL funded in K–12 schools (via ESSA's Title I/II and/or combined Federal and State funding).

California:

—The California Coalition for Inclusive Literacy has been training County Office of Education staff as UDL coaches to support the State's initiative focused on improving literacy outcomes in inclusive settings in K–12 schools.

—The Far North Literacy Consortium implements UDL district-wide in rural areas of the state to support literacy growth for disadvantaged learners, including children living in poverty, English learners, and children with disabilities.

New Hampshire:

—The NH UDL Innovation Network allows 70 schools and more than 500 educators to access training and collaboration across the State. Participants continue to engage in small teams to discuss and implement flexible and meaningful ways to apply UDL in K–12 classrooms and work to make learning inclusive and transformative for all students.

(B) Individuals with Disabilities Education Act (IDEA):

—Part B Section 611: $16.3 billion-to place the IDEA on a glide path to full funding (or 40% of the per pupil expenditure promised to districts when the IDEA was first passed in 1975).

—Part B Section 619 (preschool): $503 million-to increase access to high quality and inclusive preschools.

—Part C—Infants and Toddlers: $932 million-to assure all young children with disabilities are identified and receive services known to improve education, health and independent living outcomes.

—Part D—National Activities: To provide the infrastructure to implement programs for students with disabilities through professional development, technical assistance, and more. Recommendations are:

—State Personnel Development: $53.6 million.

—Technical Assistance and Development: $55.3 million.

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[1] See: Public Law 110–315, Public Law 113–128, Public Law 114–95, Public Law 115–224, National Education Technology Plan 2021, U.S. Department of Education.

—Personnel Preparation: $300 million
—Parent Training and Information Centers: $49.2 million
—Media and Technology: $41.4 million

Examples of UDL funded under IDEA Part D:

—The National Center on Accessible Education Materials (AEM Center) works with individual educators, school districts, and States across the Nation to help them provide educational materials and resources that are accessible to all learners, from early childhood through the workforce. In addition to providing top-quality guidance and resources, the AEMCenter continues to lead the field in adopting innovative ways to disseminate federally-funded support, including through its podcast, The Accessible Learning Experience.
—The Center on Inclusive Software for Learning works with school districts to create and sustain inclusive technology systems for all students. The CITES team created a framework of evidence based practices which it disseminates across the Nation. Importantly, CITES also works to ensure that students who use accessible technology, and their families, understand it and can incorporate it to foster success and lifelong learning.

(C) Career and Technical Education (CTE):

—State Grants and National Programs: $1.473 billion so States can develop career training pathways responsive to the needs of business and of learners that include a diverse population who may experience barriers such as poverty, low literacy, language and/or disability.

Examples of UDL in CTE: CAST's work with States, school districts and private partners increases access to well-designed curriculum and career training incorporating UDL that is especially focused on diverse youth and young adult learners. Recent examples are:

—With funding provided by the Office of Career, Technical and Adult Education (OCTAE), the Reimagining Adult Basic Education (ABE) modules were designed by CAST to help ABE teachers effectively teach and support neurodiverse adults, including those with learning disabilities. Because fewer than 3% of such teachers are trained to educate individuals with disabilities, the modules provide ABE instructors with research-based strategies that can support adult learners, including those with learning and attention issues to successfully complete state-run adult education courses.

Carl D. Perkins Act (Perkins V) funding and/or combined with State or local funding:

—Michigan Statewide CTE initiative provides training in UDL to high school educators so they can provide supportive and inclusive access to CTE courses to every student.
—Massachusetts Statewide CTE and UDL partnership promotes and supports improved access to and inclusion of students with disabilities in CTE courses.

CAST appreciates the subcommittee's consideration and urges a continuing investment in educational innovations that incorporate effective implementation of UDL while prioritizing the need to include UDL as part of the infrastructure of workforce and CTE faculty training makes sense.

As the subcommittee considers funding for career training and employment, CAST makes the following recommendation for the U.S. Department of Labor (DOL): Provide increased investments in research as well as career-exposure and training for eligible youth, young adults and adults who may experience barriers due to educational access/completion, literacy and/or disability. Key programs are:

(A) Office of Disability Employment Policy: $60.5 million to continue to develop, influence and expand employment-related policies and practices so that every youth, young adult, and adult with a disability gains access to career training and STEM career experiences.

(B) YouthBuild:$145 million to support grants that provide work-based pre-apprenticeships, in support of unemployed youth and those who left high school prior to graduation.

(C) Job Corp: $1.6 billion to ensure participants receive training that reflects the labor market's need for in-demand skills that meet industry standards including creating innovative partnerships that further modernize its training and connect industry leaders to a diverse student body.

Examples of UDL funded by DOL:

—CAST continues to develop new implementation pathways for its eportfolio, which leverages the UDL framework to offer responsive and accessible tools that help disadvantaged young adults explore STEM careers, demonstrate STEM learning, reflect on STEM career interests, and take actions to move ahead with STEM career pathways of interest. Initially developed and piloted

in partnership with YouthBuild USA, CAST's eportfolio has now been tested in a variety of CTE settings (high school, community colleges and alternative pathways) and with numerous industry partners.

—The Wisconsin Regional Training Partnership supports the implementation of CAST's UDL e-portfolio in pre-apprenticeship programs in Wisconsin and Minnesota to help prepare and assess preparedness for the Industrial Maintenance Technician apprenticeship pathway. Partners are Jobs for the Future and SPR under the Apprenticeship Inclusion Models grant funded by the Office of Disability Employment within DOL.

CAST urges the subcommittee to further invest in programs that expand the use of the UDL framework. In doing so, Congress would increase the capacity of States, districts, schools and career training programs to provide more robust professional learning and other needed technical assistance so that teachers have the tools and resources they need to teach and provide educational support to all learners. It is imperative that all youth and young adults, including first-time career seekers or those desiring new opportunities, have access to workforce development and career pathway strategies and programs that are designed from the beginning with their learning variability in mind.

CAST appreciates the opportunity to provide testimony to the subcommittee for the FY 2024 appropriations bill. We look forward to working with you as you develop a final appropriations bill that recognizes UDL as an integral component to PreK–16 education, and to increasing and sustaining a well-trained and vital workforce.

[This statement was submitted by Lindsay Jones, CAST.]

PREPARED STATEMENT OF CATALYST OF SAN DIEGO & IMPERIAL COUNTIES

Catalyst of San Diego & Imperial Counties represents a community of more than 100 funders working across sectors, aisles, and industries to increase equity-driven solutions to our region's most pressing problems. One of our greatest concerns moving into 2024 is succeeding in a full and equitable recovery from the global pandemic. We strongly urge the subcommittee to support Senator Reed and Senator Whitehouse's FY24 program requests for $4 million to enable the Bureau of Labor Statistics to include nonprofit organizations as a distinct category of employer in its Quarterly Census of Employment and Wages and related reports.

Nonprofits are essential partners to government, serving on the frontlines of COVID–19 relief and economic recovery efforts. From healthcare to housing, houses of worship to human services, education to environmental protection, governments and communities rely on nonprofit organizations to generate innovative solutions and provide critical services throughout the country. Nonprofits not only provide essential services and programs for San Diego residents; they also provide the foundation for economic growth by offering child and senior care, educational supports, career development and adult education, and workforce development. For-profit businesses cannot find the skilled workers they need without a thriving nonprofit sector.

Employing 10 percent of San Diego County workers and comprising the third largest workforce of any U.S. industry, the nonprofit sector is also a major job creator and component of local economies, outdistancing all branches of manufacturing, construction, finance, and insurance. This fact is largely unknown, due in no small part to a lack of timely information from the Department of Labor. The global economic and public health crisis caused by COVID–19 underscored and amplified the need for regular nonprofit employment information. Like other sectors, nonprofit finances were devastated, and at one point, nonprofits were estimated to have lost over 1.6 million jobs. These losses are occurring at a time of skyrocketing need and depleted resources in our communities. The lack of timely and accurate data threatens the health and wellbeing of millions of people who rely on nonprofits for services. The absence of employment information means policymakers must guess or exclude nonprofits entirely when considering the potential impact of legislative and regulatory proposals.

Last year, the Bureau of Labor Statistics (BLS) told philanthropic and nonprofit leaders that they understand and agree with the importance of the data and are willing to produce it if they have the appropriate resources. They estimate that the cost to include it is in the range of $4 million. Unfortunately, that funding did not make it into the BLS FY24 budget. This year, Senators Reed and Whitehouse submitted a request for that $4 million.

Before the pandemic, the California Association of Nonprofits released "Causes Count: The Economic Power of California's Nonprofits," detailing the immense impact of nonprofits on the state economy and to a thriving California. At that time,

nonprofit economic activity made up approximately 15 percent of California's GDP and counted for 1 in every 14 jobs in the state-and despite being exempt from corporate income tax, nonprofits paid more than $37 billion in taxes at a Federal, State, and local level.

Post-pandemic, the nonprofit workforce is burnt out after addressing years of crisis-level need in their communities and is increasingly leaving the sector for more profitable, less stressful positions in other industries. This means longer wait times for necessary services and a slowdown in the economic recovery as potential workers remain out of the labor force while waiting for family care or training.

It is essential that nonprofit leaders and policymakers have the data necessary to address the current workforce crisis in the nonprofit sector and develop sound strategies to support the sector into the future. This will ensure that essential services are available to our communities and that the economy is able to fully recover from the consequences of the pandemic.

Therefore, Catalyst strongly urges the subcommittee to support Senator Reed and Senator Whitehouse's FY24 program requests for $4 million to enable the Bureau of Labor Statistics to include nonprofit organizations as a distinct category of employer in its Quarterly Census of Employment and Wages and related reports.

Thank you.

[This statement was submitted by Megan Thomas, President & CEO, Catalyst of San Diego & Imperial Counties.]

PREPARED STATEMENT OF THE CHRISTOPHER & DANA REEVE FOUNDATION

Thank you for this opportunity to submit testimony in support of an appropriation of $10,700,000 for the Paralysis Resource Center (PRC) within the Administration for Community Living (ACL) at the Department of Health and Human Services (HHS).

I am proud to speak on behalf of the 1 in 50 individuals living with paralysis in the United States, who rely on programs like the Paralysis Resource Center to live independent and empowered lives. The Christopher & Dana Reeve Foundation has operated the Paralysis Resource Center for more than 20 years, competing in a rigorous, competitive application process every 5 years for renewal of this grant. For Fiscal Year 2024, we request funding of $10,700,000 for the Paralysis Resource Center. Of this total, we request resources be directed to the National Paralysis Resource Center in amounts at least equal to the amount made available in Fiscal Year 2023. These requests are level with the final appropriation for FY23 and mirror the Administration's FY2024 Budget Request.

When Christopher Reeve was paralyzed from the neck down due to a spinal cord injury in 1995, his family found themselves in total darkness as to what to do next. There was no phone number to call for guidance or help. There were no experts reaching out to connect them to the right rehabilitation facilities, or to discuss how they could support his return home and ongoing well-being. There was certainly no promise that an individual living with that level of spinal cord injury could lead a full and active life as a father and husband. Yet, instead of accepting that life with paralysis would be full of limitations, he dreamed of a brighter future.

That was the genesis of the Christopher & Dana Reeve Foundation: Christopher's dream to elevate the needs and rights of the 5.4 million Americans living with paralysis. But he was far from alone. The real drive behind the Paralysis Resource Center came from his wife, Dana. As a caregiver herself, she knew that paralyzed individuals and caregivers around the country needed a centralized place to call for resources and expertise.

In 1988, I sustained a C6–C7 spinal cord injury when I was shot through the neck at an end-of-school-year slumber party. I was airlifted from my small hometown of Brownfield, Texas, to a larger hospital in Lubbock, but the severity of the injury was too much for a 10-year-old to absorb. I thought I was going to recover and go to a basketball tournament in a couple of weeks. When a doctor overheard me asking a nurse why I could only move my head from side to side, he casually told me I was paralyzed and would no longer "be able to do anything." That turned my life upside down.

Despite the grim prognosis, I regained movement in my arms and returned home, where my mother became my caregiver. My mother didn't know where or how to look for resources or services. We were truly a family on a rural island trying to figure out how to get things for this little girl to help her live her best life. I want to continue to ensure that no family finds themselves in this position. I believe that there is no organization that has the type of experience and skill to do what the

Paralysis Resource Center does for the millions who seek out our information and support.

For over 20 years, the PRC has served as a free, comprehensive, national source of support for people living with paralysis and their caregivers. The PRC is the only program of its kind that directly serves individuals living with spinal cord injury, MS, ALS, stroke, spina bifida, cerebral palsy and other forms of paralysis. The services and programs described below would not be possible without the ongoing support of this subcommittee.

A. The PRC's Core Programs

Information Specialists. One of the PRC's most essential functions is the team of certified, trained Information Specialists (IS) who provide personalized support to individuals, families, and caregivers on how to navigate the challenges of life with paralysis. This team of experts, many living with paralysis themselves, are often the first port of call for individuals who are newly injured or diagnosed.

Since its inception, the PRC's Information Specialists have provided direct, one-on-one counseling to more than 120,000 people and have helped hundreds of thousands more through the PRC's Paralysis Resource Guide, which is downloadable online and a staple in hospitals and rehabilitation facilities across the country. Because the PRC's Information Specialists work at a national level, they can connect individuals, families and caregivers to resources and caregivers across state lines.

The PRC has been a resource for survivors of gun violence who have suffered non-fatal injuries and are now paralyzed. Studies have shown that gunshot wounds are the third highest cause of spinal cord injury.[1] Many survivors of gun violence, like myself can suffer from significant-long term disabilities. We assist survivors or their family members who are impacted by these events.

Peer & Family Support Program. The Peer & Family Support Program is a national network that creates connections for people living with paralysis, their families, and caregivers. To date, certified peer mentors have provided support to approximately 22,000 people receiving mentoring through in-person meetings, telephone, e-mail, and videoconferencing. The program currently has more than 530 mentors in over 40 States Since its inception, the Peer Program has also mentored more than 1,500 caregivers, providing an important peer support network for individuals who are often underserved.

Quality of Life Grants Program. Our third pillar, the Quality of Life Grants Program, operates at the community level to fund nonprofit initiatives in all 50 States, the District of Columbia and the U.S. territories. Since 1999, the Quality-of-Life Grants Program has directed over $41 million to assist over 3,700 projects. This program has increased employment trainings and accessible transportation; established adaptive sports programs and camps for children; improved access to buildings, playgrounds, and universities; helped individuals learn how to manage their financial well-being and provided support services for veterans. In 2022, the PRC created two new Quality of Life (QOL) Grants Programs, Racial Equity and Rural Unserved & Underserved Populations. The Racial Equity program aims to fund projects that explicitly enhance the quality of life of those individuals living at the crossroads of racial inequity and paralysis, and the Rural Unserved & Underserved grants will fund projects focused on promoting accessibility and participation in rural communities, and will improve access to health care, healthy food options, access to broadband and other technologies, and transportation that may not be available to the community.

Military & Veterans Program; Multicultural Outreach Program. The PRC has a comprehensive Military and Veterans Program, which provides dedicated resources to help individuals navigate military and civilian benefits and programs as they reintegrate into their communities. The PRC also facilitates an Outreach Program that is designed to engage and support underserved populations like racial and ethnic minorities, older adults, low-income earners, and LGBTQ individuals. In 2022 we featured numerous spotlight blogs, webinars and original content that highlighted racial equity awareness in the community.

B. The Importance of Federal Funding.

I would like to close my remarks by emphasizing why Federal funding for this program is so important. Federal funding for the PRC is a good investment. Our resources help people adapt their homes and gain the tools they need to return to their communities, and eventually to work. The programs funded by the PRC make people less dependent on healthcare providers, so they can reduce their medical

[1] Chen, Y., Tang, Y., Vogel, L. C., & Devivo, M. J. (2013). Causes of spinal cord injury. Topics in spinal cord injury rehabilitation.

costs-saving dollars for Medicaid and Medicare. Our national model and household name allows us to leverage a small team to have maximum impact. The PRC is smart Federal funding at work.

I think that without knowing what is out there, people can get stuck, and it will dim their light. Sometimes having the right person walk in your space at the right time can make a difference. I know that's what the PRC does, and I am grateful to expand and improve our services. I thank you for your ongoing support and urge you to protect and expand the Paralysis Resource Center so that individuals nationwide can achieve greater quality of life, health, and independence. Thank you.

[This statement was submitted by Regina D. Blye, Chief Program and Policy Officer, Christopher & Dana Reeve Foundation.]

PREPARED STATEMENT OF THE CHRONIC CARE POLICY ALLIANCE

Dear Chair Baldwin and Ranking Member Capito:

On behalf of patients with chronic conditions, the Chronic Care Policy Alliance urges the Appropriations Committee to utilize your upcoming hearing on the 2024 Health and Human Services Budget as an opportunity to ensure accountability and oversight as that department implements the health policies included in the 2022 Inflation Reduction Act (IRA). Additionally, we recommend that legislators prevent further changes to the new Medicare Drug Price Negotiation Program, including those proposed by the Biden Administration in the budget for fiscal year 2024, until the IRA has been fully implemented and the impact of these policy changes are known and understood.

The health policies in the IRA took great strides to lower patient costs and included many beneficial policies that will provide immediate relief to patients including out-of-pocket caps, capping the costs of insulin, and eliminating cost sharing for vaccines. However, the long-term impact of other provisions of the law, including the Medicare Drug Price Negotiation Program, remains unknown and could impede the development of new treatments and limit patients' ability to access new therapies in years to come.

We were joined by 36 organizations in sending the below letter to Congress and the Centers for Medicare and Medicaid Services (CMS) further explaining these concerns and urging that CMS ensure patient advocates have ample opportunity to weigh-in throughout and after IRA implementation to limit any negative impact on patients.

Further, given the uncertainty around the Medicare Drug Price Negotiation Program and other provisions of the IRA, we would urge that Congress reject any proposals to accelerate the scope of the negotiation program. The Biden Administration's proposed budget included proposal to substantially increase the number of drugs on which CMS can negotiate starting in 2026, and making drugs subject to negotiation much sooner. According to press reports, this proposal could double the number of drugs negotiated each year and make drugs subject to negotiation after only 5 years after FDA approval instead of the current 9–13 year timeframe.

This expansion of an untested policy could lead to disastrous results for patients by significantly limiting access to current and future therapies. The impact could also significantly hinder research for patients with complex or rare diseases that require intricate treatment regimes.

We appreciate the Appropriations Committee's ongoing work and oversight to ensure that patients are protected as these new policies are implemented and look forward to staying in close touch throughout the implementation process.

Sincerely.

[This statement was submitted by Liz Helms, Founder/Director, Chronic Care Policy Alliance.]

In a letter to Congress and the Centers for Medicare & Medicaid Services (CMS), the Chronic Care Policy Alliance (CCPA) was joined by 36 organizations urging Congress and the Administration to ensure that patient advocates have a seat at the table throughout the implementation of the Inflation Reduction Act's health policies. CCPA and its partners want to protect patient interests and avoid any unintended consequences by asking for patient input in the planning phase before implementation. Read the full letter:

Dear Congress:

As patient representatives, we advocate on behalf of patient interests and interpret how certain policies will positively or negatively affect them. Patients know firsthand the benefits of a strong health care system that provides access to new

and groundbreaking treatments. In recent years, we have seen great strides in the treatment of ALS, cancer and Alzheimer's disease that have increased lifespan, slowed the ravage of disease and improved the quality of lives.

Last year, Congress passed significant policies within the Inflation Reduction Act (IRA) focused specifically on patient costs. We were especially pleased by the improvements to Medicare Part D that included adding an out-of-pocket cap, establishing a $35 limit on monthly insulin costs, and eliminating cost sharing for vaccines. These policies will provide immediate relief to patients. Thank you.

However, other policies around prescription drug prices faced significant debate during the legislative process. Policymakers must keep in mind the unknown long-term impacts on the development of new treatments—especially those for complex and rare diseases—and patients' ability to access those new therapies.

Now it is time for the real work as the Administration begins the lengthy process of implementing IRA's policies. We urge Congress to continue oversight throughout the implementation process and insist that patient voices are heard.

The Medicare Drug Price Negotiation Program contained in the law seeks to establish negotiated rates, or the Maximum Fair Price (MFP), for medications. While focused on reducing drug costs, the unintended negative consequences for drug coverage, formulary priority, access and further research and development could harm patients. For example, as new prices are determined, payors may favor products on their formularies that have a negotiated price. This could ultimately make other medications more difficult to access as payors encourage use of these negotiated price medications and discourage others. Payors already utilize cost saving measures that negatively impact patients such as restrictive formularies, step therapy and strict prior authorizations. Patients need access to the correct treatments, or they will suffer. The addition of products with artificially lowered prices is likely to create yet another restrictive process for patients.

We urge Congress to ensure that regulators at CMS create specific opportunities for patient advocates to participate in the regulatory process.

Our specific recommendations include:

—Host regional roundtables to solicit feedback from patients. We strongly recommend that CMS create a structure similar to that used to implement the Affordable Care Act (ACA) and utilize the CMS regional staff to hold patient-centered roundtable discussions throughout the country to ensure that patients have the opportunity to share their experiences and insights directly with CMS, regardless of their physical location. Providing regional opportunities is particularly important in the patient community where resources may make participation at the Federal level more of a challenge than in their State and local communities.

—Release draft guidance, solicit written comments. We are pleased that CMS has announced that it will issue draft guidance that seeks public input on key provisions of the MFP program. We hope that the draft guidance includes and seeks feedback on the process, including the methodology CMS uses to determine the MFP. Soliciting written comments from the public is critical.

—Develop patient-centered criteria. CMS should also develop, with significant input from patients, patient-centered criteria that must be adhered to as CMS implements the drug pricing provisions. This will ensure patient perspectives are heard and patient needs are prioritized. The ACA required that the Center for Medicare and Medicaid Innovation develop similar criteria.

—Meaningfully engage patients in determining the MFP for each drug. Patient advocates can offer both substantial and critical perspectives as CMS considers what a price should be for a specific drug. CMS should create a process through which it will consistently and meaningfully engage with patients determining each drug's price, and ensure they have a say in the outcome.

—Study the impact of the drug pricing provisions on patients. CMS should study the impact that negotiation has on patients prior to negotiation, focusing on issues related to access to current and future therapies. For example, CMS should study the impact of the drug pricing provisions on Medicare Part D coverage, including formulary placement and utilization management.

Should you have any questions or comments, please contact Liz Helms, Founding Director, CCPA at lizh@chroniccarealliance.org. Thank you for your time and attention to these critical issues.

Sincerely,

Chronic Care Policy Alliance (CCPA)

Alliance for Aging Research; ALLvanza; American Behcet's Disease Association (ABDA); American Cancer Society Cancer Action Network—Nevada; Applied Pharmacy Solutions; Autoimmune Association; Axis Advocacy; Black, Gifted & Whole

Foundation; Cancer Support Community; Chronic Disease Coalition; Coalition of Wisconsin Aging and Health Groups; Colorado Gerontological Society; GO2 for Lung Cancer; Healthy Men Inc.; Hereditary Neuropathy Foundation; HIV + Hepatitis Policy Institute; ICAN, International Cancer Advocacy Network; International Foundation for AiArthritis; Lazarex Cancer Foundation; Let's Talk About Change; Looms For Lupus; Men's Health Network; MLD Foundation; National Association of Nutrition and Aging Services Programs (NANASP); National Hispanic Medical Association; National Patient Advocate Foundation; National Puerto Rican Chamber of Commerce; Neuropathy Action Foundation (NAF); Nevada Chronic Care Collaborative; Partnership for Innovation and Empowerment; Partnership to Fight Chronic Disease; Patients Rising Now; RetireSafe; Southern Christian Leadership Global Policy Initiative (SCL–GPI); Support For People With Oral And Head And Neck Cancer, Inc. (SPOHNC); The National Puerto Rican Chamber of Commerce.

PREPARED STATEMENT OF THE CHRONIC DISEASE ALLIANCE

SUMMARY OF FISCAL YEAR 2024 APPROPRIATIONS RECOMMENDATIONS

—Provide the National Institutes of Health (NIH) with at least $50.9 Billion, a $3.5 billion increase over FY 2023.
  —Please provide proportional increases for individual NIH Institutes and Centers.
  —Please continue to provide additional, distinct funding for the Advanced Research Projects Agency for Health (ARPA–H) at NIH, which would facilitate implementation of this important program without supplanting ongoing NIH research activities.
—Provide the Centers for Disease Control and Prevention (CDC) with at least $11.6 billion, a $2.4 billion increase over FY 2023.
  —Please provide CDC's National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) with systematic and meaningful annual increases, including a much-needed investment of additional resources or FY 2024.
  —Please provide $6 million for the Chronic Disease Education and Awareness (CDEA) Program at NCCDPHP, a $1.5 million increase over FY 2024.

On behalf of the dozens of national organizations comprising the Chronic Disease Alliance, thank you for the opportunity to submit testimony in support of Chronic Disease Day and the Federal programs that support chronic disease patients and work to prevent chronic illnesses. Chairwoman Baldwin, Ranking Member Capito, and distinguished members of the subcommittee, we extend our thanks for the significant investments in HHS through the FY 2023 omnibus package, particularly the annual increases for NIH and, most notably, CDC. As you work with your colleagues on appropriations for FY 2024, please continue to invest in programs that serve the chronic disease community, most notably NCCDPHP at CDC. Thank you again for your leadership on health funding issues and for the opportunity to present the views of the chronic disease community.

ABOUT CHRONIC DISEASE DAY

Chronic diseases account for 7 of the top 10 causes of death in America and more than 90 percent of our annual healthcare spending. Hundreds of thousands of Americans who suffer from unpreventable chronic conditions need access to care. But the deadliest and costliest chronic diseases are also the most preventable. We promote actionable resources to lower the rate of preventable chronic diseases so that our healthcare system can better support individuals with unpreventable chronic conditions and invisible illnesses.

ABOUT CHRONIC DISEASE & INVISIBLE ILLNESS

Chronic Disease Day is an opportunity for legislators to pledge to address issues that impact across the entire chronic disease community. These issues include funding needed medical research and public health programs and advancing legislation that supports a patient's ability to access the care they need. While we reflect on recent progress and opportunities for further advancement around July 10th, our community of supporters work year-round to educate policymakers about contemporary issues and to use our stories and collective voice to advocate for issues that impact across the chronic disease community.

NIH and CDC both play key roles in preventing and addressing chronic illness. There is tremendous opportunity for the chronic disease community with increased funding, particularly innovative and impactful public health efforts led by CDC and NCCDPHP, such as the emerging CDEA program. There is also tremendous overlap between chronic conditions and health disparities, and we encourage robust resources for efforts to promote health equity, such as those led by NIH's National Institute on Minority Health and Health Disparities and CDC's Social Determinants of Health Program.

[This statement was submitted by Clorinda Walley, President, Good Days.]

PREPARED STATEMENT OF THE COALITION FOR CLINICAL AND TRANSLATIONAL SCIENCE

FISCAL YEAR 2024 APPROPRIATIONS RECOMMENDATIONS

—CCTS joins the broader medical research community in asking Congress to provide the National Institutes of Health (NIH) with at least a $3.5 billion funding increase for FY23, to bring total agency funding up to a minimum of $50.9 billion annually.
—Please provide the Clinical and Translational Science Awards (CTSA) program at the National Center for Advancing Translational Sciences (NCATS) with at least a $35 million increase in dedicated line-item funding for FY23 to bring annual support for the program up to a minimum of $664.5 million.
—Please provide the Cures Acceleration Network (CAN) at NCATS with at least $90 million in dedicated funding for FY24.
—Please provide the Institutional Development Awards (IDeA) program and the Research Centers in Minority Institutions (RCMI) program at NIH with meaningful proportional funding increases for FY24.
—CCTS joins the broader public health community in requesting $500 million for the Agency for Healthcare Research and Quality (AHRQ) for FY24.
—CCTS joins the broader public health community in requesting $11.6 billion for the Centers for Disease Control and Prevention (CDC) for FY24.

Chairwoman Baldwin, Ranking Member Capito and distinguished members of the subcommittee, thank you for the strong support for the full spectrum of medical research demonstrated through the FY23 omnibus appropriations package, and for the strong language supporting the historic mission and integrity of resource utilization for the Clinical and Translational Science Awards (CTSA) program funding line. The value, importance, and impact of the CTSA program (as well as full-spectrum research at NIH) has been highlighted by our ability to quickly respond to health threats with diagnostic tools, treatments, and health information; and through ongoing work to enhance care delivery in rural and underserved communities and promote health equity. As you work with your colleagues on FY 2024 appropriations, CCTS and the broader stakeholder community encourage you to continue to support the full spectrum of medical research and provide increased funding for key clinical and translational research programs, including CTSAs, and to support ongoing investment in training and career development for physician scientists and other clinical and translational researchers.

ABOUT THE COALITION FOR CLINICAL AND TRANSLATIONAL SCIENCE

The Association for Clinical and Translational Science, Clinical Research Forum, the CTSA PIs, and the related stakeholder community work together through the Coalition for Clinical and Translational Science (CCTS) to speak out with a unified voice on behalf of the clinical and translational research community. CCTS is a nationwide, grassroots network of dedicated individuals who seek to educate Congress and the administration about the value and importance of clinical and translational research, and research training and career development activities. Our goals are to ensure that the full spectrum of medical research is adequately funded, the next generation of researchers is well-prepared, and the regulatory and public policy environment facilitates ongoing expansion and advancement of the field of clinical and translational science.

CTSA Program—Recent Local Efforts an Emerging Opportunities

The accomplishments below represent just a sampling of recent advancements from a few CTSAs. The CTSA program is a national network of institutions with similar progress and advancement in clinical and translational science taking place

across the country. Please consider CCTS a resource moving forward and let us know if you would like any additional information or a more in-depth overview of national or local efforts.

University of Wisconsin, Madison—Preventing Falls in Older Adults-Falls are a leading cause of non-fatal injuries for those 65 and older, corresponding to 800,000 hospitalizations and over 3 million emergency department visits-at a cost of $50 billion dollars-annually. A 7-week, evidence-based intervention called "Stepping On" is delivered by trained leaders and has been proven to decrease the incidence of falls. Since 2008, it has been used in 22 States and with 25,000 participants. In Wisconsin, it has resulted in a 40–50% reduction in falls and a 70% reduction in emergency department visits due to falls.

The impact of the "Stepping On" program has been extended through a subsequent program, "Pisando Fuerte," which is a culturally appropriate adaptation for older Latino adults. This adaptation was piloted and refined through a partnership with United Community Center in Milwaukee, which serves a largely Hispanic population on the city's south side. "Pisando Fuerte" has now been adopted by three community sites, with several others expressing interest in adopting it. The final version of "Pisando Fuerte" will be submitted to the National Council on Aging for inclusion in their list of programs eligible for Title III–D Older Americans Act funding.

Opioid Stewardship: Disseminating a Framework across Wisconsin—In response to the opioid crisis, Wisconsin health systems serving rural communities are developing opioid stewardship programs to facilitate appropriate opioid prescribing, disposal, diversion prevention, management of the effects of opioid use, treatment of opioid use disorder and reducing overdoses. An online toolkit developed for pharmacists who work in health systems serving rural communities was promoted through UW-Madison School of Pharmacy's Facebook and LinkedIn pages. It was presented at the Pharmacy Society of Wisconsin Educational Meeting and is featured on its website along with related podcasts. The toolkit has also been added to the University of Wisconsin School of Medicine and Public Health HIPxChange collection of toolkits.

MOVIN: Helping Older Adults Avoid Loss of Function while Hospitalized—Older patients spend 83–100% of their time in bed during a hospital stay. Limited patient ambulation during hospitalization has been independently associated with loss of functional status that affects up to 60% of older adults admitted. Hospital-acquired disability due to limited ambulation is a critical public health concern that results in negative functional, psychological and financial outcomes for patients and healthcare organizations. MOVIN® (Mobilizing Older adults Via a systems-based Intervention) addresses this problem through an evidence-based hospital mobility program centered on improving patient ambulation by addressing barriers that prevent nursing staff from getting patients up to walk.

Neighborhood Health Partnerships (NHP) program: Using Data at the Neighborhood Level to Improve Health—The goal of NHP https://nhp.wisc.edu/) is to facilitate bi-directional, action-oriented partnerships between communities and researchers. To achieve this, it produces neighborhood (ZIP-code-level) health and social determinants of health (SDOH) reports and action tools for the entire state of Wisconsin and trains community navigators to use the reports and action tools to support mutual priority-setting and, ultimately, community-engaged research projects. Within the last year, NHP delivered 425 health reports and 550 new Social Determinants of Health (SDOH) reports, each at the ZIP code level, to community groups and academic teams working across the State in local neighborhoods. The new SDOH reports were co-designed with 45 stakeholders representing public health, communities, research, and healthcare delivery organizations. Of note, the State health department requested NHP health and SDOH reports for the entire state to use for several Federal chronic disease prevention grant applications, while many local health departments in Wisconsin are using these neighborhood reports to set priorities for their existing programs and seek funding to develop new programs for underserved areas with poor health.

Reducing Vaccine Hesitancy during the Covid-19 Pandemic—Led by the Collaborative Center for Health Equity (CCHE) (https://ictr.wisc.edu/cche/), this project with the Wisconsin Primary Health Care Association (WPHCA, the member association for the Federally Qualified Health Centers in Wisconsin) promotes vaccine confidence among providers, staff and patients. This work with WPHCA laid the foundation for a collaborative effort between the UW Prevention Research Center, Southwestern Wisconsin Community Action Program, and other local partners to provide relevant public health messaging through a new project, "Communities Confronting Covid-19" or C3. Through C3, CCHE developed and disseminated the stories of local "champions" as well as information through radio ads and social media

targeting counties in rural southwestern Wisconsin. The C3 team has found promising findings in the evaluation of its community-based messaging campaign that can shed light on directions for public health communication.

Assessing Covid Mortality Risk and Vaccination Barriers in Wisconsin by County—Potential barriers to COVID–19 vaccination were calculated for each Wisconsin ZIP code using seasonal flu vaccination data from the Wisconsin Department of Public Health. There are many potential barriers to seasonal influenza vaccination, including rates of insurance coverage, access to health care and concerns about vaccine safety and efficacy. While there are important distinctions between COVID–19 and seasonal flu vaccination, flu vaccination rates can help health professionals anticipate the challenges ahead and plan accordingly. For more information, see the Neighborhood Health Partners website (https://nhp.wisc.edu/covid-19/) for the tool and graphics.

University of Washington

Innovative Cancer Vaccine in Phase 2 clinical trials, Nora Disis, UW; https://newsroom.uw.edu/news/breast-cancer-vaccine-safely-generates-anti-tumor-immunity.

Vaccines and monoclonal antibody treatments for opioid addiction and overdose, Marco Pravetoni, UW; https://magazine.washington.edu/uw-medicine-researchers-test-vaccines-for-opioid-addiction/.

Protecting Our Community: A Pragmatic Randomized Trial of Home-Based COVID Testing with American Indian and Latino Communities. A collaboration between NIGMS funded The Centers of Biomedical Research Excellence (COBRE) program at Montana State University, Bozeman, MT, with UW CTSA (ITHS). https://www.iths.org/news/radx-grant-awarded-to-msu-its-partners-for-covid-19-research/.

A pilot study of Alaska Indigenous Health & Wellness Intervention. This is a new pilot study at Alaska Indigenous Research Program Director, Alaska Native Tribal Health Consortium, Community Health Research Services, Anchorage, AK.

University of Alabama, Birmingham

Maternal morbidity and mortality, and hypertension—A study by Dr. Alan Tita (and colleagues) titled, Treatment for Mild Chronic Hypertension During Pregnancy, was recently published in The New England Journal of Medicine. Dr. Tita demonstrated the health benefit of tighter control of blood pressure during, particularly among underserved populations, and led to an immediate revision of practice guidelines. https://www.uab.edu/news/health/item/12744-study-shows-treating-preexisting-high-blood-pressure-in-pregnancy-improves-maternal-and-fetal-outcomes.

Gene therapy for sickle cell disease—Through another study recently published in The New England Journal of Medicine, Dr. Julie Kanter (and colleagues) demonstrated the effectiveness of gene therapy for sickle cell disease. https://www.nejm.org/doi/full/10.1056/NEJMoa2117175.

Repurposing a commonly available hypertension during for Type 1 diabetes—Dr. Guanlan Xu (and colleagues) recently demonstrated that a commonly available oral therapy for hypertension had a positive impact on patient with type 1 diabetes. https://pubmed.ncbi.nlm.nih.gov/35241690/.

Obesity and inexpensive approaches to weight loss management—Through a study recently published in The Journal of the American Medical Association, Dr. Humaira Jamshed (and colleagues) presented the results of a randomized clinical trial on time restricted eating and its impact on weight loss and cardiometabolic health. https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2794819.

[This statement was submitted by Linda B. Cottler, PhD, MPH, FACE, President, Association for Clinical and Translational Science and Harry P. Selker, MD, MSPH, Chairman, Clinical Research Forum.]

PREPARED STATEMENT OF THE COALITION FOR HEALTH FUNDING

Centers for Disease Control & Prevention	At least $11.581 billion
National Institutes of Health	$50.924 billion
Food & Drug Administration	$3.963 billion
Indian Health Service	$51.42 billion
Health Resources & Services Administration	At least $10.5 billion

Agency for Health Research Quality	No less than $500 million

The Coalition for Health Funding—an alliance of 84 health organizations representing more than 100 million patients and consumers, health providers, professionals and researchers—welcomes the opportunity to submit this statement for the record about the importance of health funding. Together, our member organizations speak with one voice before Congress and the administration in support of federally funded health programs with the shared goal of improved health and well-being for all. Each member organization has individual funding priorities within the Department of Health and Human Services (HHS), but collectively we believe that to improve public health, we need strong, sustained, predictable funding for all Federal agencies and programs across the continuum to ensure we are prepared for future health crises, while also protecting the overall health and security of our Nation.

HHS agencies have different roles in addressing our Nation's mounting health demands, but they are all interconnected. For example, investment in medical research at the National Institutes of Health (NIH) is important, but on its own won't improve public health. We need the Food and Drug Administration (FDA) to approve new treatments. We need the Centers for Disease Control and Prevention (CDC), Health Resources and Services Administration (HRSA), Substance Abuse and Mental Health Services Administration (SAMHSA), and Indian Health Service (IHS) to ensure we have qualified health professionals who can move discoveries into health care and public health delivery, support Americans while they're awaiting new cures, and prevent them from getting sick in the first place. We need the Agency for Healthcare Research and Quality (AHRQ) to provide evidence on what treatments work best, for whom, and in what circumstances. And, we need the Administration for Community Living (ACL) to support those who are aging and those who have disabilities—as well as their caregivers.

HHS agencies do all this important work protecting Americans health for relatively little money as a share of the Federal budget. In fiscal year (FY) 2023, discretionary health spending accounted for nearly $138 billion, or 8 percent of all discretionary Federal spending. Of this, almost half supported medical research at the NIH, with the remainder supporting all other public health activities—disease prevention & response, health & safety security, workforce development, and access to primary and preventive care. Biomedical research, treatment, prevention, and health promotion programs are all critical to success moving forward. Our public health infrastructure must be equipped to handle the myriad challenges that it faces every day. Without robust funding for all agencies and programs within the public health continuum, we will fall short on the promise of protecting Americans and improving their health. Shortchanging public health and health research programs—or cutting health programs at the expense of other programs—leaves Americans vulnerable to health threats and does nothing to prevent these problems from arising in the first place. It also harms our National security and military readiness.

Having learned from the COVID–19 pandemic that these areas of spending cannot be afterthoughts, we urge you to fund them accordingly. Research, mental health, substance use disorders, and chronic disease are just some of the areas of public health that have been negatively impacted by the pandemic and require increased investments. Despite the funding included in the emergency appropriations packages, we have seen setbacks in most, if not all, areas of public health. To that end, we are calling for the following levels of investment for specific public health agencies in FY 2024.

—CDC: At least $11.581 billion
—NIH: $50.924 billion
—FDA: $3.963 billion
—IHS: $51.42 billion
—HRSA: At least $10.5 billion
—AHRQ: No less than $500 million

To achieve these necessary targets, appropriators must also raise the 302(b) allocation for the Labor-HHS-Education subcommittee to address its important needs. The era of budget sequestration hollowed out many of the very public health agencies we depended on to keep our country healthy. That's why the Coalition for Health Funding has partnered with the Campaign to Invest in America's Workforce, Committee for Education Funding, and Coalition on Human in a letter soon to come with at least 270 signers urging Congress to raise the subcommittee's allocation in FY 24 over FY 23 levels. Moving backwards cannot be an option—we've seen the results.

Finally, the Coalition is concerned about the reported possibility of draconian cuts to programs across the Federal funding landscape, including significant cuts to pro-

grams in the Labor, Health and Human Services and Education jurisdiction. Dramatic cuts to these programs will create undue harm for all Americans. Whether through spending caps that act as cuts or arbitrary spending limits such as capping FY 2024 at FY 2022 levels, cutting vital health programs at a time when a decade of sequestration combined with 3 years of an unprecedented pandemic and high inflation has stretched them thin is not in the best interests of the American public. These cuts could eviscerate our ability to respond to public health crises like the fentanyl epidemic while severely damaging our ability to identify and respond to future pandemics, not to mention the harm it would cause to biomedical research. Further, an unhealthy population does not meet the requirements for military service jeopardizing our National security. We strongly oppose these plans and urge the subcommittee to agree to an increase that will strengthen these programs on behalf of all Americans who rely on them.

We hope in your ongoing deliberations on fiscal year 2024 and beyond you will invest in sustained long-term funding for the agencies we trust with American lives. These agencies need the resources to develop the next generation of tools necessary to protect the public's health from other health threats and to ensure the solvency of Medicare's Trust Fund moving forward. We look forward to working with the subcommittee in these endeavors and hope you will turn to the Coalition for Health Funding as a resource now and in the future.

[This statement was submitted by Mila Becker, President, Coalition for Health Funding.]

PREPARED STATEMENT OF THE COALITION OF SKIN DISEASES

THE FOUNDATION'S FISCAL YEAR 2024 L–HHS APPROPRIATIONS RECOMMENDATIONS

—At least $50.924 billion for the National Institutes of Health (NIH).
  —Proportional funding increases for National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS), National Institute of Allergy and Infectious Diseases (NIAID) and the National Center for Advancing Translational Science (NCATS)
—Please provide $11 billion for the Centers for Disease Control and Prevention (CDC).
  —Please provide $6 million for the Chronic Disease Education and Awareness Program.

Chairwoman Baldwin, Ranking Member Capito, and distinguished members of the subcommittee, thank you for your time and your consideration of the priorities of the skin diseases community as you work to craft the FY2024 L–HHS Appropriations Bill.

The Coalition of Skin Diseases (CSD) advocates on behalf of the 84 million Americans living with a skin disease. As the largest consortium of skin disease patient advocacy organizations in the United States, the efforts of the CSD aim to ensure that all individuals living with dermatological diseases and skin traumas receive the care they need to live healthy and productive lives.

By working independently, in coalition, and alongside advocacy organizations committed to patients living with dermatological conditions, the CSD endeavors to be at the forefront of progress toward a day where all individuals affected by skin disease have access to life-preserving/changing treatments and high-quality care. We aim to accomplish this by:

—Fostering education and awareness of skin diseases and disorders,
—Advocating for access to appropriate and quality health care and treatments,
—Contributing to burden and related skin disease research, and
—Strengthening dermatologic patient advocacy organizations through the sharing of resources

The CSD is a 501c3 non-profit organization founded in 2007 by several national dermatological patient organizations, which has since grown to 34 patient advocacy groups. The coalition is passionate about raising the profile of skin disease and supporting those living with a skin disease by providing the patient perspective in medical, research, political and regulatory arenas. The CSD is run by a Board of Directors composed of representatives from member organizations and is sustained by funds provided through membership dues, grants and sponsorships and individual contributions.

NATIONAL INSTITUTES OF HEALTH

NIH hosts a modest research portfolio on skin diseases and CSD works closely with NIH to advance critical activities across all skin diseases. Across all skin diseases, the NIH supports growing research that has helped us better understand skin diseases and support ambitious projects that focus on large studies and scientific research.

CENTERS FOR DISEASE CONTROL AND PREVENTION

Please provide $6 million for the Chronic Diseases Education and Awareness Program at the Centers for Disease Control and Prevention (CDC). This program seeks to provide collaborative opportunities for chronic disease communities that lack dedicated funding from ongoing CDC activities. Such a mechanism allows public health experts at the CDC to review project proposals on an annual basis and direct resources to high impact efforts in a flexible fashion. Continued support for this program will benefit the skin diseases community by allowing for more grants to be funded aimed at raising awareness and expanding educational opportunities for CSD organizations. The more funding available, the more opportunities there are to ensure better provider education and general public awareness.

Thank you for the opportunity to testify before you today. CSD looks forward to working with you all to advance medical research and public health activities that will improve patient outcomes for the members of our community suffering from skin diseases.

[This statement was submitted by Kelly Barta, President, Coalition of Skin Diseases.]

PREPARED STATEMENT OF COMMUNITIES IN SCHOOLS

Thank you for the opportunity to provide testimony regarding the FY 2024 Labor, Health and Human Services, Education, and Related Agencies Appropriations bill.

Communities In Schools® (CIS®) is a national organization that ensures every student, regardless of race, zip code, or socioeconomic background has what they need to realize their potential in school and beyond. Working directly inside 3,270 schools across the country, CIS connects more than 1.8 million students to caring adults and community resources that help them see, confront, and overcome the barriers that stand between them and a brighter future. The CIS evidence-based model of integrated student supports (ISS) embeds a navigator ("site coordinator") in every partner school to connect students to caring adults and critical resources essential for overcoming academic and non-academic barriers to success. Together, we build a powerful change movement made up of peers, students, and alumni committed to shaping an equitable path to education for generations.

CIS strongly supports the Biden administration's request for $25 million to stand up a competitive grant program related to integrated student supports within the Full-Service Community Schools program. We further support the administration's proposed increase for the Full-Service Community Schools program.

Integrated student supports (ISS) are a student-centered approach to promoting students' academic success by developing or securing coordinating supports that target academic and non-academic barriers to achievement. A designated coordinator manages steps like the planning and integration of programming and resources, allowing teachers to teach and principals to focus on leading the school. The coordinator then leverages community-based resources to connect students and families with academic, health, and other wellness support—all while creating and contributing to a climate of safety and trust. ISS, one of four Community School pillars, can be deployed in schools as a critical pillar that functions as an onramp for each of the other three Community School pillars: (1) expanded and enriched learning time and opportunities; (2) active family and community engagement; and (3) collaborative leadership and practices. Operating an evidence-based Community School model relies on locally led and tailored school-based coordinators managing the ISS pillar. Additionally, ISS meets the highest standard of evidence in the Every Student Succeeds Act.

Evidence-based ISS, included in the CIS model, can rapidly evolve within schools and districts while also pivoting to meet evolving needs of students and communities. In the wake of last year's tragedy in Uvalde, Texas, CIS of San Antonio led a coalition of experienced Texas-based CIS staff in coordinating crisis intervention and community resource navigation for the Uvalde Consolidated School District, a school that was not served by CIS at the time. On the heels of the 1 year anniver-

sary, CIS San Antonio has now expanded to serve the Uvalde community in six schools.

It is this ability to expand and rapidly adapt to provide services in locations—such as small and rural districts—that meets the policy objective of the administration to design a competitive ISS grant program. By proposing the ISS grants alongside the FSCS funding, competitive grants can serve as a ramp up to full-service community school in communities lacking resources. ISS can be helpful in under-resourced urban and rural communities that might not have the capacity to operate a FSCS, but can put in place targeted and evidence-based ISS that are responsive to student needs in real time.

Given the value and impact of ISS, we believe the proposed $25 million for ISS will allow community-based organizations to continue scaling the basic standard of ISS to implement an evidence-based, data-driven initiative that can effectively address a range of student and family needs around emotional, mental, and physical health, as well as academic needs. The growing field of ISS has proven scalability to meet the needs of communities in a cost-effective, efficient, and impactful ways. A $25 million investment in ISS will greatly accelerate implementation of this effective student and family support across the country.

Finally, as an example of what a seed investment can accomplish, I would offer a CIS case study from 2018. In 3 years, CIS used a private $12.6 million investment to rapidly bring ISS and site coordinators to the highest-need schools across diverse geographic areas in what we called a Challenge School Grant. The investment was a 40/60 match, with affiliates raising 60 percent of implementation costs at an average of $84,000 per school. During the 3-year implementation of this Challenge School initiative, CIS was able to bring ISS to 162 new schools and serve 85,000 new students. Therefore, a $25 million investment in this area has the potential to bring critical services into more than 400 of the nation's highest-need schools.

We urge Congress to fulfill President Biden's FY24 budget request of $368 million for FSCS, including $25 million for competitive grants, to support integrated student supports that address our-of-school barriers to learning through partnerships with social and health service agencies and providers.

[This statement was submitted by Rey Saldaña, President and CEO, Communities In Schools.]

PREPARED STATEMENT OF THE CONSORTIUM OF SOCIAL SCIENCE ASSOCIATIONS

On behalf of the Consortium of Social Science Associations (COSSA), I offer this written testimony for inclusion in the official committee record. For fiscal year (FY) 2024, COSSA urges the Committee to appropriate:

—$50.924 billion for the National Institutes of Health;
—$11.581 billion for the Centers for Disease Control and Prevention, including $215 million for the National Center for Health Statistics;
—At least $500 million for the Agency for Healthcare Research and Quality;
—At least $900 million for the Institute of Education Sciences; and
—$173.6 million for the Department of Education's International Education and Foreign Language programs.

First, allow me to thank the Committee for its long-standing, bipartisan support for scientific research. Strong, sustained funding for all U.S. science agencies is essential if we are to make progress toward improving the health and economic competitiveness of the Nation.

NATIONAL INSTITUTES OF HEALTH

COSSA joins the 373 organizations in support of at least $50.924 billion for the National Institutes of Health (NIH) base budget in FY 2024. COSSA appreciates the subcommittee's leadership and its long-standing bipartisan support of NIH, especially during difficult budgetary times. We also appreciate the Congress's interest in innovating and pushing the agency forward through support for high-risk, high-reward endeavors. It is critical that efforts to accelerate discovery in new, creative ways work in tandem with—not at the expense of—robust, sustainable support for fundamental and curiosity-driven research.

To that end, COSSA urges the subcommittee to ensure that funding for the Advanced Research Projects Agency for Health (ARPA–H) supplement the $50.924 billion recommendation for NIH's base budget, rather than supplant the investments NIH makes to biomedical and behavioral research across its institutes and center. To be truly transformative, increased investment is needed on all fronts.

In addition, as the COVID–19 pandemic has underscored, it is behavior change—not medical intervention alone—that can help gain control in the days and weeks

immediately following a public health emergency. To that end, COSSA urges the subcommittee to prioritize investment in NIH's Office of Behavioral and Social Sciences Research (OBSSR), housed within the Office of the NIH Director. This critical office coordinates basic, clinical, and translational research in the behavioral and social sciences in support of the NIH mission, and co-funds highly rated grants in the behavioral and social sciences in partnership with individual institutes and centers. We are appreciative of the $1.1 million increase provided to OBSSR in the final FY 2023 appropriations bill; however, behavioral and social sciences research at NIH remains grossly underfunded. For example, OBSSR's FY 2023 budget of $40 million represents only 1.3 percent of the total budget of the NIH Office of the Director; under the President's proposal, this would decrease even further.

In addition, it is estimated that NIH funds roughly $700 million in research related to behavioral and social science annually across its institutes and centers; however, about 62 percent of that is also classified as neuroscience research, leaving around $270 million annually for non-neuroscience related social and behavioral studies. This amounts to less than 1 percent of the entire NIH budget annually. Given all we have learned from the pandemic over the last few years, research on the social influences of health is needed now more than ever. We urge the Committee to emphasize support for OBSSR and direct NIH to finally support the office at levels commensurate with the need for these critical insights.

CENTERS FOR DISEASE CONTROL AND PREVENTION

COSSA urges the subcommittee to appropriate $11.581 billion for the Centers for Disease Control and Prevention (CDC), including $215 million for CDC's National Center for Health Statistics (NCHS). Social and behavioral science research plays a crucial role in helping the CDC carry out its mission by informing the CDC's behavioral surveillance systems, public health interventions, and health promotion and communication programs that help protect Americans and people around the world from disease. One needs only to look at the varied responses across different communities to COVID–19 guidance and policies surrounding social distancing, mask-wearing, and vaccination to understand the critical role understanding the social aspects of public health plays in keeping Americans safe and healthy.

In addition, as the Department of Health and Human Services' principal statistical agency, NCHS produces data on all aspects of our health care system, including opioid and prescription drug use, maternal and infant mortality, chronic disease prevalence, health care disparities, emergency room use, health insurance coverage, teen pregnancy, and causes of death. As a result of the rising costs of conducting surveys and years of flat or near-flat funding, NCHS has had to focus nearly all its resources on continuing to produce the high-quality data that communities across the country rely on to understand their health. Additional funding would allow NCHS to respond to rising costs, declining response rates, and an ever-more complex health care system and capitalize on opportunities surrounding advances in statistical methodology, big data, and computing to produce better information more quickly and efficiently, while reducing the reporting burden on local data providers.

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

COSSA urges the subcommittee to appropriate no less than $500 million for the Agency for Healthcare Research and Quality (AHRQ), which would allow AHRQ to rebuild portfolios terminated as a result of years of cuts and expand its research and training portfolio to address our Nation's pressing and evolving health care challenges. AHRQ funds research on improving the quality, safety, efficiency, and effectiveness of America's health care system. It is the only agency in the Federal Government with the expertise and explicit mission to fund research on improving health care at the provider level (i.e., in hospitals, nursing homes, and other medical facilities). Its work is complementary—not duplicative—of other HHS agencies and requires robust support, especially given the critical role hospitals and group care settings have played in the COVID–19 pandemic.

INSTITUTE OF EDUCATION SCIENCES

COSSA requests at least $900 million for the Institute of Education Sciences (IES) in FY 2024. Within the Department of Education, IES supports research and data to improve our understanding of education at all levels, from early childhood and elementary and secondary education, through higher education. Research further examines special education, rural education, teacher effectiveness, education technology, student achievement, reading and math interventions, and many other areas. IES-supported research has improved the quality of education research, led to the development of early interventions for improving child outcomes, generated

and validated assessment measures for use with children, and led to the establishment of the What Works Clearinghouse for education research, highlighting interventions that work and identifying those that do not. With increasing demand for evidence-based practices in education, adequate funding for IES is essential to support studies that increase knowledge of the factors that influence teaching and learning and apply those findings to improve educational outcomes.

INTERNATIONAL EDUCATION & FOREIGN LANGUAGE PROGRAMS

The Department of Education's International Education and Foreign Language programs play a major role in developing a steady supply of graduates with deep expertise and high-quality research on foreign languages and cultures, international markets, world regions, and global issues. COSSA urges a total appropriation of $173.6 million ($152.1 million for Title VI and $21.5 million for Fulbright-Hays), which would help make up for lost investment and purchasing power over many years of flat-funding. In addition to broadening opportunities for students in international and foreign language studies, such support would also strengthen the Nation's human resource capabilities in strategic areas of the world that impact our National security and global economic competitiveness.

Thank you for the opportunity to present this testimony on behalf of the social and behavioral science research community.

[This statement was submitted by Wendy Naus, Executive Director, Consortium of Social Science Associations.]

PREPARED STATEMENT OF TREYVIOUS COPELAND

I firmly believe in Ryan Reynolds's quote, "I do not expect success. I prepare for it."

Due to my involvement in the Florida A&M University (FAMU) TRIO Talent Search program, I can comfortably leave my high school knowing that I have been prepared and equipped with a solid foundation that not only has allowed me to maneuver through my high school tenure swiftly but will allow me to maneuver a little easier through college and life after college as well.

FAMU TRIO has provided an outlet for me to receive preparation to combat my struggle of not being a stellar test taker, allowing me to get into universities that were once out of reach because of my previous test scores. In addition to that outlet, FAMU TRIO taught me to develop characteristics that will last a lifetime, like resilience, consistency, and being adaptive to different environments.

My determination to master these life skills allowed me to achieve things like graduating from Tallahassee Community College with my associate's degree during the obstacles of Covid-19 before the end of my junior year in high school (resilience), performing tasks repetitively to become better at them (consistency), and changing my study habits to fit more challenging courses when I began dual enrollment at Florida A&M University (being adaptive). While these attributes have already helped me, I am optimistic that they will continue to help me as I begin college as a full-time student and even after my college tenure.

As a first-generation college student who does not receive much help from my family regarding fulfilling my academic endeavors, I can genuinely attest to my involvement in a TRIO program, making it easier for my preparation to meet opportunities and form an abundance of success in my future. I have been able to visit colleges without damaging my family's pockets, begin to think about the future long before it becomes the present, and be highly flexible to circumstances that come my way. As a minority, opportunities to grow may also seem just as scarce as they are for a first-generation college student, so to have overcome so much while preparing to be an African- American, first-generation college student with the help of my TRIO program means so much more to me than I have words for.

I am proud to say that I have received acceptance into 32 colleges, over $2.8 million in merit scholarships, and over $45,000 in various scholarships. I am one of the 750 students in the Gates Scholar Cohort VI (to which over 51,000 students applied this year). I am Gadsden County High School's class of 2023 valedictorian and continue growing daily. Without the resources, assistance, and opportunities provided to me by FAMU TRIO, it would be much more difficult for me to be the proverbial rose growing from concrete.

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GADSDEN COUNTY HIGH SCHOOL STUDENT ACCEPTED TO 32 COLLEGES

The student has a weighted GPA of 4.72
By Madison Glaser
Published: May. 3, 2023 at 10:16 PM EDT

TALLAHASSEE, Fla. (WCTV)—The Gadsden High School marching band set the stage for the 2023 top 10 students reveal, and it's becoming a tradition that students look forward to every year.

Treyvious Copeland was named Gadsden County High School's 2022–2023 valedictorian after earning a GPA well over 4.0. The young people earned the top 10 spots and reportedly brought in millions of dollars in scholarships and dozens of college acceptances.

Gathering in the gymnasium of Gadsden County High School, 10 students were on the hunt for that #1 spot and a chance to reveal the college of their choice.

Treyvious Copeland claimed that spot with a weighted GPA of 4.72., earning himself $2.8 million in merit scholarships and over $45,000 in miscellaneous scholarships and awarded the Bill and Melinda Gates Foundation Scholarship which pays for the entirety of his college.

Copeland was accepted into 32 colleges.

"I'm very thankful for my family especially my mom because she's worked like really hard," said student Treyvious Copeland. "I've worked hard, but she's worked really hard to get me to where I am today."

Venom and Mr. FAMU made the drive to Gadsden County to cheer on Copeland.

Copeland, a soon-to-be Rattler, plans on majoring in pharmacy.

"It began when I first became dual-enrolled there in August so when I became dual-enrolled there and I was on campus getting to be with other students," Copeland said. "It really helped me see that this is truly my home, that I enjoy being here and they have a stellar pharmacy program that I'm ready to enter."

Adriane Peters has worked with Copeland for a couple of years through Tallahassee's Chapter of the Links INC. and said they knew he was destined for greatness from the beginning.

"His initiative is what really stood out to us even as a beau this year. He was a leader in that he came up with great ideas for his community service project and lead our team to give blankets and bedding to toddlers that may not have that this year," said Adriane Peters.

Copeland shared that he's ready for the next phase.

"I'm excited. I'm excited for today. I'm excited for the future. I'm excited for my classmates cause they have worked very hard as well," Copeland said.

Copeland said that over the past 4 years, he's worked on being a multi-tasker, resilient and focused on understanding his priorities and is looking forward to taking those skills with him to college.

This is Gadsden County High School's third annual Top 10 reveal, a tradition they look forward to continuing for years to come.

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PREPARED STATEMENT OF THE COUNCIL OF ACADEMIC FAMILY MEDINE

The member organizations of the Council of Academic Family Medicine (CAFM) are pleased to submit testimony on behalf of programs under the jurisdiction of the Health Resources and Services Administration (HRSA) and the Agency for Healthcare Research and Quality (AHRQ) at the Department of Health and Human Services. CAFM collectively includes family medicine medical school and residency faculty, community preceptors, residency program directors, medical school department chairs, research scientists, and others involved in family medicine education. We urge the Committee to appropriate at least $59 million for the Primary Care Training and Enhancement (PCTE) program, authorized under Title VII, Section 747 of the Public Health Service Act HRSA. In addition, we recommend the Committee fund AHRQ at a level of at least $500 million in discretionary spending and specifically fund $5 million dedicated to AHRQ's Center for Primary Care Research.

More than 44,000 primary care physicians will be needed by 2035, and current primary care production rates will be unable to meet the demand, according to the authors of Annals of Family Medicine (Petterson, et al Mar/Apr 2015). The PCTE and AHRQ programs enhance our Nation's workforce, improving primary care to achieve better health outcomes and reduced costs.

Primary Care Training and Enhancement—Title VII

The PCTE Program (Title VII, Section 747 of the Public Health Service Act) has a long history of funding training of primary care physicians. As experimentation with new or different models of care continues, departments of family medicine and family medicine residency programs will rely further on Title VII, Section 747 grants to help develop curricula and research training methods for transforming practice delivery. Future training needs include training in new clinical environments that include integrated care with other health professionals (e.g., behavioral health, care coordination, nursing); development and implementation of curricula to give trainees the skills to build and work in inter-professional teams that include diverse professions; and development and implementation of curricula to develop leaders in practice transformation. Moreover, new competencies are required for our developing health system.

The COVID–19 pandemic has highlighted many of the failings of the current health care and public health infrastructure. The PCTE program can help address these flaws by supporting the primary care workforce. For example, additional funding is needed for residencies and medical school departments to help address faculty retention, public health competencies, recruit and retain students into primary care, develop new curriculum related to the pandemic, address health equity concerns, and to increase full scope primary care physicians. Title VII funding for primary care training is an evidence-based investment in the future care of the Nation.

A 2021 report by The National Academy of Sciences, Engineering and Medicine found that despite the demonstrably better patient outcomes that have resulted from Title VII investments, Title VII funding remains only a tiny fraction of the total GME funding; reduced to less than 10% since the 1960s.[1] We urge your continued down payment for this program and an increase in funding levels to $59 million in FY 2024 to allow for a robust competitive funding cycle. This funding level will help continue important Title VII programs who use primary care training funding to develop innovative programs and curricula related to interdisciplinary training in rising new competencies.

Budget documents from FY 2023 indicated that HRSA was no longer funding the category of medical schools under the PCTE program. Specifically, HRSA retired measure 6.I.C.25. Funding of academic administrative units (departments or divisions of medical schools) has been a critically important piece of the PCTE program for many years.

For this reason, we ask for the following report language to accompany the increased PCTE funding: Funding of medical school departments/divisions (academic administrative units) under the HRSA Primary Care Training and Enhancement Program (PCTE) has been a critical part of the PCTE program both in its role in medical student selection of primary care training programs and in facilitating scholarly activity in departments of family medicine. The Committee directs HRSA to not eliminate this funding and to continue funding opportunities to support administrative academic units within medical schools.

Agency for Health Care Research and Quality (AHRQ)

Primary care clinical research (PCR) is a core function of AHRQ. PCR includes translating science into patient care, better organizing health care to meet patient and population needs, evaluating innovations to provide the best health care to patients, and engaging patients, communities, and practices to improve health. AHRQ has proved to be uniquely positioned to support best practice PCR and to help disseminate the research nationwide. However, reduced levels of AHRQ funding in the past have exacerbated disparities in funding primary care research. Important primary care research initiatives have been unfunded in recent years such as research for patients with Multiple Chronic Conditions (MCC) and the statutorily authorized Center for PCR.

We greatly appreciate the inclusion of increased AHRQ funding in the FY2023 omnibus package and ask for a further increase in FY2024 to $500 million. The President's FY2024 budget request includes $11 million in funding for primary care research in general. We ask that $5 million be provided as a line item to the Center for Primary Care Research within AHRQ to help coordinate and direct primary care research funding at AHRQ; $2 million was provided in FY 2023. Additional funding will continue and expand the following goals: (1) development of clinical primary care research, (2) real-world application of evidence, (3) practice and health system transformation, (4) how high functioning primary care systems and practices should

[1] National Academies of Sciences, Engineering, and Medicine 2021. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. Washington, DC: The National Academies Press. https://doi.org/10.17226/25983.

look, (5) how primary care practices serving rural and underserved populations survive, and (6) how health extension systems connect research entities with practices and communities.

In 2020, the RAND Corporation published a report appropriated by Congress and commissioned by AHRQ that assessed federally funded PCR since 2012 regarding gaps and to recommend improvements. The report emphasized the significant role AHRQ plays in PCR. RAND made several recommendations, one of which was to provide targeted funds to create a proper hub for Federal PCR. This is important because PCR is a distinct science that differs from health services research. With the $5 million in dedicated funds for PCR, AHRQ could prioritize and coordinate investments in PCR directly improving the health and wellbeing of Americans. The National Academy of Medicine's report on Primary Care concurs with RAND's assessment on the importance of targeted funding for PCR, demonstrating the variety of stakeholders which share common ground on the importance of prioritizing PCR.[2]

AHRQ primary care funding is important for programs in rural States like Wisconsin. Between the years of 2015 and 2023 Wisconsin received a total of $23,926,144 from AHRQ. Of these grants, the state recently received funding specifically for the expansion of primary care telehealth practices. While the workforce continues to navigate the impacts of Covid-19, it is critical to prioritize funding to address challenges that arose during the pandemic.

CAFM looks forward to working with the subcommittee to protect HRSA's PCTE Program and AHRQ—both entities which enhance our Nation's primary care workforce and infrastructure.

[This statement was submitted by Winston Liaw, MD, MPH, Chair, Academic Family Medicine Advocacy Committee.]

PREPARED STATEMENT OF THE COUNCIL OF GRADUATE SCHOOLS

On behalf of the Council of Graduate Schools (CGS), I, Suzanne T. Ortega, President of CGS submit this written testimony for the record regarding Fiscal Year (FY) 2024 appropriations. As the subcommittee on Labor, Health and Human Services, Education, and Related Agencies begins to consider FY 2024 appropriations legislation, please give special attention to graduate education and training programs administered by the U.S. Department of Education and the National Institutes of Health (NIH). The programs administered by these agencies: promote access to graduate education, training, and scholarship; broaden participation of underrepresented groups in the academic disciplines; and creates opportunities for international engagement and collaboration.

For over 60 years, CGS has served as the National organization dedicated to advancing graduate education and research. Our membership includes nearly 500 institutions of higher education in the United States, Canada, and abroad, representing over 1.8 million graduate students. Collectively, CGS member institutions grant 87 percent of all U.S. doctorates and majority of U.S. master's degrees. As a higher education association, we are proud to represent a diverse and dynamic group of institutions, ranging from public and private research-intensive institutions to regional comprehensive institutions, Minority-Serving Institutions, Hispanic-Serving Institutions, and Historically Black Colleges and Universities. The CGS member institutions are committed to providing high-quality education and training programs to their graduate students.

For FY 2024, CGS requests that the subcommittee appropriate at least, but preferably more than the amount requested in the President's FY 2024 Budget. For the U.S. Department of Education, CGS encourages the subcommittee to make robust investments in graduate education programs, including: the Graduate Assistance in Areas of National Need; the Ronald E. McNair Postbaccalaureate Achievement Program; and the Child Care Access Means Parents in School. These programs not only provide access to graduate education for a diverse cadre of talented students, but they are also helping to prepare the next generation of the American workforce.

—*Graduate Assistance in Areas of National Need (GAANN)* provides valuable opportunities for graduate students to conduct vital research and produce scholarship that will help meet the Nation's most pressing needs and keep the United States at the forefront of academic research. As the only grant aid program available to graduate students through the Department of Education, GAANN is a critical source of support for academically talented graduate students that

[2] National Academies of Sciences, Engineering, and Medicine 2021. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. Washington, DC: The National Academies Press. https://doi.org/10.17226/25983.

face financial barriers in accessing a master's or doctoral degree. In the last 10 years, funding for GAANN has decreased significantly, and the number of GAANN awards have decreased by 50 percent. It is time for Congress to renew its commitment to GAANN and appropriate at least $35 million for this program in the fiscal year 2024.

—*Ronald E. McNair Postbaccalaureate Achievement Program (McNair Scholars)* provides funding to 151 institutions of higher education to prepare eligible participants for doctoral studies through the involvement in research and scholarly activities. McNair Scholars are typically from disadvantaged backgrounds and have demonstrated strong academic potential with the goal of attaining doctoral degrees. CGS strongly recommends an appropriation of at least $61.2 million for this program in the fiscal year 2024.

—*Child Care Access Means Parents In School (CCAMPIS)* provides much-needed grants to institutions of higher education to support or establish campus-based childcare services to low-income students, including those in graduate school. In a May 2022 blog post, authored by Michelle Asha Cooper, Ph.D., former-Acting Assistant Secretary, Office of Postsecondary Education, it mentioned that the average cost of childcare was between $9,200 to $9,600 annually. At the same time childcare costs are rising, there are limits to the amount of funds the Department of Education can award to institutions of higher education. This is an important program that graduate students and their families rely on. CGS strongly recommends an appropriation of at least $95 million for this program in the fiscal year 2024.

In addition, CGS encourages the subcommittee to fund the following Department of Education programs:

—Strengthening Historically Black Graduate Institutions: $102.3 million

—Strengthening Master's Degree Programs at Historically Black Colleges and Universities: $21 million

—Promoting Postbaccalaureate Opportunities for Hispanic Americans: $28.8 million

—International and Foreign Language Studies: $173.6 million

—School and Campus-Based Mental Health Service: $150 million

—Systemwide Holistic Student Supports: $30 million

—Graduate Fellowships to Prepare Faculty in High-Need Areas at Colleges of Education: $10 million

As the world's largest biomedical research agency, the National Institutes of Health (NIH) is at the forefront of conducting and funding groundbreaking research in a multitude of fields, including biomedical, behavioral, and social research. For FY 2024, CGS encourages an appropriation of at least $50.924 billion for NIH's foundational work. At a recent hearing, Senate Appropriations Committee Chair Patty Murray (D–WA), said "As Senator Collins and I have said from the start of these hearings, we are very determined to get back to regular order and make sure we pass the funding necessary to keep our families safe and healthy, and keep our Nation competitive—and that simply has to include providing robust funding for the National Institutes of Health." CGS encourages continued Federal investment in NIH research and training programs, including: the Graduate Partnership Program (GPP); the Graduate

Summer Opportunities to Advance Research Program (G–SOAR); the Postbaccalaureate Research Education Program (PREP), and NIH MD/PhD Partnership Training Program. In addition, CGS strongly supports funding for the Next Generation Researcher Initiative which cultivates early-stage investigators entering the biomedical and behavioral research workforce. The Ruth L. Kirschstein National Research Service Awards (NRSA) for Individual Fellow and Trainees provides predoctoral and postdoctoral research training in specified fields of study. The Kirschstein-NRSA also assists fellows and trainees with childcare cost awards, which is important for researchers with families and caregiving responsibilities.

Thank you for the opportunity to submit written testimony on the FY 2024 Departments of Labor, Health and Human Services, Education, and Related Agencies Appropriations bill. CGS looks forward to your support for the programs included in this testimony, and others that promote access to graduate education and scholarship, strengthen diversity, equity, and inclusion at the Nation's universities, and creates international engagement and collaboration. If you have any questions, please do not hesitate to contact Ms. Amy Scott at amscott@cgs.nche.edu or Mr. Nick Cox at ncox@cgs.nche.edu.

Sincerely.

[This statement was submitted by Suzanne T. Ortega, President, Council of Graduate Schools.]

PREPARED STATEMENT OF THE COUNCIL OF STATE AND TERRITORIAL EPIDEMIOLOGISTS

Chair Baldwin, Ranking Member Capito, and members of the subcommittee, thank you for the opportunity to submit this testimony in support of at least $340 million in Fiscal Year (FY) 2024 funding for the Data Modernization Initiative (DMI) and $120 million for the Epidemiology and Laboratory Capacity (ELC) program at the Centers for Disease Control and Prevention (CDC). I am Sherri Davidson, State Epidemiologist at the Alabama Department of Public Health, and Executive Board member of the Council of State and Territorial Epidemiologists. CSTE represents public health epidemiologists nationwide working on the front lines to respond to every emerging threat to public health-including food-borne illness, Ebola, Marburg, measles, influenza, opioid overdoses, Zika, and more.

While we made improvements over the course of the COVID–19 pandemic, our public health data systems have only been partially upgraded, remain in dire need of security enhancements, and sometimes still rely on obsolete surveillance methods leading to delayed detection and response to public health threats of all types. In some situations, paper-based systems, phone calls, spreadsheets, and faxes requiring data entry by hand remain in use, leaving us woefully behind and ill-equipped to combat the spread of infectious disease and other public health threats.

Delayed detection and response have dire consequences. In just this past year, our members have needed to respond to concurrent outbreaks of COVID–19, pediatric hepatitis-associated with adenovirus, mpox, Ebola Sudan virus, Marburg virus, and the surge in pediatric hospitalizations due to the respiratory syncytial virus (RSV). The US will remain at high risk for new, emerging, and reemerging diseases. Guided by the CDC, State and local health departments across the country need sustained support to ensure effective public health epidemiologic data systems are in place to rapidly detect emerging threats and facilitate immediate response to keep our population safe.

Prior to the COVID–19 pandemic, CSTE initiated the call for improved public health epidemiologic data systems. The pandemic made it clear that this need cannot wait. With our Data: Elemental to Health Campaign partners, we asked Congress to provide first ever dedicated funding for public health data systems and to build a 21st century public health data superhighway. Thanks to this subcommittee, Congress answered the call and has provided more than $1 billion to date mostly through one-time supplemental funding for CDC's DMI. This funding is making a critical difference, but a modern public health data infrastructure cannot function without sustained, annual resources.

In my home state of Alabama, this funding is making a difference. When the Mobile County Health Department (MCHD) needed information on reportable conditions, they previously relied on manual data downloads and inadequate software. Thanks to DMI funding in our state, they now have near-real-time access to backend disease data and state-of-the-art visualization applications for all reportable conditions. Instead of unstable slow, manual processes, they have developed an infrastructure that provides them with the data they need to act quickly at the local level. MCDH and the Alabama Department of Public Health have continued to build on the newly implemented data visualization and sharing process for all reportable conditions, not just COVID. This model of innovation and data modernization better equips the epidemiologists in Alabama to improve health outcomes and ensure the community can thrive.

The DMI is a commitment to building the next generation data workforce and data systems that the public expects for daily operations, which are also 'response-ready' for the next public health emergency with capacity to surge and scale. We need far more resources to meet our Nation's current and long-term public health surveillance needs at the state, territorial, local and Tribal (STLT) levels, which the Data: Elemental to Health campaign estimates will cost at least $7.84 billion over 5 years. In the immediate term, we need robust, sustained, annual funding for DMI to ensure we are providing resources for public health systems and infrastructure, including at State and local health departments, to keep pace with evolving technology.

DMI is an enterprise approach and there are five key interconnected pillars essential for public health data modernization. They are: Electronic Case Reporting, the National Notifiable Disease Surveillance System, the Electronic Vital Records System, Syndromic Surveillance, and Laboratory Information Systems including Electronic Laboratory Reporting (ELR).

We need electronic case reporting (eCR) to give health care providers a means to seamlessly communicate with public health. eCR will help guarantee that when providers see patients—in any setting—patient demographics, clinical information, and

test results for all reportable conditions are automatically shared with State and local public health and then able to be seamlessly incorporated into CDC's National Notifiable Disease Surveillance System (NNDSS). DMI investments in eCR are making a difference. More than 20,200 health care facilities adopted eCR between January 2020 and October 2022, bringing the total number of facilities connected to over 20,400. As of May 12, more than 25,300 facilities in all 50 States are actively sending electronic initial case reports to public health using eCR. In fact, all 50 States, DC, and Puerto Rico and 13 local jurisdictions have received initial electronic case reports and more than 24.5 million reports have been sent electronically from healthcare to public health agencies. eCR reduces the burden on providers who will no longer have to manually report once eCR is fully established. Departments are actively working to upgrade their systems to receive and process these reports, but many upgrades are still needed to fully scale and optimally process and use eCR.

Resources are needed to make improvements in NNDSS and rapid data submission from States to CDC. For example, STLT health department staff serve as disease detectives contacting and interviewing cases and gathering detailed information to learn how and where they may have become infected—are they part of a cluster or outbreak, or what co-factors may have led to a more severe illness? During the Zika response, case investigations conducted by the local health department identified persons working on elevators were at increased risk of infection as standing water often collected in the bottoms of open-air elevator shafts serving as breeding location for mosquitos.

We need electronic ordering of lab tests to help ensure critical information (such as race and ethnicity) is captured at the time of test order to then support the exchange of information with public health to launch a rapid response. Seamless electronic communication is critical. Investments here have also shown early success. ELR, functioning across the country, enables States, localities, territories, Tribes, and the Federal Government to have timely information on laboratory results, often forming the first pieces of information to initiate case investigations and immediate response action at STLT health departments. Without ELR, public health would not be able to support timely life-saving measures and know what is happening in virtually every place across Alabama. In Alabama, and many jurisdictions, this information is transmitted and ready for analysis in near real time.

We need improvements to our electronic vital records systems to ensure real-time transmission of birth and death data for statistical and monitoring purposes. We must make sure systems are interoperable so physicians, coroners, medical examiners, and funeral directors can seamlessly report deaths through their existing electronic records systems—eliminating delays and reducing errors.

Standards-based interoperability will also help identify threats as they emerge. Today, across the Nation, nearly one third of all emergency department visits are not reported to the National Syndromic Surveillance Program, which helps detect, monitor, control and prevent emerging diseases.

These five pillars are interwoven, and each plays a key role in moving the United States from an outdated and burdensome patchwork of systems to a 21st century public health data infrastructure that provides complete, accurate, and rapid actionable data. Again, DMI is an enterprise-wide approach, which will support widespread and rapid access to public health data for all public health programs at all levels of government for all diseases and conditions. DMI will help break down siloes and ensure all systems are integrated and interoperable, and States like Alabama can more efficiently use data for public health action and to communicate data to CDC.

Equally important is a skilled workforce that includes epidemiologists, public health informaticists, data scientists, and other experts—all of whom work together so that the public health surveillance system can detect and monitor current threats and be ready for the next pandemic.

The ELC program strengthens epidemiologic and lab capacity in all 50 States, eight territories, and five large local health departments. The ELC program is unique to CDC as it is the sole support for core epidemiology and labs specifically intended to respond to outbreaks across the spectrum of infectious diseases. Increased funding is needed to enhance core epidemiologic response, which allows epidemiologists to respond to and support outbreaks for multiple disease threats. ELC's budget line, which has not been increased since 2011, is woefully inadequate to support State and local response needs.

The ELC program is unique to CDC as it is the only source of support for core epidemiology and laboratories specifically intended to respond to outbreaks across the spectrum of infectious diseases. Increased funding is needed to enhance core epidemiological response, which allows epidemiologists to respond to and support out-

breaks for multiple disease threats unlike restricted disease categorical grants. Increased funding will also help to build the epidemiology workforce, allowing State and local health departments to begin to move towards establishing a minimum epidemiology workforce. The COVID–19 response demonstrated additional funds are needed for basic public health tools.

CSTE applauds President Biden for proposing an unprecedented investment of $11.581 billion in CDC through his FY 2024 budget request. As part of this significant and well-warranted proposed increase, the President calls for $340 million for DMI to continue "bringing systems up to date with technological advancements, improve understanding of early warning signals through increased reporting of syndromic and disease surveillance data, decrease clinical and public health reporting lags, and improve the timeliness and accuracy of death reports." In addition to these proposed increases, base funding for ELC must be increased to support noncategorial State and local public health infectious disease epidemiologic and laboratory capacity. We respectfully request the subcommittee provide funding of at least $340 million for DMI and at least $120 million for ELC at CDC in Fiscal Year 2024.

Thank you.

[This statement was submitted by Sherri Davidson, PhD, MPH, State Epidemiologist, Alabama Department of Public Health, Executive Board Member, Council of State and Territorial Epidemiologists.]

PREPARED STATEMENT OF THE COUNCIL ON SOCIAL WORK EDUCATION

Department of Health and Human Services (HHS): Substance Abuse and Mental Health Services Administration (SAMHSA): $25 million for the Minority Fellowship Program (MFP) at Heath Resources and Services Administration (HRSA): $225.8 million for HRSA's Behavioral Health Workforce Education and Training (BHWET) grant program; $55.014 million for Scholarships for Disadvantaged Students; $82 million for the Geriatrics Workforce Enhancement Program (GWEP) and the Geriatrics Academic Career Award (GACA); $15 million for continued support of a demonstration program to strengthen the mental and substance disorders workforce; $20 million for continued support of the Loan Repayment Program for Substance Use Disorder Treatment Workforce; $50.9 billion for National Institutes of Health (NIH); NIH report language on Office of Behavioral and Social Sciences Research working groups.

Department of Education (ED): $13,000 for the maximum individual Pell Grant.

CSWE is a nonprofit national association representing over 900 accredited baccalaureate and master's degree social work programs, as well as individual social work educators, practitioners, and agencies dedicated to advancing quality social work education. We appreciate your efforts and leadership on issues that impact social work, social work education, and the wellbeing of individuals, families, and communities and social and economic justice. We encourage you to consider the following appropriations requests that will support social work programs and social work students in the fiscal year (FY) 2024 appropriations process. Pressing societal challenges and public health challenges like the substance use disorder crises, growing mental and behavioral health needs, workforce shortages, and rising higher education costs, are just some of the challenges facing social work students and practitioners. Your support of these appropriations requests will help meet these challenges. Federal funding helps strengthen the pipeline of social workers, addresses the needs of vulnerable and at-risk populations, and supports students, including those from disadvantaged backgrounds. Social work students go on to work in a diversity of fields including child advocacy, geriatrics, school social work, healthcare and other fields. As policymakers continue to focus on the social determinants of health, support for social workers, who are the workforce at the center of addressing these social factors, will be critical. CSWE's FY 2024 requests (as detailed below) illustrate support for important programs that address vital health workforce needs, provide invaluable student aid, address the social determinants of health, and promote important health-care research. We respectfully ask for your support of these requests during the FY 2024 appropriations process.

Substance Abuse and Mental Health Services Administration: $25 million for the Minority Fellowship Program (MFP). For more than 45 years, MFP has been increasing the number of professionals preparing for leadership roles in mental health and substance use fields and working to reduce health disparities and improve behavioral health-care outcomes for racial and ethnic populations. CSWE urges the committee to include $25 million, in line with the authorized amount, for the MFP in FY 2024.

Health Resources and Services Administration: $225.8 million for HRSA's Behavioral Health Workforce Education and Training (BHWET) program. CSWE was pleased to see continuous investments for the BHWET program in the FY 2023 Labor-HHS–ED appropriations bill. BHWET supports the recruitment and education of behavioral health-care providers, which is critical as the Nation continues to combat the pandemic, the opioid crisis, and substance use disorders. The number of training programs supported by BHWET has grown tremendously over the past several years, particularly amongst social workers. Social workers represent the most diverse health profession in the Nation and as efforts are taken to bolster the public health infrastructure, social workers represent a model for continued workforce growth and diversity. In total, over 4,314 behavioral health professionals and 1,671 behavioral health paraprofessionals were trained through the program in academic year (AY) 2021–22. 72% percent of these sites were in underserved communities. At the end of the academic year, 58 percent of respondents were already working medically underserved communities, and 28 percent were already working in a Health Professions Shortage Area (HPSA). Upon follow-up after a year, 46 percent of respondents work or train in medically underserved communities. As the Nation's demand for well-equipped behavioral health-care providers continues to grow, we urge you to support $225.8 million for BHWET in FY 2024.

—Clarify HRSA's authority to support pre-licensure behavioral health programs via the BHWET program and provide $5 million for a demonstration project. One of the major obstacles to addressing the ongoing behavioral health provider workforce shortage is the bottleneck for behavioral health providers when transitioning from education to professional settings. While Congress' support has enabled schools of social to educate the next generation of care providers, there is currently a gap of support for pre-licensure social workers. Pre-licensure social workers are fully educated, degree-holding care providers who have not yet taken the licensure exam and been approved by their state board. These pre-licensure social workers can provide behavioral health care services under the supervision of a fully-licensed social worker, expanding supply of and access to health professionals, particularly in underserved areas. Funding for a demonstration project from HRSA will allow for the test of models and best practices to maximize the impact pre-licensure social workers can provide.

—To support this effort, CSWE requests the following language be included in the FY 2024 report: "Pre-Licensure Behavioral Care Providers.-The Committee recognizes the role that degree-holding, pre-licensure behavioral health care professionals, such as pre-licensure social workers, can play in addressing the behavioral care provider shortage. Included in the above total for BHWET, the Committee provides $5 million for a demonstration project to evaluate the feasibility of a program supporting behavioral health professions schools, behavioral health care sites, and other relevant organizations in hiring pre-licensure social workers and other behavioral health professionals to provide care under the supervision of a fully-licensed professional."

—$55.014 million for Scholarships for Disadvantaged Students. This program helps ensure that the United States has the pipeline of health professionals to meet health needs of underserved individuals and communities. Furthermore, this program provides much needed opportunities for students from disadvantaged backgrounds.

—$82 million for the Geriatrics Workforce Enhancement Program (GWEP) and Geriatrics Academic Career Award (GACA). GWEP and GACA supports training and educating health professionals, including social workers, as well as direct care workers, and family caregivers in the care of older adults. They are the only Federal programs that focus on developing a health-care workforce that maximizes patient and family engagement while improving health outcomes for older adults. GWEPs and GACAs are highly successful in leading and preparing the health care workforce, unpaid caregivers and members of the community to address the complex needs of older adults living with chronic conditions and disabilities, and the social and environmental health determinants impacting their ability to live as independently as possible.

—$15 million for continued support of a demonstration program to strengthen the mental and substance disorders workforce.

—$20 million for continued support of the Loan Repayment Program for Substance Use Disorder Treatment Workforce.

National Institutes of Health (NIH): $51 billion in FY 2024 for the National Institutes of Health. CSWE appreciates the continued support from Congress and the increased funding for NIH. To build on the advances in research, CSWE hopes you will support continued investments in biomedical and health-related research that incorporates the social and behavioral science research necessary to better under-

stand and address the needs of high-risk populations including children, minority, and geriatric populations. Social and structural determinants of health play a large role in the health disparities that plague society. Social factors play a major role in people's health and as a result NIH needs to fund behavioral and social science research that tests innovations in the design of health care and integrate social care into health care and health care into social services. In addition, research must be funded that tests the effectiveness of these integrated services. NIH should expand research opportunities in this area to provide meaningful, comprehensive, and long-lasting improvements in health care delivery. CSWE requests the following report language be included in the FY 2024 Labor-H report: The Committee believes that a more robust and focused NIH commitment to behavioral and social science research and training would yield significant improvements to the Nation's health due to the important connections between social and physical conditions and health. Many public health challenges are rooted in individual and social behavior, yet there is no centralized focus at the NIH to support the training of the next generation of researchers in this scientific discipline. Instead, it is left to the individual NIH Institutes and Centers to support trainees and researchers in this space leaving many social and behavioral scientists without NIH support. The Committee directs the Office of the Director to create a program to award fellowships to early career researchers focused on behavioral and social science research specifically in the areas of mental health and substance use disorders to incentivize and retain research training in this important public health issue area.

Department of Education: $13,000 in FY 2024 for the maximum individual Pell Grant. Pell Grants are critical to ensuring access and affordability in higher education. In 2020–2021, 6,350,546 Pell awards were made totaling $26,457,465,535 in aid. CSWE supports increasing the amount of Pell funding that is supported by mandatory spending and expanding eligibility to graduate students. Student aid programs, particularly grant programs, represent important investments and help students avoid crushing debt burdens when they graduate.

—Support for the Public Service Loan Forgiveness (PSLF) Program. PSLF is an integral program to ensuring a pipeline of professionals in public service serving in high-needs areas. CSWE encourages Congress to continue support for this vital program and programs like the Temporary Expanded Public Service Loan Forgiveness (TEPSLF), which assists public service workers who were enrolled in ineligible loan repayment programs. In addition to continuing support for PSLF, CSWE asks Congress to continue oversight of how the Department of Education is implementing the program.

—Support for Paid Internships for Social Workers. Social work students are required to participate in at least 400 hours of field experience and at the graduate level masters students are required to complete at least 900 hours. These experiences are critical to ensuring the development of a professional social work workforce. CSWE was pleased to see in the FY 2024 President's Budget Request that the Department of Education will conduct analysis of the of its recent experiment under the Experimental Sites Initiative that lifted the restriction on payments of Federal Work Study funds for students who are working in credit-bearing positions.

—CSWE requests the following report language be included in the FY 2024 Labor-H report: The Committee appreciates the Department's response to its request for information on the use of financial aid to support social work students in field experience placements. The Committee looks forward to Federal Student Aid's report on the Experimental Sites Initiative for Federal Work Study with disaggregate findings for social work students before the end of calendar year 2023.

[This statement was submitted by Halaevalu F. O. Vakalahi PhD, MSW, MEd, President and Chief Executive Officer, Council on Social Work Education.]

PREPARED STATEMENT OF COVENANT HOUSE INTERNATIONAL

Covenant House International (CHI) is the largest charitable organization in the Americas building a bridge to hope for young people facing or overcoming homelessness, including survivors of human trafficking. Annually, we reach over 12,000 young people in 25 cities in the U.S. alone by providing 542,000 nights of housing, on-site workforce development programs, behavioral health services, and other wrap-around supportive services. This testimony supports a request of $300 million in Fiscal Year (FY) 2024 funding for the Runaway and Homeless Youth Act (RHYA) program, administered by the U.S. Department of Health and Human Services. This request includes two separate programs in the appropriations table, as follows:

First Line Item: Consolidated Runaway and Homeless Youth (RHY) Programs

Description of Program: The Consolidated Runaway and Homeless Youth Act (RHYA) programs prevent trafficking, identify survivors, and provide services to runaway, homeless, and disconnected youth. The grants provided through the RHY program includes:

—*Basic Center Programs:* provides temporary shelter and counseling services to youth who have left home without permission of their parents or guardians, have been forced to leave home, or are experiencing homelessness or housing instability, who might otherwise end up in the law enforcement, child welfare, mental health, or juvenile justice systems.

—*Transitional Living Programs and Maternity Group Homes:* provides longer-term housing with supportive services, including Maternity Group Homes for pregnant and parenting youth

—*National Communications System:* 24/7 national phone, text, and online communications system which connects youth and families in crisis with prevention services and reunifies families

—*National Technical Assistance Center:* provides training and technical assistance to all RHYA grantees

Second Line Item: Service Connection for Youth on the Streets

Description of Program: The Service Connection for Youth on the Streets program is commonly called the Street Outreach Program and is funded by the Runaway and Homeless Youth Act. These funds are granted to community-based organizations to provide education, prevention, treatment, counseling, connection, and referrals to vital services to prevent sexual abuse and human trafficking for youth at-risk of and experiencing trafficking and homelessness. At Covenant House, every day we see young people striving to overcome the challenges they have experienced in their young lives, i.e., experiences in the child welfare system, undiagnosed mental health issues, domestic violence, and low-wage jobs often due to the lack of a high school diploma. Young people experiencing homelessness on the street describe increased levels of drug trafficking, human trafficking, violence, and just overall isolation and disconnect from community, from family, and from friends.

Last year, supported by RHYTPA and private philanthropy, the Covenant House network in the 25 U.S. cities provided 542,000 nights of housing for youth with an average of 1,500 youth receiving housing each night and 6,200 youth served in residential programs. But beyond these housing numbers, RHYTPA funding has been effective in creating successful outcomes related to employment, education, and access to services. Last year, our data found that throughout our network, 2,000 youth gained or maintained employment, 2,100 were enrolled in school, 1,900 moved to stable housing, and 120 obtained a high school diploma or equivalency.

RHYTPA goes beyond basic emergency shelter and is one of the few Federal supports of transitional housing. As young people find themselves at-risk of or experiencing homelessness due to family dysfunction, eviction and the lack of affordable housing, or other life-altering situations, transitional housing programs provide a pathway to independence. This can be particularly important for youth experiencing homelessness that have aged out of the foster care system or those with other systems involvement. In a 2021 analysis Covenant House did across 15 U.S. cities over a 12-month period, we found that nearly three-quarters of youth who accessed transitional housing, particularly for longer periods, achieved stable housing. Importantly, the data showed youth of color had higher rates of stable exits to stable housing and higher rates of employment after utilizing transitional housing.

Finally, RHYTPA recognizes the unique intersection between youth homelessness and becoming a victim of human trafficking. Based on our research reported in 2018 from 13 cities with University of Pennsylvania and Loyola University New Orleans, one in five youth interviewed reported being survivors of trafficking, including 27 percent of LGBTQ+ youth. Our research found 22% of youth interviewed were offered money for sex on their first night being homeless. While RHYTPA has been critical to our network maintaining services and providing early intervention services, the program does not have enough resources to meet the demand. Typically, less than one-third of eligible applications receive funding. Within our own network, we know that a number of applications scored at the highest level and would have received funding if this program received additional resources.

[This statement was submitted by Bill Bedrossian, CEO, Covenant House International.]

PREPARED STATEMENT OF THE CREUTZFELDT-JAKOB DISEASE FOUNDATION

Chairwoman Baldwin, Ranking Member Capito, and Members of the subcommittee:

We appreciate the opportunity to submit this testimony in strong support for funding of the crucial prion disease work being undertaken by the Centers for Disease Control and Prevention in partnership with public health agencies around the country and the National Prion Disease Pathology Surveillance Center (NPDPSC). We request Congressional support in increasing the Prion Disease Surveillance appropriation through the CDC, Emerging and Zoonotic Infectious Diseases, by $1 million, for a total of $8.5 million and that the NIH consider Prion Disease as an Alzheimer's Disease Related Dementia (ADRD), which would allow NIH funds allocated to these groups of diseases to also be applied to prion diseases.

OVERVIEW

Creutzfeldt-Jakob Disease (CJD), is a rare, 100% fatal, degenerative brain disease that causes rapidly progressive dementia. CJD is transmissible and presently has no treatment or cure. CJD accounts for approximately 1 out of 6,000 deaths per year in the U.S. However, the unreported and undiagnosed number of cases remains unclear.

CJD is caused by the presence of an abnormal "prion" protein in the brain and is known as a prion disease. CJD/Prion disease surveillance receives modest support through the Centers for Disease Control and Prevention (CDC). We need your support to strengthen and continue the coordination of CJD and other prion disease surveillance activities and to assure the safety of the American public.

VARIANT CJD (VCJD), AND BOVINE SPONGIFORM ENCEPHALOPATHY

One form of this disease in humans, variant CJD (vCJD), is known to be caused by ingesting beef contaminated with Bovine Spongiform Encephalopathy (BSE), commonly known as "mad cow" disease. The most recent U.S. case of vCJD was announced in 2013 and confirmed by the NPDPSC in 2014. Limited BSE testing by the USDA adds another layer to the already deepening concerns regarding possible risks to humans. In recent years, the USDA has decreased random testing for BSE from 40,000 to 25,000 tests per year (12,719 tests in 6 months, or 1 test per 3,302 live cows). Hence, surveillance of BSE in this country is largely dependent on demonstrating the lack of transmission to humans through human disease surveillance. The two most recent cases of vCJD in Europe are believed to be due to occupational exposure and several cases of vCJD have been transmitted between individuals via blood transfusions. Hence, vCJD risk is not confined to eating contaminated food.

CHRONIC WASTING DISEASE

Emerging laboratory data show that Chronic Wasting Disease (CWD), a naturally occurring prion disease of deer and elk, could potentially transmit to humans and other mammals, posing a new threat to public health. Human surveillance through brain tissue examination is the only way to definitively diagnose human prion diseases, determine their origin, and determine whether the spread of CWD found in elk and deer in 30 States in the U.S. and in 5 Canadian provinces has become a human risk. A study in progress has reported that CWD was transmitted to macaques (primates that are genetically similar to humans) by feeding them contaminated deer meat. Unlike the BSE outbreak in cattle, CWD prions are highly infectious among its own species and the disease transmits by contact and through contaminated environment, including soil and plants, in free ranging and farmed animals. Additionally, multiple lines of experimental evidence indicate that sheep and cows are susceptible to CWD. Since CWD has been proven to cross several species barriers, this opens up the possibility of transmission to humans as well, either directly by eating contaminated venison or indirectly through infected domestic animals. Continued prion disease surveillance, particularly through examination of human brain tissue, is imperative to evaluate whether CWD has or can spread to humans.

The NPDPSC, funded by the CDC and located at Case Western Reserve University in Cleveland, Ohio, is our line of defense against the possibility of an undetected U.S. human prion disease epidemic as experienced in the United Kingdom.

Prion disease surveillance is funded at $7.5 million per year. Expenses have since risen for the resources required to perform adequate surveillance given the increasing number of cases as expected by the aging American population, increasing autopsy costs over time, screening for COVID19, and taking extra precautions nec-

essary for COVID19. Without an increase in funding commensurate with these increased expenses, surveillance will be compromised.

Request #1 Report Language: Prion Disease.—The Committee includes an increase of $1 million to expand the surveillance efforts of human prion diseases, including Creutzfeldt-Jakob Disease, through the National Prion Disease Pathology Surveillance Center and the CDC. Monitoring the prevalence of prion diseases, including whether a disease was acquired from animals or other humans, is particularly critical for Chronic Wasting disease (CWD)-endemic areas.

Increasing the appropriation would allow the NPDPSC to meet increasing autopsy costs and continue to develop more efficient detection methods while providing an acceptable level of prion surveillance. Reduction of funding or maintaining static funding to the NPDPSC would eliminate an important safety net to U.S. public health, making the U.S. the only industrialized country lacking prion surveillance, which in turn would jeopardize the export of U.S. beef. The increase in funding would allow the NPDPSC to expand its scope to address the growth in CWD among deer and elk, and explore whether CWD could spread to humans. Additionally, increasing prion disease surveillance in the U.S. would allow increased surveillance at the National (CDC) and state (state public health departments) levels, which has been severely affected by competing concerns within the CDC division (including COVID19).

Background: The NPDPSC is funded entirely by the CDC from funds allocated by Congress. The CDC traditionally keeps approximately half of the appropriation for epidemiologic surveillance projects and funding prion disease surveillance at the state level.

Increasing the appropriation from $7.5M to $8.5M will allow the NPDPSC to persist and continue to develop more efficient detection methods while providing an acceptable level of prion disease surveillance. The requested $1M addition to the appropriation (total of $8.5M) would enable the NPDPSC to maintain appropriate surveillance, tissue collection, diagnostics and diagnostic test development of prion disease cases from CWD endemic States to determine whether CWD is transmissible to humans and if so, what risk this poses to public health (e.g., transmission risks from human to human). Acceptable national surveillance is not possible at a lower level of funding.

The National Prion Disease Pathology Surveillance Center is the only laboratory-based organization in the U.S. that monitors human prion diseases and is able to determine whether a patient acquired the disease through the consumption of prion contaminated beef ("mad cow" disease) or meat from elk and deer affected by CWD.

The NPDPSC also monitors all cases in which a prion disease might have been acquired by infected blood transfusion, from the use of contaminated surgical instruments, or from contaminated human growth hormone. Because standard hospital sterilization procedures do not completely inactivate prions that transmit the disease, these incidents put a number of patients under unnecessary risk and require costly replacement of contaminated surgical equipment.

The NPDPSC also plays a decisive role in resolving suspected cases or clusters of cases of food-acquired and medically transmitted prion disease that are often magnified by the media, stirring intense public alarm. To date, the NPDPSC has examined approximately 8,000 suspected cases of suspected prion disease and has definitely confirmed presence and type of prion disease in more than 5,100 cases.

The NPDPSC is the primary line of defense in safeguarding U.S. public health against prion diseases because the U.S., unlike other BSE affected countries such as the UK, the European Union, and Japan, does not have a sufficiently robust animal prion disease surveillance system.

The NPDPSC offers assurances, to countries that import (or are considering importing) meat from the United States, that the U.S. is free of indigenous human cases of "mad cow" disease. In the past, South Korean and Chinese health officials resumed importation of U.S. beef to their country after a visit to the NPDPSC provided assurances regarding rigorous human prion surveillance.

Since its inception in 1997, the NPDPSC has collected and stored approximately 8,000 brains and many more samples of cerebrospinal fluid from cases of suspected prion disease, making it the largest prion disease biobank in the world. Increased funding is required to continue to preserve these precious specimens for future international research efforts as well as to serve as reference materials to evaluate potential emerging prion diseases (e.g., CWD).

Request #2 Report Language: Creutzfeldt-Jakob Disease.—The Committee encourages NIH to recognize Creutzfeldt-Jakob Disease (CJD) and other prion diseases, which are rapidly progressive and fatal neurodegenerative diseases, as an Alzheimer's Disease and Related Dementia (ADRD). CJD is caused by the abnormal folding of the prion protein in the brain, and closely resembles ADRDs. Enhanced

research of CJD, through the BRAIN Initiative and the Alzheimer's Disease research portfolio, will be valuable to the study of ADRDs and vice versa, and further integration will benefit scientific pursuits in both fields with the goal of new treatments for neurodegenerative diseases.

Background: Some funding for prion disease research comes from the NIH, primarily the NINDS. However, the CJD Foundation, prion disease and other ADRD researchers, and families recognize the need to devote more funds to exploring prion disease, and especially to integrating the scientific discoveries of prion disease into other ADRDs to improve diagnosis, biomarkers, and develop treatments.

There are many similarities between ADRD and prion disease. Primarily, all ADRD are due to an abnormal form of normal cellular protein that causes disease (e.g., a-beta and tau in Alzheimer's disease, alpha-synuclein in Lewy body dementia). These abnormal proteins affect certain areas of the brain causing neurodegeneration and neurocognitive decline. Similarly, prion disease is due to an abnormal form of the normal prion protein. ADRDs have already benefited from prion disease research and will undoubtedly continue to do so. Inclusion of prion disease as an ADRD:

1. Allows ADRD researchers to study the prion paradigm in other related conditions, enabling the use of more valid animal models, as animals naturally develop prion disease but not other neurodegenerative diseases.
2. Allows technologies originally developed for prion disease to be used in other ADRDs without the need for separate funding.
3. Allows potential treatment targets to be expanded across ADRD and prion disease.
4. Allows caregiver and health services research of ADRD to be applied to prion disease.

Thank you for the opportunity to submit this testimony.

[This statement was submitted by Deborah R. Yobs, President/Executive Director, CJD Foundation.]

PREPARED STATEMENT OF CURE ALZHEIMER'S FUND

Chairwoman Baldwin, Ranking Member Capito, and members of the Senate Labor, Health & Human Services, Education, and Related Agencies (LHHSE) Appropriations subcommittee, I am Tim Armour, President, and CEO of Cure Alzheimer's Fund. I want to thank Congress for its ongoing commitment to, and support for, sustained and continued funding for Alzheimer's disease research at the National Institutes of Health (NIH), and to submit this written testimony to respectfully request an investment of at least an additional $321 million in Fiscal Year 2024 above the final enacted amount for Fiscal Year 2023 for Alzheimer's disease research at the NIH.

Cure Alzheimer's Fund is a national nonprofit, based in Massachusetts, that funds research with the highest probability of preventing, slowing, or reversing Alzheimer's disease. Since its founding in 2004, Cure Alzheimer's Fund has invested more than $170 million in research through 712 grants across the United States and internationally.

The commitment of this subcommittee to investing in Alzheimer's disease research at NIH is paying dividends. More is being learned about this complex disease. Disease-modifying treatments are becoming available. Progress is being made. This is a direct result of the Federal investment from this subcommittee. The Federal nexus for this investment is that Alzheimer's disease is a national crisis that impacts all Americans.

Cure Alzheimer's Fund is focused on investing in novel research that is not yet ready for NIH funding. This is often because initial data sets must be compiled. Cure Alzheimer's Fund can make a targeted grant to a researcher for them to generate their initial data, obtain proof of concept, and then be in a position to approach NIH for larger-scale funding, A report by Cure Alzheimer's Fund shows that there is a 7.6X return of investment for every dollar Cure Alzheimer's Fund invested in research in 2018–2020.

Cure Alzheimer's Fund invested $47 million into Alzheimer's disease research in these years, which led to $350 in funding from the NIH for this research. Without the support for Alzheimer's disease research at NIH, this public-private partnership would not be possible. Cure Alzheimer's Fund supported researchers would not be able to turn to NIH for larger-scale funding if NIH was not provided with the necessary resources.

https://curealz.org/reports/2022-report-leverage/.

This public-private partnership is a successful model of funding for Alzheimer's disease research. But, it can only be successful if the public aspect continues to receive the investment necessary for NIH to be able to pursue novel concepts. If Cure Alzheimer's Fund supported researchers cannot turn to NIH for funding after showing the promise of their initial data, then research will stop. Not slow, but stop. This has the potential to reverse the gains that have been made in the last few years; gains that have been made possible by the continuing commitment to providing NIH with the resources it has identified through its "Bypass Budget" as being necessary to fight this awful disease. Resources that are necessary to accept the "hand-off" from private groups such as Cure Alzheimer's Fund.

Cure Alzheimer's Fund has been supporting research into Gamma-Secretase Modulators (GSMs). GSMs are novel agents alter the activity of gamma-secretase by selectively reducing levels of the longer, plaque-forming amyloid beta (Ab42) in favor of the shorter, nontoxic forms. In the lab, the GSM, at low and safe doses, decreased plaque formation and neuroinflammation. The current disease-modifying treatments available now are infusion treatments, whereas, the GSMS will be an oral pill, making it much easier for patients and more cost-effective for the system.

Cure Alzheimer's Fund has been supporting research by Rudy Tanzi at Massachusetts General Hospital/Harvard Medical School and Steve Wagner at the University of California, San Diego (UCSD) since 2011. (Although Dr. Wagner passed away in March of 2022, the research continues at UCSD.) The research into the GSMs received an NIH Blueprint Grant in 2015. And the GSMs are scheduled to enter clinical trials this year. Clinical trials which will be supported by NIH. Clinical trials supported by NIH which are only possible because of the continued commitment from this subcommittee to providing NIH will the necessary resources for it to fight this terrible disease.

https://curealz.org/news-and-events/alzstream-webinar-bringing-gamma-secretase-modulators-to-trials/.

https://curealz.org/news-and-events/gamma-secretase-modulators-for-ad/.

The necessary resources will allow NIH to continue to invest in different areas of research. Areas such as lifestyle changes that can reduce the risk of Alzheimer's disease. Demographic and ethnic and racial impacts on the development of Alzheimer's disease. And the role that the world around us, or exposome, plays in increasing risk for Alzheimer's disease. These are areas in which Cure Alzheimer's Fund has invested, and that I have highlighted in my past written testimony to the subcommittee. And areas in which this subcommittee has expressed interest through its Report Language to the appropriations bills.

Alzheimer's disease is a complex genetic disease, but there are external risk factors that can impact its development. Because of available funding from NIH, Cure Alzheimer's Fund supported researchers have been able to receive larger-scale funding for their research into the factors. The National Plan as part of the National Alzheimer's Project Act has added a sixth goal of "prevention.' Although genetics and aging are the main risk factor in developing Alzheimer's disease, recent research has shown how lifestyle changes can modify external risk.

https://curealz.org/news-and-events/the-innate-immune-protection-hypothesis-of-alzheimers-disease/.

https://curealz.org/news-and-events/rudy-tanzi-ph-d-shield-model-to-reduce-risk-of-alzheimers-disease/.

This subcommittee has included report language to explore the impact of the exposome on the development of Alzheimer's disease. This is research that Cure Alzheimer's fund has been supporting since 2014. Cure Alzheimer's Fund has supported research by Dr. Caleb Finch into the role pollution and particulate matter play in the development of Alzheimer's disease.

https://curealz.org/research/translational-research/air-pollution-and-app-processing/.

We know that there are racial differences in the risk of developing Alzheimer's disease. But studies have been limited by small sample sizes. Cure Alzheimer's Fund is supporting a collaboration between Washington University in St. Louis and Emory University to share research to increase the sample size. This research is being conducted at the two Alzheimer's Disease Research Centers at these institutions: research centers supported by NIH.

https://curealz.org/research/foundational/biomarkers-diagnostics-studies-of-risk-resilience/characterization-of-alzheimers-disease-molecular-biomarker-profiles-throughout-the-pathobiological-continuum-2/.

Novel research such as this is only possible because of the commitment of this subcommittee. Your past support has answered important questions, while also raising new ones. Now is not the time to lessen this commitment and turn back vital research.

So much is being learned, but so much more needs to be learned. And public-private partnerships such as the one between Cure Alzheimer's Fund and NIH are leading the way. But, this partnership is only possible because NIH has the necessary resources to invest in the best science. It is an important time for this subcommittee to again demonstrate its commitment to providing NIH will vital funding to combat Alzheimer's disease.

Thank you for your continued support of Alzheimer's disease research, and for the opportunity to submit this written testimony and to respectfully request at least an additional $321 million above the final enacted level in Fiscal Year 2023 for Fiscal Year 2024 for Alzheimer's disease research at NIH. Cure Alzheimer's Fund has worked closely with the subcommittee in the past and looks forward to being your partner as we work toward Alzheimer's disease research having the necessary resources to end this awful disease.

Respectfully Submitted May 18, 2023.

[This statement was submitted by Timothy Armour, President and CEO, Cure Alzheimer's Fund.]

PREPARED STATEMENT OF DATA QUALITY CAMPAIGN

The Data Quality Campaign is the Nation's leading voice on education data policy and use. We envision a world where data is used to drive systemic change, economic mobility, and student success. To make this a reality, DQC works to modernize statewide longitudinal data systems (SLDS) that connect preschool through workforce data (P–20W data) to better serve data users—individuals, the public, and system leaders—so they have the information they need to foster successful journeys through education and the workforce.

DQC recommends the subcommittee provide at least $100 million in funding for the Statewide Longitudinal Data Systems (SLDS) program and $40 million in funding for the Workforce Data Quality Initiative (WDQI) grant program for fiscal year 2024.

Data systems are an indispensable tool for making informed decisions about priorities within communities, and existing State data systems are ill-equipped to address the complex and intertwined challenges that have emerged as a result of a multi-year pandemic. States need Federal support to evolve their data systems with a focus on access and use and support responsive policymaking. Currently the best mechanism for providing Federal financial support to meet these goals is bolstering funding through the SLDS and WDQI grant programs.

SLDS and WDQI grants, and related agency technical assistance, support state policymakers, practitioners, individuals, and other stakeholders responsible for improving data collection and use. Since their creation, the SLDS and WDQI grant programs have helped States establish longitudinal data systems that provide families, students, educators, workforce leaders, and other officials with better, more timely data while protecting that data. These data systems help policymakers and practitioners answer questions about program outcomes and make key information transparent to families, students, and the public. They also support program evaluations and studies that examine long-term learning and other trends and identify opportunity gaps.

Unfortunately, many data systems are outdated, siloed, and under equipped to meet current needs. For example, according to a recent report from the U.S. Department of Education, just 31 percent of SLDS States and territories surveyed reported that K–12 student data was linked to workforce data.[1] Only 53 and 51 percent reported linkages to early childhood and postsecondary data, respectively. And the linkages that exist represent the most basic and rudimentary of data linkages, almost all are incapable of delivering data that is high quality, timely, and actionable such that it meets today's policy and practice needs.

States and localities need Federal support to update critical data infrastructure so it evolves to support nimble decisionmaking and drive positive impacts for individuals and communities. Updating state data systems and programs—from early childhood through the workforce—will enable them to be more effective, accountable, and efficient including by:

—Assisting parents in enrolling their children in early learning programs to boost kindergarten readiness rates and enable parents to return to work.

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[1] U.S. Department of Education. National Center for Education Statistics. Profile of State Data Capacity in 2018: Statewide Longitudinal Data Systems (SLDS) Survey Descriptive Statistics. https://nces.ed.gov/Pubs2021/2021126/.

—Connecting students and families to wrap-around services designed to accelerate learning loss exacerbated by the pandemic.
—Auto-admitting eligible high school students into college to reverse major postsecondary enrollment declines.
—Providing a more complete picture of the value of postsecondary pathways so students and job seekers can make informed decisions about which education and career pathways are right for them, and policymakers can identify which approaches are effective or not.
—Identifying unemployed or underemployed workers who are eligible for Pell Grants or other sources of financial aid to support enrollment in postsecondary education or training to reskill and upskill for new careers.

An increased investment in these programs—$100 million for SLDS and $40 million for WDQI—would enable planning for the next evolution of state data systems; support updates to data system technology; build stronger data linkages between early learning, elementary and secondary, and postsecondary education, workforce, health, and other data systems; support the human capacity needed to use and manage the information effectively and securely; publish better quality data about individual and program performance along the education-to-workforce pipeline; and support the creation of research-practice partnerships. Investing in data infrastructure will, most importantly, provide State and local leaders the ability to better serve their communities. This increased investment should also accompany report language that clarifies what existing Federal funding streams can improve data capacity and infrastructure to maximize support for system upgrades and expansions.

Modernizing state data systems to meet these needs requires robust data governance, privacy, and security. Joint privacy guidance for SLDS and WDQI grantees will help them develop effective, integrated data systems and the policies and procedures that safeguard data in line with existing privacy laws. Federal agencies also should provide the technical assistance States need to ensure robust privacy and transparency safeguards are in place.

Specifically, to address existing confusion about the patchwork of privacy laws and infrastructure funding streams, DQC requests the subcommittee consider the following bill and report language for Fiscal Year 2024:

PROPOSED BILL LANGUAGE FOR FISCAL YEAR 2024

Department of Education, Institute of Education Sciences

—*Statewide Longitudinal Data Systems*.—The Committee includes $100,000,000 for State Longitudinal Data Systems (SLDS) for competitive grants to support the development, maintenance, and expansions of State longitudinal data systems. Increased support for the SLDS program will further strengthen State data infrastructure and linkages, contribute to improved data access and use for evidence-based policymaking, and build capacity in States to secure and protect data.

Department of Labor, Employment and Training Administration

—*Workforce Data Quality Initiative*.—The Committee has included $40,000,000 for the Workforce Data Quality Initiative to support competitive grants to develop and enhance longitudinal data systems that integrate education and workforce data. This initiative will help build State and local capacity to track employment and educational outcomes of Workforce Innovation & Opportunity Act (WIOA) program participants, including those with disabilities, and provide information about job success rates and training programs.

PROPOSED REPORT LANGUAGE FOR FISCAL YEAR 2024

Department of Education

—*Strengthening Data Capacity and Infrastructure*.—The Committee directs the Secretary to clarify for eligible grantees that improving data capacity, including integrated data infrastructure, analysis activities, and human capacity, is a permissible use of grant funds in accordance with the Foundations for Evidence-based Policymaking Act and OMB's implementing guidance. Further, the Secretary should provide technical assistance, highlight best practices, and take other steps to encourage State and local grantees to build this capacity, which is essential to understanding student needs, improving coordination across programs, measuring results, and evaluating which strategies and interventions are most effective while maintaining the privacy of individuals' data.
—*Strengthening Data Privacy*.—The Committee directs the Secretary in conjunction with the Secretary of Labor to provide guidance and technical assistance on integrated data systems and student and worker privacy. This guidance

should build on and expand the guidance issued by the Privacy Technical Assistance Center in January 2017 (PTAC–IB–4).

Thank you for your consideration of DQC's FY24 appropriations requests. We look forward to working with the subcommittee and your colleagues in the 118th Congress to make this vision a success.

[This statement was submitted by Jennifer Bell-Ellwanger, President and CEO, Data Quality Campaign.]

PREPARED STATEMENT OF DATA SCIENCE 4 EVERYONE

Honorable Members of the U.S. Senate Appropriations Committee,

As the Director of State Policy for Data Science 4 Everyone, I strongly advocate for increased funding to support K–12 data science education and literacy, as highlighted in this written testimony. Our organization is committed to promoting data science education for all, regardless of age, background, or experience level, as we believe that data science literacy is essential for empowering individuals to make informed decisions and address complex problems in their personal and professional lives.

The need for data science education and literacy in K–12 has never been more critical than it is today. With the exponential growth of data and technology, the ability to understand and analyze data is essential for success in almost every field. Yet, many individuals lack the skills and knowledge necessary to leverage data effectively. This knowledge gap can lead to missed opportunities, incorrect decisions, and even harm. According to the National Assessment of Educational Progress (NAEP) 2021 results, "overall, student achievement in mathematics decreased in 2021 compared to 2019, with the largest declines seen at grades 5 and 8." (National Center for Education Statistics, 2021) This significant drop in achievement has implications for future success, and it is essential to invest in education that prepares students for the demands of the modern workforce. The COVID–19 pandemic has exacerbated the issue of learning loss, with "an estimated 12 to 16 months of learning loss in mathematics for students" due to school closures and disruptions to traditional learning environments. (Data Science 4 Everyone, 2021) Investing in K–12 data science education and literacy can help address this problem by equipping students with essential skills to succeed in the data-driven economy.

Data Science 4 Everyone is dedicated to bridging this gap and making data science education accessible to everyone. We work to support innovative and effective data science curricula, training programs, and tools that can be used in a variety of settings. Our programs are designed to be inclusive, interactive, and engaging, and they have been proven to be effective in increasing data literacy and analytical skills.

We strongly believe that the Federal Government has an essential role to play in supporting K–12 data science education and literacy. The U.S. government can help to provide the resources necessary to expand access to data science education and ensure that everyone has the skills necessary to participate in the data-driven economy. By investing in data science education, the Federal Government can help to create a more informed and empowered citizenry, promote economic growth, and support innovation.

Increased funding opportunities can build on data science and data literacy education for students, schools, and States in a variety of ways. First and foremost, additional funding will allow us to provide more support and resources to educational institutions to create and sustain K–12 data science programs. This includes offering professional development opportunities for K–12 educators, providing access to the latest tools and technologies, and supporting the development of data-driven curricula that align with current industry practices (National Science Foundation, 2021). Increased funding can also help us expand our efforts to make K–12 data science education accessible to underserved and underrepresented communities, ensuring that everyone has an equal opportunity to learn and thrive in the data-driven economy. Furthermore, increased funding can enable us to create more partnerships with State education agencies and local communities to address specific data literacy needs and gaps, ensuring that data science education is tailored to the unique needs of each region. All of these efforts will require additional research to transition data science programs from pilots to scale. This includes new assessment tools, software programs for the classroom, and other critical research and development efforts. The appropriations we requested are a $60M split between Institute of Education Sciences (IES) Research, National Science Foundation (NSF) Research, and Teacher-Quality Partnerships (TQP). Increased funding opportunities will be a vital catalyst for building a strong foundation of data science education and literacy

for K–12 students, schools, and States, ensuring that we can meet the demands of the rapidly changing technological landscape.

Furthermore, increased funding can enable us to create more partnerships with State education agencies and local communities to address specific data literacy needs and gaps, ensuring that data science education is tailored to the unique needs of each region. Increased funding opportunities will be a vital catalyst for building a strong foundation of data science education and literacy for K–12 students, schools, and States, ensuring that we can meet the demands of the rapidly changing technological landscape.

In conclusion, we urge the U.S. Senate Appropriations Committee to support increased funding for K–12 data science education and literacy. We believe that this investment will have a significant positive impact on the lives of individuals, businesses, and communities across the country. Thank you for your time and consideration.

Citations:

Data Science 4 Everyone. (2021). Investing in K–12 Data Science Education and Literacy: A Proposal for the 2024 Fiscal Year Appropriations. Retrieved from https://www.datascience4everyone.org/—files/ugd/69648a__c7279fff4b6e410ca553e149295c1b79.pdf.

National Center for Education Statistics. (2021). National Assessment of Educational Progress (NAEP) 2021 Results. Retrieved from https://nces.ed.gov/nationsreportcard/subject/publications/main2021/pdf/2022451.pdf.

National Science Foundation. (2021). Improving undergraduate STEM education. https://www.nsf.gov/funding/pgm__summ.jsp?pims__id=504976.

[This statement was submitted by Samantha Leav, Director of State Policy for Data Science 4 Everyone.]

PREPARED STATEMENT OF DAVE PURCHASE PROJECT

My name is Dr. Paul LaKosky and I serve as the Executive Director of Dave Purchase Project, the North American Syringe Exchange Network (NASEN), and the Tacoma Needle Exchange in Tacoma, Washington. I am pleased to submit testimony on behalf of these organizations and as a member of a large coalition of public health, HIV, viral hepatitis, and harm reduction organizations to urge Congress to appropriate $150 million for the Infectious Diseases and the Opioid Epidemic program at the Centers for Disease Control and Prevention (CDC) at the Department of Health and Human Services (HHS) to save lives and address the overdose crisis by supporting and expanding access to syringe services programs (SSPs).

Named in honor of its late, pioneering founder, Dave Purchase, Dave Purchase Project houses the Nation's first legal syringe services program, created in 1988 at the height of the HIV epidemic in the United States. The program seeks to stop the spread of bloodborne pathogens, such as HIV and hepatitis C, among people who use drugs and to reduce the harm to individuals and communities associated with drug use. Although initially intended to address the spread of HIV, Dave Purchase Project now provides national leadership in its response to the opioid crisis. It also facilitates syringe services in Tacoma and throughout Pierce County, Washington.

Dave Purchase Project also houses the North American Syringe Exchange Network (NASEN). In 1992, NASEN formed to support syringe services programs (SSPs) and to expand the network of organizations and individuals that advocate for these life-saving programs. NASEN is the first and largest supplier of low-cost harm reduction resources in the US. In 2022, NASEN acquired and distributed approximately $12.5 million in harm reduction resources to the approximately 500 SSPs in the US, Puerto Rico, and the US Virgin Islands. NASEN also provided support valued at $30,000 to 25 newly emerging and/or struggling SSPs through start-up grant packages. As the Executive Director of these organizations, I am familiar with providing direct services to people who use drugs in Washington State, and with the significant gaps and need for resources and services nationwide.

The United States continues to experience a public health emergency related to overdose, with over 106,000 overdose deaths counted between November 2020 and November 2021 and deaths increasing by an alarming 45% since January 2020. According to provisional CDC data, overdose deaths continue to accelerate in Washington, increasing by 28% in the latter half of 2021.

Overdose deaths have increased more dramatically among Black people and communities of color. In 2020, Black people had the largest percentage increase in overdose mortality—48.8%. The Hispanic or Latino community experienced a 40.1% increase in overdose deaths as compared to white people who experienced a 26.3% in-

crease. American Indians and Alaska Natives experienced the highest rate of overdose mortality of all ethnic groups in 2020, a mortality rate 30.8% higher than that of white people.

SSPs are an essential component of preventing overdose deaths. Tacoma Needle Exchange provides sterile syringes, which helps prevent the spread of infectious diseases such as HIV, as well as services such as opioid overdose prevention and awareness training, naloxone training and distribution, wound care, and referrals for medication assisted treatment and other medical and social services. Our outreach staff meets people where they are and helps them address their needs in the safest and healthiest way possible, free of judgment and stigma.

The following is but one example of what we do, and why we do it. In 2020 and 2021, in response to the housing crisis, we increased our outreach to individuals living houseless in encampments in Pierce County, WA. One of our outreach workers was able to connect to a disabled veteran who was experiencing active addiction and had been living houseless for several years. He was in rough shape as a result of an assault and had open, infected, wounds that required immediate attention. Our outreach worker cleaned and dressed the wounds and was subsequently able to get this individual a new tent in a safe location. He then referred the individual to our peer care navigator who was able to get the individual into medically assisted treatment for his opioid use disorder. The navigator was also able to secure a place to live for this individual in a tiny home village for veterans.

SSPs are the most effective way to get naloxone into the hands of people who use drugs and who are most likely to be at the scene of an overdose. From 2016–2022, our team distributed approximately 35,000 doses of naloxone and 3000 overdose reversals were reported back to us (and many more occurred that went unreported). People who use drugs are essential partners in preventing overdose fatalities and are best reached by SSPs. In fact, more than 99% of the reported overdose reversals were performed by community members—other drug users, family members, friends, bystanders—and not by first responders. With additional resources, SSPs could reach more people with naloxone, which would help reduce the dramatically increasing number of overdose deaths.

Congress must respond to the overdose crisis, as well as work to prevent and reduce infectious diseases related to drug use, such as HIV and hepatitis C, by supporting and expanding access to SSPs. Infectious diseases associated with opioid and other drug use have dramatically increased across the U.S. Since 2010, the number of new hepatitis C infections has increased by 380%. Outbreaks of viral hepatitis and HIV among people who inject drugs continue to occur nationwide. The CDC has documented over 30 years of studies that show that SSPs reduce overdose deaths and infectious diseases transmission rates as well as increase the number of individuals entering substance use disorder treatment. These studies also confirm that SSPs do not increase illicit drug use or crime and save money.

SSPs are among the only health care services trusted and used by people who use drugs and so can effectively engage this highly stigmatized population. SSPs help protect the community (including first responders) by ensuring safe disposal of syringes, reducing rates of infectious diseases, and can help by providing a pathway to effective mental health and substance use treatment and other medical care.

Unfortunately, the Nation has insufficient access to SSPs and the COVID–19 pandemic has decreased access to these life-saving services when the need for services has increased dramatically. NASEN's March 2020 survey of 173 SSPs—almost 40% of SSPs nationwide—showed a 43% decrease in SSP services as a result of COVID–19. A similar Drug Policy Alliance survey showed that 91% of respondents experienced an increase in clients in 2020. Funding shortfalls and increased need for services have persisted into 2022. As a result of increasing need coupled with decreased, limited resources, SSPs cannot reach the millions of people who could benefit from their life-saving services, including overdose prevention and access to critical health care.

Federal funding would expand access to critical and effective SSP programs. NASEN's own data show that there are only approximately 400–600 SSPs operating nationwide. The United States could easily use as many as 4000 programs—7–10 times the number in existence now. NASEN routinely provides program support packages with essential harm reduction supplies to organizations wishing to start SSPs. We consistently have a wait list of 25–30 organizations seeking assistance, no matter how many support packages we distribute.

A study that assessed the startup costs of an individual program estimated that it would cost (in 2020 dollars) $490,000 for a small rural program and $2.1 million for a large urban program, resulting in an average start-up cost of $1.3 million per program. Based on these numbers, the requested funding could provide modest in-

creases to currently operating SSPs to help address funding shortfalls and help expand the number of SSPs nationwide.

Finally, expanding access to SSPs would reduce health care costs, including for infectious diseases treatment. Hepatitis C treatment can cost more than $30,000 per person, while HIV treatment can cost upwards of $560,000 per person. Averting even a small number of cases would save millions of dollars in treatment costs in a single year.

The Infectious Diseases and Opioid Epidemic Program at CDC helps to eliminate infections related to injection drug-use and improve their prevention, surveillance, and treatment. It also strengthens and expands access to SSPs. In FY2021, CDC provided technical assistance to help ensure high-quality, comprehensive services and best practices for SSPs.

If Congress were to provide $150 million in FY23 funding, CDC could significantly expand SSPs at this critical time to help prevent overdose deaths, the spread of HIV and viral hepatitis, and connect people to life-saving medical care. It is urgent that Congress respond now and forcefully to this crisis or more lives will be lost to overdose and countless people will continue to contract infectious diseases that seriously compromise their personal health as well as the public health, creating long-term costs for all.

I speak to you as a public health researcher and SSP supporter and provider, but also—and more importantly—as the older brother of someone who has struggled with addiction his entire adult life. However, in January 2022, after many months of transient homelessness and estrangement from my family, he entered a residential treatment facility for his substance use disorder. He stated he was tired of the isolation, the homelessness, and the constant feeling that he was vulnerable and worthless. Mostly, he said, "I miss the family." This is not the first time he has been in treatment—and likely not the last. But with the support he receives from his treatment team, his recovery community, and my family, we see improvements in his personality and his outlook on life.

Thank you for your time and consideration of my testimony. Please do not hesitate to contact me, Jenny Collier at jcollier@colliercollective.org, or Bill McColl at bmccoll@colliercollective.org if you have questions or need additional information.

[This statement was submitted by Paul LaKosky, Ph.D., Executive Director, Dave Purchase Project.]

PREPARED STATEMENT OF THE DIGESTIVE DISEASE NATIONAL COALITION

SUMMARY OF FISCAL YEAR 2024 APPROPRIATIONS RECOMMENDATIONS

—Provide the National Institutes of Health (NIH) with at least $51 billion, a 7.3% increase over FY 2023

—$2.6 billion (7.3% increase) for the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) with an increased emphasis on nutritional research and functional GI disorders such as gastroparesis

—Provide an aggressive implementation of the National Cancer Moonshot and ARPA–H

—Provide funding increases for the Department of Defense (DoD) Peer-Reviewed Medical Research Program

  —Inclusion of Gulf War Illness, Food Allergies, Hepatitis B, Inflammatory Bowel Diseases, and Pancreatitis

—Funding increases for the Department of Defense Peer-Reviewed Cancer Program

  —Continued inclusion of Pancreatic Cancer, Colorectal Cancer, Liver Cancer, and Stomach Cancer

—Provide funding increases for the Department of Veterans Affairs Medical and Prosthetics Research Program with an ongoing emphasis on Gulf War Illness and functional GI disorders.

—Provide $117.5 million in funding for the Centers for Disease Control and Prevention (CDC).

—$50 million for CDC's Colorectal Cancer Prevention Program

—$60 million for CDC's Division of Viral Hepatitis

—$1.5 million for CDC's Inflammatory Bowel Diseases (IBD) program

—$6 million for the CDC's Chronic Disease Education and Awareness (CDEA) program

Thank you for the opportunity to present testimony on behalf of the Digestive Disease National Coalition and to share the experiences of the digestive diseases community. Chairwoman Baldwin, Ranking Member Capito, and distinguished subcommittee members, thank you for continuing to invest in medical research and public health programs through the FY 2023 omnibus appropriations package. Recent years of funding increases have led to notable advances in digestive disease research and new opportunities for meaningful public health collaborations. As you work with your colleagues on FY 2024 appropriations, please maintain this momentum and the commitment to increase funding for medical research and public health programs that serve digestive disease patients and raise awareness of the wide-ranging impacts on affected individuals and their families.

About the Digestive Disease National Coalition.—The Digestive Disease National Coalition (DDNC) is an advocacy organization comprised of the major national voluntary and professional societies concerned with digestive diseases. The DDNC focuses on improving public policy and increasing public awareness of diseases of the digestive system. Our mission is to work cooperatively to improve access to and the quality of digestive disease health care to promote the best possible medical outcome and quality of life for current and future patients. Digestive diseases are disorders of the digestive tract, which include the esophagus, stomach, small and large intestines, liver, pancreas, and gallbladder. Some of these diseases are classified as acute, as they occur over a short period, while others are chronic, life-long conditions. 60 to 70 million Americans are affected by these diseases, accounting for 21.7 million hospitalizations and $141.8 billion in health care costs.

Patient Stories—

Ellyn Mantell: Ostomy Patient Advocate

As a national ostomy advocate, support group leader, and mentor, Ellyn Mantell has heard countless times that "ostomy is a lifesaver!" And it is! She has survived 23 abdominal surgeries over 23 years, innumerable hospitalizations and Emergency Room visits, infections, PICC line installations, and peritonitis, she can say unequivocally, that her Ileostomy not only saved her life, but it also actually gave her a life. She had lost all hope of any control over the plans she had made, the places she wanted to visit, and the family she wanted to hold and love. Each morning began with the question: will she be in the Emergency Room or the Operating Room today? Every few weeks, one of those rooms was where she found herself.

Born with a megacolon, exacerbated by a connective tissue disorder, caused a lifetime of digestive and excretory issues and complications. Her first barium enema was at 9 years old. Unfortunately, there was no guidance or research on dysmotility and she felt ashamed and misunderstood by every medical person who treated her. She was depressed and humiliated. Additionally, there was no awareness that what should be a normal bodily function simply wasn't for her, and, along the way, she learned, many others. she believes that until digestive diseases are recognized, understood, and treated with positivity, countless will continue to suffer. Funding needs to be made available for more research, education, and awareness of all digestive diseases!

Sadly, over the years, she has heard of many who have stated: "They would rather die than live with an ostomy." And many have died. The stigma, carried out in the media and films, reinforces that those of us are less than others because we have an ostomy. What should be known is that they are strong and empowered by their new anatomy. My goal is to make "OSTOMY" A HOUSEHOLD WORD! She believes with your help, financial support, and strong voices, we will accomplish that...and all will know how fortunate we are.

The United States must keep advancing treatments for digestive diseases and improving medical technology and devices to treat these medical conditions to achieve the best quality of life.

In closing, she wishes to thank you for considering her testimony. She had had the privilege of meeting with Congressional aids through the Digestive Disease National Coalition. There is so much more to be done. Please support robust funding for digestive research and public health programs at NIH, DOD, VA, and CDC. Thank you.

[This statement was submitted by Jeanine Gleba, DDNC, Chairperson and Dr. Caroll Koscheski, MD DDNC, President, Digestive Disease National Coalition.]

PREPARED STATEMENT OF AMARA DOWDELL

When entering college, I had no clue what the Ronald E. McNair Postbaccalaureate Achievement Program was. I knew about medical and nursing school but not about graduate school and earning a Ph.D. As an underrepresented student, I needed to learn the many paths and options I could take while majoring in a STEM field. Before college, obtaining a Ph.D. was never an option for me, but thanks to the McNair Program, now it is.

Becoming a part of the McNair program was among the most significant decisions I have made in my college career at Florida International University. This program has provided me with professional development workshops, research opportunities, and the ability to attend conferences and visit graduate schools. Through mentorship, my college experience has improved tremendously.

I have received tremendous support and encouragement from the McNair staff at FIU. Participating in the McNair Program has given me the confidence and skills to become a competitive applicant. In the coming year, I will be applying to graduate school. I cannot wait to begin obtaining a Ph.D. in Immunology.

PREPARED STATEMENT OF DR. SHATOYA BLACK

I was born and raised in Chicago to a single mother of six children, and I was the oldest. My parents were 13 and 14 years old when I was born, and my mother worked hard to obtain a high school diploma, which she accomplished as a young mother. Her mother only completed the eighth grade and attempted to get a GED later but could not pass the writing portion.

Our family mantra was "Black Family Strong: Bend, but Do Not Break." The responsibilities of raising my siblings at a young age to support my mother seemed unfair as a child. Then, I got old enough to understand the impact of the lack of support from our fathers, both physically and financially. I learned early on what it meant to work hard and sacrifice selflessly.

I started working at 16 and had my daughter at 19 years old, which motivated me more because I was determined not to be a statistic. I began to imagine there was better to obtain in life but did not know what it looked like outside of generational societal norms that chase us down as options. I declared that "I am not a statistic," from there, it seemed like the path was no longer clear since I decided to do something different than the norm in our community.

Going to school was never a part of that option or the plan. I desired to start my community multiple-purpose center and had the resilience and grit to do what it took to figure out a pathway to success. The odds were against me, but my destiny was calling, and TRIO helped me determine the path.

In 2008, I was working at a bank and needed surgery to remove cancer cells, but at that time, I did not have the job benefits to take time off. The job still agreed to support me but, in the end, did not follow through with what they promised, causing me to lose the financial support to take care of myself. When it was time for them to speak up about my sickness, they indicated not being aware of my illness, and that is when my life changed drastically. At the end of 2009, I found a place to stay in Dekalb, Illinois, but I did not want to leave my family. Although uncertain, disappointed, and overwhelmed, I took the apartment in Dekalb to give my daughter and me a fresh start.

I still had the same goal of finishing my certificate at the community college. However, I realized that the course offerings depended on geographic location, so all options differed. Navigating college as a first-generation student and single mother was so overwhelming. I was so overwhelmed with all that was going on in my life, and college felt like an added stressor until I became a part of TRIO.

I participated in TRIO Student Support Service while pursuing my bachelor's degree at Northern Illinois University. One of the students I knew encouraged me to apply for the program after taking me to visit the TRIO office. After being accepted and assigned a counselor, being in TRIO became a breath of fresh air for me.

TRIO programs and services provide holistic support and leadership that have yielded many opportunities for me to see my education journey from a different perspective. They opened doors and created doors of opportunities that challenged me outside of my comfort zone. TRIO advisors provided consistency and insight that allowed me academic and personal direction, assisting in trailblazing a path for myself beyond the limitation that society put on our abilities to excel.

As a single mother, I wanted to break generational curses and ensure I was present for my daughter. TRIO provided a space for us called College Parents Group to ensure we had support from a community that understood the extra steps we took as parents to be successful without neglecting our responsibilities. We had indi-

vidualized attention, but most importantly, they genuinely cared about our well-being as students. Every service, opportunity, program, and meeting provided space to grow beyond having college access. They demonstrated how to prepare for life after college because first-generation college students become first-generation professionals.

Each timeframe below represents life-changing milestones and holds a story of opportunity and access that connects me to TRIO's legacy.

—2011: I graduated with my associate degree from Kishwaukee College
—2013: I Graduated with my bachelor's from Northern Illinois University and participated in TRIO.
—2015: I graduated with my master's degree from Northern Illinois University
—2016: I began working as an academic advisor and coach for TRIO at Rock Valley College.
—2019: I began implementing TRIO retention and completion strategies for the entire college.
—2019: I became the project director of a TRIO program at Illinois State University.
—2020: I earned my Doctorate.
—2021: I created the First-Generation Triumph podcast.
—2022: I became president of the Illinois TRIO state association.

TRIO changed the trajectory of my life as an adult student in college and still has a lasting impact as a first-generation professional. The work done for decades with grass root efforts is unmatched because, for decades, TRIO understood our value before serving this population of students became a popular thing to do. TRIO works, and the legacy is rich with people who find joy in the work for the students and professionals.

I am honored that I now get to pay it forward by providing intentional and impactful opportunities/services for the TRIO students I serve at Illinois State University. It is not just about TRIO's local work but also on state, regional, and national levels while providing continued training to develop emerging leaders. My story continues with my ability to pay it forward, but it could not have started without TRIO.

PREPARED STATEMENT OF DUKE HEALTH

Duke Health (the conceptual integration of the Duke University Health System, the schools of Medicine and Nursing, and other health and health research centers across Duke University) would like to express appreciation for Federal support provided to academic health centers across the United States. The multi-year COVID–19 public health emergency and ongoing challenges facing the healthcare workforce have illustrated how critical the investments from this subcommittee are for strengthening healthcare infrastructure in the United States to accelerate research and provide high-quality care to patients at all times.

Duke Health is committed to conducting innovative basic and clinical research, rapidly translating breakthrough discoveries to patient care and population health, providing a unique educational experience to future clinical and scientific leaders, improving the health of populations, and actively seeking policy and intervention-based solutions to complex global health challenges. Reflecting Duke Health's mission of "Advancing Health Together," this written testimony outlines Duke Health's biomedical research and healthcare priorities that represent sound investments in vital programs at HHS that make a difference in the lives of patients across the United States. Thank you for this opportunity to submit written testimony.

NATIONAL INSTITUTES OF HEALTH (NIH)

Duke Health is grateful for Congress' robust investments in NIH, which has allowed the United States to be on the cutting edge of new biomedical advances. In fiscal year (FY) 2024, Duke Health requests a program level of at least $50.924 billion for NIH's foundational work, an increase of $3.465 billion above the comparable FY 2023 program level, which would allow NIH's base budget to keep pace with the biomedical research and development price index (BRDPI) and allow meaningful growth of 5%.

Duke Health strongly urges lawmakers to ensure that any funding for the new Advanced Research Projects Agency for Health (ARPA–H) supplements our recommendation for NIH's base budget, rather than supplant the essential foundational investment in the NIH.

Racial and ethnic minorities continue to be underrepresented in clinical research, contributing to the existing disparities in our healthcare system. We urge the Com-

mittee to encourage NCATS to ensure the UNITE initiative is reflected in its funded programs and activities.

Duke Health appreciates the inclusion of $52 million in the FY 2023 Consolidated Appropriations Act (Public Law 117–328) for the National Institute of Allergy and Infectious Disease to support Regional Biocontainment Laboratories (RBLs) for research, operation support, and training new researchers in biosafety-level (BSL) 3 practices. Continued Federal investment in the RBLs will strengthen the Nation's research on biodefense and emerging infectious disease agents and improve our response to future public health emergencies. For FY 2024, Duke Health respectfully requests $52 million to be shared among the 12 research institutions to conduct research on developing tests for new antiviral compounds, vaccines, and point of care tests; support operations costs and purchase of equipment to keep the laboratories up to date and safe; and support personnel trained in biosafety level 3 and 2 practices to ensure the highest level of expertise is brought to bear on these research needs that are critical for the security of the U.S.

Finally, Duke Health asks the subcommittee not to include language that would limit the use of nonhuman primates in research, which could cripple the search for treatments and cures for many human diseases, especially therapeutics and vaccines for current and future global disease threats.

CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC)

The CDC serves as the command center for the Nation's public health defense system against emerging and reemerging infectious diseases. Now, more than ever, investments in the Nation's public health infrastructure and public health defense systems are critical. Duke Health urges the subcommittee to provide no less than $11.581 billion for the CDC in FY 2024. Within the CDC, Duke Health also requests the Committee consider including $10 million for the Sickle Cell Disease (SCD) surveillance program within the National Center for Birth Defects and Developmental Disabilities' Blood Disorder Division. Additional Federal funding for CDC's SCD Data Collection Program is necessary to allow the program to be expanded to include additional States with the goal of covering the majority of the U.S. SCD population over the next 5 years.

NIH AND CDC FIREARM VIOLENCE RESEARCH

Duke Health is grateful for investments from Congress to support firearm violence research. As outlined in the FY 2024 NIH Budget Justification to Congress, violence is a widespread public health problem that has profound impacts on lifelong health, opportunity, and well-being. Duke Health asks the Committee to consider $35 million for the CDC and $25 million for the NIH to conduct public health research into firearm morbidity and mortality prevention. We also encourage Congress to explore opportunities for building out and further supporting this research at all other appropriate agencies, to ensure that federally funded research can explore the full scope of this public health issue.

HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)

Duke Health appreciates the subcommittee's continued investment in Title VII health professions training programs and Title VIII Nursing Workforce Development programs at HRSA. These programs help ensure a well-trained pipeline of health professionals to meet growing healthcare delivery needs facing the United States. These programs also increase the diversity and cultural competency of our Nation's healthcare workforce, which is increasingly important as the U.S. population ages and becomes more diverse. For FY 2024, Duke Health respectfully requests that the subcommittee provide $980 million to Title VII health professions programs, and $530 million to Title VIII Nursing Workforce Development programs. Title VII and Title VIII are the only Federal programs that support education/training opportunities for an array of aspiring and practicing health professionals, both facilitating career opportunities and bringing healthcare services to rural and underserved communities.

Duke Health also supports programs to address clinician well-being, as authorized under Title VII and established in the recently enacted Dr. Lorna Breen Health Care Provider Protection Act, and urges Congress to provide additional funding for these activities.

Duke Health urges the subcommittee to provide $24 million in FY 2024 for the National Cord Blood Inventory (NCBI) at HRSA. This program is charged with building a genetically and ethnically diverse inventory of at least 150,000 new units of high-quality umbilical cord blood for transplantation. These cord blood units, as well as other units in the inventories of participating cord blood banks, are made

available to physicians and patients for blood stem cell transplants through the C.W. Bill Young Cell Transplantation Program. Cord blood banks participating in the NCBI Program, including the Carolinas Cord Blood Bank in the Duke University School of Medicine, also make cord blood units available for preclinical and clinical research focusing on cord blood stem cell biology and the use of cord blood stem cells for human transplantation and cellular therapies.

Blood stem cell transplantation is potentially a curative therapy for many individuals with leukemia and other life-threatening blood and genetic disorders. Each year, nearly 18,000 people in the U.S. are diagnosed with illnesses for which blood stem cell transplantation from a matched donor is their best treatment option. Often, the first-choice donor is a sibling, but only 30 percent of people have a fully tissue-matched brother or sister. For the other 70 percent, a search for a matched unrelated adult donor or a matched umbilical cord blood unit must be performed. Umbilical cord blood units have the advantage of use without full matching which specifically meets the needs of patients of non-Caucasian ancestry. These patients have the lowest chance of finding a complete match, but can still have access to transplantation therapy using a partially matched banked umbilical cord blood donor unit.

Duke Health respectfully requests the subcommittee provide $35 million for the C.W. Bill Young Cell Transplantation Program through the NCBI at HRSA in FY 2024. The Carolinas Cord Blood Bank (CCCB) at Duke is a member bank of the NCBI of the C.W. Bill Young Cell Transplantation Program. The goal of this program is to increase the number of transplants for recipients suitably matched to biologically unrelated donors of bone marrow and umbilical cord blood. The CCBB is one of the largest cord blood banks in the world. Cord blood units that are banked at CCBB are listed on the National Marrow Donor Program (NMDP) Be the Match(r) Registry, an accumulated listing of donated cord blood units from participating banks that are available to provide donors for patients needing a hematopoietic stem cell transplant to treat cancer or certain genetic diseases.

Thousands of mothers have donated their cord blood to the CCBB. Banked units are comprised of African-American, Hispanic-American, Asian-American, and Caucasian samples. This diversity helps patients of all racial and ethnic backgrounds find suitable matches for transplantation. The CCBB has distributed cord blood units for transplantation to several thousand patients since 1999. Cord blood recipients of CCBB units include children and adult patients facing life-threatening illnesses who need a "stem cell" transplant from an unrelated donor to provide them with healthy blood cells. Many of these patients have been affected by leukemia, lymphoma, severe aplastic anemia, or other fatal diseases of the blood or immune system, or certain inherited metabolic diseases. In addition to life-saving transplants, the CCBB also provides cord blood units for research. These units are made available to investigators for critical research in the area of cord blood and stem cell biology. The impact of funding has far reaching impacts, and Duke Health urges the subcommittee to support this request.

Duke Health urges $50 million to provide student loan repayment for infectious disease (ID) and bio-preparedness health professionals who qualify under the Biopreparedness Workforce Pilot Program. Requested funding would provide up to $50,000 in loan repayment to as many as 1,000 ID professionals who work in health professional shortage areas and Federal health facilities.

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY (AHRQ)

Duke Health urges the subcommittee to provide not less than $500 million for the Agency for Healthcare Research and Quality in FY 2024. AHRQ supports research to improve healthcare quality, reduce costs, advance patient safety, decrease medical errors, and broaden access to essential services. As the lead Federal agency for funding health services research and primary care research, AHRQ is the bridge between cures and care, and ensures that Americans get the best healthcare at the best value.

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (SAMHSA)

Duke Health appreciates investments in the National Child Traumatic Stress Network (NCTSN) grant program at SAMHSA, especially efforts to provide additional funding for this program during the pandemic and in support of pediatric trauma attributed to gun violence. For FY 2024, Duke Health urges the subcommittee to provide $150 million for NCTSN, which matches the president's budget request, and no less than $93.9 million, which equals the current appropriated funding level.

NCTSN, which is coordinated by the UCLA-Duke University National Center for Child Traumatic Stress, increases access to services for children and families who experience or witness traumatic events. This unique network of frontline providers, family members, researchers, and national partners is committed to changing the course of children's lives by improving their care and moving scientific gains quickly into practice across the U.S. In recent years, estimates from the NCTSN Collaborative Change Project (CoCap) have indicated that each quarter about 50,000 individuals—children, adolescents, and their families—directly benefited from services through this Network. Since its inception, the NCTSN has trained more than one million professionals in trauma-informed interventions. Hundreds of thousands more are benefiting from the other community services, website resources, educational products, community programs, and more. Over 10,000 local and State partnerships have been established by NCTSN members in their work to integrate trauma-informed services into all child-serving systems, including child protective services, health and mental health programs, child welfare, education, residential care, juvenile justice, courts, and programs serving military and veteran families.

OFFICE OF THE ASSISTANT SECRETARY FOR PREPAREDNESS AND RESPONSE (ASPR)

Duke Health requests that the subcommittee provide $11.5 million fully authorized funding for the Military and Civilian Partnership for the Trauma Readiness Grant Program for FY 2024 within ASPR. Originally known as MISSION ZERO, this critical program provides funding to ensure trauma care readiness by integrating military trauma care providers into civilian trauma centers. These partnerships allow military trauma care providers to gain exposure treating critically injured patients in communities and keep their skills sharp to increase readiness for deployment. Additionally, they allow civilian trauma care providers to gain insight into best practices from the battlefield that can be integrated into civilian care. Building upon investments made in the past two fiscal years, fully funding this program will help to improve the Nation's response to public health and medical emergencies.

PREPARED STATEMENT OF THE DYSTONIA MEDICAL RESEARCH FOUNDATION

SUMMARY OF RECOMMENDATIONS FOR FISCAL YEAR 2024

—Provide $50 billion for the National Institutes of Health (NIH) and proportional increases across its Institutes and Centers.
—Continue dystonia research supported by NIH through the National Institute on Neurological Disorders and Stroke (NINDS), the National Institute on Deafness and other Communication Disorders (NIDCD), and the National Eye Institute (NEI).
—Provide the Centers for Disease Control and Prevention (CDC) with at least $11 billion to facilitate timely public health efforts.
—Please provide $6 million for the new Chronic Disease Education and Awareness Program at CDC.

Dystonia is a neurological movement disorder that causes muscles to contract and spasm involuntarily. It affects men, women and children. Dystonia can be generalized, affecting all major muscle groups, and resulting in twisting, repetitive movements and abnormal postures or focal, affecting a specific part of the body such as legs, arms, hands, neck, face, mouth, eyelids and vocal cords. Currently, it is estimated that at least 300,000 individuals in North America suffer from dystonia, making it more common than Huntington's, muscular dystrophy, and ALS. There is no known cure for dystonia.

In 1967 at the age of 10, I lost the ability to write with either hand. Five years later, my father (at the age of 53) and I were diagnosed with focal dystonia, affecting our hands, which spasm and twist when we attempt to write. My sister, her son, and my daughter were later given the same diagnosis. Unlike the others, with every passing year, my daughter's dystonia began to affect other regions. By 19, she was unable to walk or feed herself. Later that year, she underwent deep brain stimulation (DBS) surgery which changed her life. She was later able to return to and graduate from college and now lives a relatively normal and active life.

I realized at the time of my daughter's diagnosis that I needed to do more. I became a clinical trial participant at the NIH and volunteered for any studies that

could help researchers in finding a cure and or better treatments. I also became a passionate advocate for dystonia research funding.

Dystonia Research at the National Institutes of Health (NIH)

The Dystonia Medical Research Foundation urges the subcommittee to continue its support for natural history studies on dystonia that will advance the pace of clinical and translational research to find better treatments and a cure. In addition, we encourage Congress to continue supporting NINDS, NIDCD, and NEI in conducting and expanding critical research on dystonia.

Currently, dystonia research at NIH is supported by the National Institute of Neurological Disorders and Stroke (NINDS), the National Institute on Deafness and Other Communication Disorders (NIDCD), and the National Eye Institute (NEI).

Most of the dystonia research at NIH is supported by NINDS. NINDS has utilized several funding mechanisms in recent years to study the causes and mechanisms of dystonia. These grants cover a wide range of research including the genetics and genomics of dystonia, the development of animal models of primary and secondary dystonia, molecular and cellular studies in inherited forms of dystonia, epidemiology studies, and brain imaging. We continue to work with the leadership of NINDS on the recommendations stemming from our 2018 meeting that focused on defining emerging opportunities in dystonia research.

Key findings include 1) noting that the heterogeneity of dystonia poses challenges to research and therapy development. 2) There is more to be learned from genetic subtypes, along clinical, etiology, and pathophysiology axes. 3) In order to facilitate key advancements in research technology, there needs to be more research collaboration. 4) New research priorities should include the generation and integration of high-quality phenotypic and genotypic data. 5) Reproducing key features in cellular and animal models, both of basic cellular mechanisms and phenotypes, leveraging new research technologies. 6) Collaboration is necessary both for collection of large data sets and integration of different research methods.

It is of great significance that several dystonia patient advocacy group, led by the Dystonia Medical Research Foundation, actively took part in the meeting and are working to ensure that Congress continues to support robust NIH funding.

NIDCD and NEI also support research on dystonia. NIDCD has funded many studies on brainstem systems and their role in spasmodic dysphonia, or laryngeal dystonia. Spasmodic dysphonia is a form of focal dystonia which involves involuntary spasms of the vocal cords causing interruptions of speech and affecting voice quality. NEI focuses some of its resources on the study of blepharospasm. Blepharospasm is an abnormal, involuntary blinking of the eyelids which can render a patient legally blind due to a patient's inability to open their eyelids. We were pleased to see that Congress has encouraged both NIDCD and NEI to expand their research into both spasmodic dysphonia and blepharospasm.

We thank the committee for the increase for NIH in fiscal year 2022. We know firsthand that this will further NIH's ability to fund meaningful research that benefits our patients.

CDC's Chronic Disease Education and Awareness Program

We strongly support and thank the subcommittee for support of the Chronic Disease Education and Awareness Program at CDC. This critical program would provide a dedicated pool of resources that could be deployed to support meritorious public health projects with stakeholders. This program seeks to provide collaborative opportunities for chronic disease communities that lack dedicated funding from ongoing CDC activities. Such a mechanism allows public health experts at the CDC to review project proposals on an annual basis and direct resources to high impact efforts in a flexible fashion.

Patient Perspectives

Blepharospasm

I drive through Atlanta's brutal traffic when suddenly, my eyes clamp shut. I pry my left eye open with thumb and forefinger, steer with my right hand. My eyes open for a few seconds, then close with no warning. What is happening? Over the next few months, these spasms progress from eyes to lower face, neck, and shoulders. A year later I am diagnosed with Dystonia, a debilitating, little-known disease. A healthy 49-year-old mother of three, I now fight constant pain; can no longer work, drive or perform basic activities. Even walking our dog is a dangerous fall risk.

Spasmodic dysphonia

Spasmodic dysphonia (SD), a focal form of dystonia, is a neurological voice disorder that involves "spasms" of the vocal cords causing interruptions of speech and

affecting voice quality. My voice sounds strained or strangled with breaks where no sound is produced. When untreated, it is difficult for others to understand me. I receive injections of botulinum toxin into my vocal cords every 3 months for temporary relief of symptoms. This has worked well for me for over a decade. At the start of this year, my insurance coverage changed when my husband's company changed providers. As a result, I had to undergo an extensive review process and change methods for obtaining my medicine. The review lasted for four weeks. Multiple times during this time, my doctor and I were told that I had been denied coverage. We had to make numerous phone calls to encourage the company and specialty pharmacy to review my case again and again. These phone calls were extremely difficult as my voice deteriorated from the delay in treatment. The automated phone systems were the worst, but the representatives also had trouble understanding my broken voice and I had to repeat my information over and over. Finally, the company determined my treatment is medically necessary and has approved it for 1 year. After a seven-week delay, I am scheduled for my injection and am looking forward to a period of spasm-free speaking.

We are grateful to those persons who share their stories with the DMRF and other dystonia patient groups to help raise awareness of dystonia. The DMRF was founded in 1976 and since its inception, the goals have remained to advance research for more effective treatments of dystonia and ultimately find a cure; to promote awareness and education; and support the needs and wellbeing of affected individuals and their families.

Thank you for the opportunity to present the views of the dystonia community, we look forward to providing any additional information.

[This statement was submitted by Carole Rawson, Vice President of Public Policy, Dystonia Medical Research Foundation.]

PREPARED STATEMENT OF THE EDUCATION TRUST

On behalf of The Education Trust, a national nonprofit committed to advancing policies and practices to dismantle the racial and economic barriers embedded in the American education system, thank you for the opportunity to present testimony on the Fiscal Year 2024 (FY24) Senate Labor, Health and Human Services, Education, and Related Agencies (L–HHS–ED) Appropriations bill. We request that the L–HHS–ED bill make substantial investments to ensure that essential education programs have the resources they need to ensure the greatest impact for students of color and students from low-income backgrounds.

While there are many programs under your jurisdiction that are critical in facilitating the achievement of students of color and students from low-income backgrounds, in FY24, Ed Trust is focused on the following:

- —Strengthening the Pell Grant program by increasing the maximum award to keep pace with inflation, at a minimum, and ideally, doubling the maximum award.
- —Supporting teachers and school leaders by including funding at the below minimum levels, alongside related report language:
  - —ESSA (Every Student Succeeds Act) Title I–A ($20.54 billion)
  - —Incentivizing States and localities to evaluate their education funding formulas and policies and implement equitable reforms ($100 million)
  - —ESSA Title II–A ($3 billion)
  - —The Teacher and School Leader Incentive Program (TSLIP) ($200 million)
  - —The Supporting Effective Educator Development Program (SEED) ($140 million)
  - —HEA (Higher Education Act) Title II's Teacher Quality Partnership (TQP) grants ($300 million)
  - —Restoring funding to the School Leader Recruitment and Support Program (SLRSP) ($40 million)
  - —Maintaining FY23 omnibus report language increasing equity in advanced coursework
- —Enabling enhanced preparation for teaching candidates at historically Black colleges and universities (HBCUs) and minority-serving institutions (MSIs) by allocating at least $45 million in funding for the Augustus F. Hawkins Centers of Excellence Grant program
- —Developing and strengthening evidence-based student success programs by allocating at least $165 million in funding for the Post Secondary Student Success Grant program
- —Supporting student parents by allocating at least $500 million in funding for the Child Care Access Means Parents in School (CCAMPIS) program

We urge increased support by the Committee for these crucial programs to help meet the needs of students of color and students from low-income backgrounds.

STRENGTHENING THE PELL GRANT PROGRAM

The Pell Grant program is the cornerstone of Federal financial aid. The program benefits over 6 million students annually and continues to serve as the primary Federal investment designed to allow students from low-income backgrounds to access higher education. More than one-third of White students, two-thirds of Black students, and half of Latino students rely on Pell Grants every year.[1] Pell Grant dollars are well-targeted to those in need: 97 percent of Pell recipients come from families with annual incomes at or below $60,000; 83 percent of Pell recipients come from families with annual incomes at or below $40,000; and 44 percent of recipients come from households with annual incomes at or below $15,000.[2]

Increase the Maximum Pell Grant Award

The maximum Pell Grant award has failed to keep pace with the rapidly rising cost of college over the past several decades. In 1980, the maximum Pell Grant award covered 77 percent of the cost of attendance at a public university. Today, it covers just over 28 percent, the lowest portion in over 40 years. Bold action must be taken to halt and reverse this damaging trend.

We are appreciative of previous increases to the maximum award in prior appropriations bills, including the $500 increase in the Fiscal Year 2023 (FY23) omnibus, and we respectfully request that you continue to annually increase the maximum award amount. It is also worth noting that nearly 1,200 organizations have gone on record supporting the doubling of the Pell Grant.

In FY24, Congress should, at minimum, increase the maximum award upward from $7,395 to keep pace with inflation. It is also time for Congress to implement an ambitious plan to reverse the downward trend of Pell's purchasing power through doubling the maximum award, including expanding the mandatory funding stream, ensuring that the maximum Pell award covers at least half of the cost of attendance at a public 4-year institution.

SUPPORTING STUDENTS, TEACHERS, AND SCHOOL LEADERS

Increase funding for ESSA's Title I–A; ESSA's Title II–A (Supporting Effective Instruction); the Teacher and School Leader Incentive Program (TSLIP), the Supporting Effective Educator Development (SEED) program, HEA's Title II Teacher Quality Partnership (TQP) grants; incentivize States and localities to evaluate their education funding formulas and policies and implement equitable reforms; and maintain FY23 report language supporting increasing equity in advanced coursework.

Congress should build on the prior $850 billion funding increase for Title I contained in the FY23 omnibus by including a $2.15 billion funding increase in FY24 budget for ESSA's Title I–A program. However, it is important to note that most public education funding is distributed via State and local formulas. Therefore, any Federal funding increases of this size should be accompanied by levers that encourage States and districts to address the inequities inherent in those formulas. This is a tremendous opportunity to spark systemic reform of the status quo sends $23 billion more to predominantly White school districts than predominantly non-White school districts, per EdBuild. Ed Trust's own report, released late last year, demonstrated that districts with the most students of color on average receive substantially less (16%) State and local revenue than districts with the fewest students of color, and high-poverty districts receive 5% less State and local revenue than low-poverty districts. Furthermore, districts with the most English learners receive 14% less State and local revenue, compared with districts with the fewest English learners.

We urge the committee to think boldly about how make the overall education funding system more equitable, including inserting report language to that effect, and to include the $100 million set-aside designated for this purpose within the President's FY24 budget request in the L–HHS–ED Appropriations bill.

Furthermore, research and experience show the powerful impact that teachers and school leaders have on student learning. ESSA's Title II–A program provides grants to States and districts that can be used to invest in and develop educators.

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[1] Congressional Budget Office (CBO), January 2017 baseline projections for the Pell Grant program, http://bit.ly/2mLy0nk, Table 2; and Ed Trust calculation NPSAS:12 using PowerStats.

[2] Analysis of Federal Pell Grant Program Annual Data Report, available at https://www2.ed.gov/finaid/prof/resources/data/pell-data.html.

These funds can be used to, among other things, address inequities in access to effective teachers and school leaders, provide professional development, and improve teacher recruitment and retention. States and districts can also apply for additional competitive grant dollars for programs like TSLIP and SEED, which are targeted at specific, evidence-based strategies for improving teacher and school leader effectiveness and increasing educator diversity. Additionally, HEA's Title II TQP grants, awarded to partnerships between high-need districts and teacher preparation programs at institutions of higher education, can be used to recruit underrepresented populations to the teaching profession. As Ed Trust's work continues to demonstrate the positive impact that diverse teachers and school leaders of color can have on the academic achievement of both students of color and White students, we remain supportive of Federal dollars to increase and bolster the diversity of the educator pipeline.

Finally, research shows that Black, Latino and Native students, students with disabilities, and students from low-income backgrounds are under-represented in advanced programs and courses (gifted and talented, advanced placement, international baccalaureate, honors courses, dual enrollment, etc.). We support the continuation of report language included in the FY23 omnibus that noted that funds under ESEA (Elementary and Secondary Education Act) may be used to implement open enrollment, automatic enrollment, and/or universal screening practices; to increase course access and success; to provide coaching and training for educators; to purchase materials; and/or cover exam fees for under-represented students. The language also encouraged the Department to resume collecting data on passing rates for all Advanced Placement subject areas.

Considering the Nationwide attention to the need to invest in educators, especially as schools work to counteract the negative impacts of the COVID–19 pandemic and combat ongoing educator shortages, Congress appropriated increases for most of these programs in FY23: $2.19B for the Title II–A grant, $90M for the SEED program, and $70M for HEA's Title II TQP grants, and level funded TSLIP ($173M).

At a minimum, in FY24, Congress should: increase Title I–A to $20.54B; allocate $100M to incentivize States and localities to evaluate their education funding formulas and policies and implement equitable reforms; increase Title II–A, TSLIP, SEED, and TQP beyond FY23 levels: $3B, $200M, $140M, and $300M, respectively, and maintain report language supporting increasing equity in advanced coursework.

Restore funding for the School Leader Recruitment and Support Program

Landmark research funded by the Wallace Foundation has found "virtually no documented instances of troubled schools being turned around without intervention by a powerful leader," and the School Leader Recruitment and Support Program is the only Federal program specifically focused on investing in evidence-based, locally driven strategies to strengthen school leadership in high-need schools. A seven-year study of school districts that created pipelines to develop school leaders saw increasing gains in student achievement over time, showing how a sustained initiative can demonstrate positive effects on student learning.

There is still a great deal of work to do, especially when it comes to identifying and efficiently preparing effective turnaround leaders, as well as sustainably supporting them to accelerate academic achievement, close gaps, and maintain improvement over time for all students and in every community. Developing strong leaders to build essential relationships with students and the communities in which they operate is fundamental to helping students catch up with the unfinished learning due to the COVID–19 pandemic. The SLRSP is a key lever for seeding the next generation of effective school leader development programs, promoting equity, advancing ongoing innovation, and sharing innovative lessons on transformational leadership with the broader field.

In FY24, Congress should restore funding for the School Leader Recruitment and Support Program to at least $40M, the amount included in the FY23 and FY24 President's Budget Requests and a moderate increase from what was included in FY22 Senate Labor-HHS–ED Appropriations bill.

Increase funding for the Augustus F. Hawkins Centers of Excellence Grant Program

Research has shown that students of color benefit immensely from having teachers of color, particularly one of the same racial background: they are less likely to be chronically absent or suspended from school, more likely to be recommended for gifted and talented programs, and Black students from low-income backgrounds who have a Black teacher for at least 1 year in elementary school are less likely to drop out of high school and more likely to consider college. And while students of color

make up the majority of students in public schools, the diversity gap for teachers of color still exists across every State.

The nationwide impact of HBCUs, MSIs, Hispanic-serving institutions (HSIs), and Tribal colleges and universities (TCUs) on producing teachers of color cannot be overstated. HBCUs, TCUs, and MSIs, collectively, award only 11% of the Nation's bachelor's degrees in education, yet they produce more than 50% of the bachelor's degrees earned in education by Hispanic, Native Hawaiian and Pacific Islander students.[3] HBCUs graduate approximately half of the Nation's Black teachers with bachelor's degrees.[4] HSIs prepare 90% of Hispanic teachers, and along with other MSIs, constitute a vital pipeline to maintain diversity among our Nation's teachers.[5] The initial investment in this program by Congress was supplemented by the Department of Education last year, resulting in $18M going to 12 different grantees nationwide, including three in Texas, a State with a K–12 student body that is comprised nearly 75% non-White students: Sam Houston State University, University of Houston Clear Lake, and University of Texas-El Paso.

Additionally, to ensure the maximum effectiveness of the program, we recommend the inclusion of the following report language:

"The Committee recognizes the importance of high-quality teacher preparation on student learning and teacher retention, and therefore directs the Secretary to prioritize grants to eligible institutions that propose to establish or scale up high-quality teacher preparation pathways that offer extensive preservice clinical training and mentoring by exemplary teachers in grade and subject areas deemed high need by their state. The Committee also recognizes the value of a racially diverse teacher workforce and directs the Secretary to prioritize grants to eligible institutions that commit to increasing the number and proportion of students of color they serve by providing scholarships or grants, based on financial need, as well as academic supports to help teacher candidates successfully complete the preparation program and state licensure requirements, and to publicly report on these efforts and outcomes."

Finally, the FY24 President's Budget proposal recommended continued and additional funding for the program, and a recent Senate Dear Colleague letter in support of increasing funding to the program to $45 million had 17 signatories. Increasing Congress' investment beyond the highly appreciated $15M investment made in the FY23 omnibus would provide key funding to HBCUs, TCUs, and MSIs to provide increased and enhanced clinical experience and increased financial aid to prospective teachers of color, who face higher burdens in college access and affordability than their White peers.

In FY24, Congress should allocate at least $45M for the Augustus F. Hawkins Centers of Excellence Grant Program.

SUPPORTING COLLEGE STUDENTS

Increase funding for the Postsecondary Student Success Grant Program

Despite the gains made in high school graduation rates over the past several decades, the fact remains that only 6 in 10 students earn a college degree after 6 years of undergraduate study, and Black and Hispanic individuals have a lower rate of degree attainment than their White and Asian-American peers. The COVID–19 pandemic exacerbated this problem: undergraduate enrollment has declined by nearly 8% across the board since fall of 2019. These challenges present the possibility of long-term negative effects on students, their families, state and national economies, and the country.

Congress, with the support of 21 organizations including Ed Trust, included a $45M investment in Postsecondary Student Success Grants, an increase of $40M from FY22, in the FY23 omnibus. That is a positive development that we look forward to helping the Department implement, but we will need much more to reverse these damaging trends. Prior proposals from the Biden administration and both chambers of Congress understood the size and scope of the problem of low college completion rates, and we hope the committee will revisit those when deciding how

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[3] Branch Alliance for Educator Diversity, "Homepage," available at https://www.educatordiversity.org/.

[4] Jacqueline Jordan Irvine and Leslie T. Fenwick, "Teachers and Teaching for the New Millennium: The Role of HBCUs," The Journal of Negro Education 80 (3) (2011): 197–208, available at http://www.jstor.org/stable/41341128; National Association for Equal Opportunity in Higher Education: Comments to the Department of Education proposed rule changes for teacher preparation programs available at: http://nafeonation.org/wp-content/uploads/2015/01/NADEC__Teacher__Prep__Regulations__Discussion__Document__2-2-15__.pdf.

[5] Hispanic Association of Colleges and Universities, "Teacher Diversity," https://www.hacuadvocates.net/teacherdiversity?1 .

much to invest moving forward. The FY24 President's Budget proposal included a request for $165M for this concept, as does a FY24 Senate Dear Colleague letter led by Senators Heinrich, Schatz, and Brown, and signed by 9 additional senators. We support that funding level for this appropriations cycle.

In FY24, Congress should allocate at least $165M for the Postsecondary Student Success Grant Program.

Increase funding for the Child Care Access Means Parents in School (CCAMPIS) Program

Over 20 percent of undergraduate students are parents of dependent children, and within that cohort, 1.7 million are single mothers. As detailed further in this letter from 56 organizations in support of this funding ask, including Ed Trust, increasing the funding for CCAMPIS would provide child care support for approximately 100,000 more student parents, giving them access to the child care services they need to get to and through college. This population is increasing year after year, and in a survey by the Hope Center of over 20,000 student parents, 70% indicated their current childcare provider was unaffordable. Furthermore, an Ed Trust report from August 2022 showed that on average, a student parent would need to work 52 hours a week to cover child care and tuition costs at a 4-year public college or university, and that the out-of-pocket costs for attending public college are substantially higher in relation to their childless peers. It is essential that Congress scale up the only program specifically designed to deliver on-campus child care to Pell-eligible student parents, which would dramatically enhance their chances of achieving educational success and financial stability.

In FY24, Congress should allocate at least $500M for the Child Care Access Means Parents in School (CCAMPIS) Program.

Thank you for the opportunity to submit testimony. The Education Trust looks forward to working with Congress to allocate Federal funds in a way that addresses the critical equity gaps that our Nation's students from low-income backgrounds and students of color continue to face. We are happy to respond to any questions or concerns that you may have on these topics.

Sincerely.

[This statement was submitted by Denise Forte, President and Chief Executive Officer, The Education Trust.]

PREPARED STATEMENT OF THE ELDER JUSTICE COALITION

Chair Baldwin, Ranking Member Capito:

On behalf of the 3,000-member Elder Justice Coalition, a group of individuals and organizations dedicated to ending elder abuse, neglect and exploitation we are asking for the following funding levels for elder justice programs within the HHS Administration for Community Living for FY 2024:

—$100 million for formula grants to state adult protective services (APS) programs

—$50 million to fund the Older Americans Act Title VII Long Term Care Ombudsman program

—Continuing current funding levels for the National Adult Maltreatment Reporting System (NAMRS) and other competitive elder justice grant funding

BACKGROUND

Elder abuse is the antithesis of healthy aging. The triple evils of abuse, neglect and financial exploitation are obvious and absolute threats to the health and safety of those older adults who are its victims. In terms of reported cases, in 2019, just over 1.3 million reports of abuse, neglect or exploitation were received by Adult Protective Services programs nationwide, of which two-thirds were deemed eligible to investigate.[1]

Elder abuse is on the rise across the Nation. Financial abuse and scams also continue to run rampant. For example, according to the FBI Internet Crime Complaint Center, people over the age of 60 were the largest group of US cybercrime victims in 2021 and accounted for the most losses of $1.68 billion.[2] Further, the FTC found

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[1] HHS Administration for Community Living, 2019 National Adult Maltreatment Reports Survey. Available at https://namrs.acl.gov/getattachment/Learning-Resources/Adult-Maltreatment-Reports/2019-Adult-Maltreatment-Report/2019NAMRSReport.pdf.aspx?lang=en-US.

[2] Federal Bureau of Investigation, Internet Crime Complaint Center, "Internet Crime Report 2021."

that romance scams alone resulted in victims losing $547 million in 2021, an 80 percent increase over 2020.[3] This category of scams is especially disturbing because it involves perpetrators seeking out isolated and lonely older adults—a group enlarged and enhanced by the pandemic. Of course, these statistics only refer to reported cases; many cases go unreported due to shame, stigma, and lack of knowledge of where to report these crimes.

STATE APS PROGRAM FORMULA GRANTS

Particularly during the pandemic, scams such as contact tracing scams, virus and antibody test kits, vaccines, and miracle cures proliferated.[4] To address the scam and other abuse and neglect that arose, Congress provided $376 million to APS and ombudsman programs for FY 2021 and FY 2022 through pandemic relief legislation, including $100 million through bipartisan legislation. That funding was critical, especially since this programming has historically been significantly underfunded. Millions of older Americans were reached for the first time by expanding support for APS with pandemic funding. APS used this expanded funding in many vital ways depending on community need, including:

—Providing emergency housing including shelters and wrap-around social services for elder abuse victims across the country (and Alabama now has a strong network of these programs);
—Supporting Tribal APS programs in meeting growing demands;
—Providing emergency housing for its APS clients and working with local hospitals to provide in-home services for APS clients;
—Expanding successful multidisciplinary teams across the State that work to raise awareness on elder abuse prevention at the local level;
—Hiring badly needed additional personnel and purchasing vehicles for APS investigations in rural areas.

Considering the successful outcomes from this funding, we are thankful that the subcommittee also provided first-time discretionary funding of $15 million for state APS program formula grants via the general appropriations process in FY 2023, fulfilling a long-time Congressional promise made by authorizations in the 2010 Elder Justice Act. $15 million is a good first step, but it unfortunately is nowhere near what these APS programs need to have in order to sustain these great initiatives for preventing and addressing abuse. Providing $100 million in dedicated funding would mean that these programs can continue. Elder abuse, neglect, and fraud incidences in our communities are only getting worse, not better.

LONG TERM CARE OMBUDSMAN PROGRAM

During the pandemic and afterward, long term care ombudsman programs have faced significant challenges. For months on end, ombudsman programs were unable to visit nursing homes to speak to residents in person. They also lost hundreds of thousands of volunteer hours that they have counted on to make the program work with its limited funding; in 2019, State programs counted 514,095 volunteer hours, whereas in 2021, the program only had 149,135 volunteer hours contributed-an almost 80 percent decrease in volunteer work. Paid staff are necessary to fill in these gaps—in other words, staff funded with money the program does not have to spare. Despite this dramatic drop in manpower and in-person access issues, their workload remained steady. In 2019, ombudsman programs nationwide closed 198,502 reports, and in 2021, programs still closed over 165,000 reports.

Complaints increased further in 2022 as ombudsmen continued to return in person to nursing homes. One state ombudsman program increased staff and saw an increase in complaints because ombudsmen were more available to residents. That state received 28% more complaints from residents between 2021 and 2022 and 107% more complaints were identified by ombudsmen through observations when their visits increased. They also had a 79% increase in complaints from facility staff.

In short, the numbers of complaints and the older population are not declining, and the program is still unable to fill in its staffing and volunteer gaps. Significant increases for the program are needed to keep up with this demand and ensure the safety of nursing home residents.

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[3] Federal Trade Commission, "Reports of romance scams hit record highs in 2021." Available at https://www.ftc.gov/news-events/data-visualizations/data-spotlight/2022/02/reports-romance-scams-hit-record-highs-2021.

[4] United States Senate Special Committee on Aging, "Fraud Book." Available at https://www.aging.senate.gov/imo/media/doc/Fraud%20Book%202021.pdf.

OTHER ELDER JUSTICE PROGRAMS

We also strongly urge the subcommittee to provide continued funding for other elder justice programs, including the National Adult Maltreatment Reporting System (NAMRS, the unified Federal database for state adult protective services reporting) and other competitive elder justice grants. Though it was only created recently, NAMRS has been extremely useful in painting a comprehensive picture of the elder abuse landscape. In addition to maintaining its funding, we also call on the subcommittee to instruct ACL and state APS programs to gather more data and research on abuse prevalence in diverse communities via the NAMRS reporting process.

CONCLUSION

Our focus must be on prevention as well as helping those who are victimized. Elder abuse prevention funding is ultimately an investment. Elder abuse, neglect, and fraud victims will need Federal assistance such as SNAP, housing, Medicaid, or some combination, adding extra costs to these programs.

Perhaps most compelling to consider: a victim of elder abuse is never the same; their lives are upended; they could go from prosperity to poverty in one scam. Elder justice is achieved when we are successful in preventing elder abuse. We urge your support of our requests.

[This statement was submitted by Robert Blancato, National Coordinator, Elder Justice Coalition.]

PREPARED STATEMENT OF THE ELDERCARE WORKFORCE ALLIANCE

Dear Chair Baldwin, Ranking Member Capito, and Members of the subcommittee:

I write on behalf of the Eldercare Workforce Alliance (EWA), a coalition of 35 national organizations—representing health care professionals, family caregivers, consumers, direct care workers, and providers—joined together to address the health care workforce needs in caring for an aging America. As the subcommittee begins consideration of funding for programs in FY 2024, EWA urges you to provide adequate funding for programs designed to increase the number of health care professionals prepared to care for America's growing population of older adults and to support family caregivers in the essential role they play in this regard. We urge you to support a total $82 million in funding for geriatrics programs in Title VII of the Public Health Service Act administered by the Health Resources and Services Administration (HRSA); $468.512 million in funding for programs administered by the Administration for Community Living (ACL) that support the vital role of family caregivers in providing care for older adults; and $49 billion to support the research efforts of the National Institute of Health (NIH) including $226M committed to Alzheimer's disease and related dementia research.

The number of Americans over age 65 is expected to double between 2000 and 2030, totaling more than 70 million people and accounting for almost 20% of the American population by the end of the next decade. Today's health care workforce is inadequate to meet the special needs of older Americans, many of whom have multiple chronic physical and mental health conditions and cognitive impairments. Of equal EWA—FY2023 Appropriations Request to the House Labor-HHS-Education & Related Agencies subcommittee 2 importance is supporting the legions of family caregivers who annually provide billions of hours of uncompensated care that allows older adults to remain in their homes and communities. Without a national commitment to expand training and educational opportunities, the workforce will continue to grow even more constrained and care for our Nation's older adults will be compromised. This is why, the Title VII geriatrics programs, ACL programs that support family caregivers, and the research efforts of National Institute on Aging are so critical to ensuring there are skilled eldercare workers and well-supported family caregivers available to meet the complex and unique needs of older adults.

EWA specifically requests the following levels of funding:

Title VII Geriatrics Programs

Appropriations Request: $82 Million

The Title VII geriatrics programs include the Geriatrics Workforce Enhancement Program (GWEP) and the Geriatrics Academic Career Awards (GACA). These Title VII geriatrics workforce programs, administered by the Health Resources and Services Administration, are the only Federal programs dedicated to training the entire workforce in the care of older adults. The two initiatives have four main goals:

—Foster education and engagement with family caregivers by training providers who can assess and address the care needs and preferences of older adults.
—Promote interprofessional team-based care by transforming clinical training environments to integrate geriatrics and primary care delivery systems.
—Improve the quality of care delivered to older adults by providing education to families and caregivers on critical care challenges like Alzheimer's disease and related dementias.
—Reach underserved and rural communities by ensuring clinician-educators are prepared to train the geriatrics workforce of today and tomorrow.

For FY2024, we request a sufficient increase in funding to close current geographic and demographic gaps in geriatrics workforce training. The COVID–19 pandemic, and its disproportionate and devastating impact on older adults, demonstrated the crucial need to equip the primary care workforce to meet the needs of diverse geriatric populations. GWEPs and GACAs are highly successful in leading and preparing the health care workforce, unpaid caregivers and members of the community to address the complex needs of older adults living with chronic conditions and disabilities, and the social and environmental health determinants impacting their ability to live as independently as possible. The increased funding would support 80 GWEPs and 60 GACAs (at salaries more commensurate with those of NIH academic career grantees).

Administration for Community Living Family Caregiver Support Programs:

Appropriations Request: $462.512 Million

National Family Caregiver Support Program: This program provides a range of support services to family and other unpaid caregivers annually, including counseling, respite care, training, and assistance with locating services that help family caregivers care for their loved ones at home for as long as possible. We request that Congress work toward funding the National Family Caregiver Support Program at $334 million in FY 2024. Included in the funding request for the National Family Support Program, $400,000 is needed to sustain the efforts of the RAISE Family Caregiving Advisory Council in creating and updating a National Family Caregiving Strategy and carrying out their other responsibilities. $387.9 million request

Native American Caregiver Support: This program provides grants to eligible Tribal organizations to provide support for family and informal caregivers of Native American, Alaskan Native, and Native Hawaiian elders. It offers information and outreach, access assistance, individual counseling, support groups and training, respite care and other supplemental services. In FY2014, more 934,000 caregivers were served through this program. $22.612 million request

Alzheimer's Disease Program: A critical focus of these programs is to support the family caregivers who provide countless hours of unpaid care, thereby enabling their family members with dementia to continue living in the community. Funds will go to evidence-based interventions and expand the dementia-capable home and community-based services, enabling additional older adults to live in their residence of choice. $35 million request

Lifespan Respite Care: This program funds grants to improve the quality of and access to respite care for family caregivers of children or adults of any age with special needs. $20 million request

Direct Care Workforce Center and Competitive Grants:

Appropriations Request: $8 Million

This program is authorized in Title IV of the Older Americans Act (OAA), in coordination with the Secretary of Labor, to carry-out the demonstration of new strategies for the recruitment, retention or advancement of direct care workers. If funding is appropriated, ACL would begin with demonstrations that could prove the concept of what approaches were effective.

BOLD Infrastructure for Alzheimer's Act:

Appropriations Request: $20 Million

Alzheimer's and Related Dementias Public Health Centers of Excellence: This legislation establishes Alzheimer's centers of excellence and funds State, local, and Tribal public health departments to increase early detection and diagnosis, reduce risk, prevent avoidable hospitalizations, reduce health disparities, and support the needs of caregivers and care planning for people living with the disease across the country.

The Eldercare Workforce Alliance commends you on your past support for geriatrics workforce programs and asks that you join us in supporting the eldercare workforce at this critical time—for all older Americans deserve quality care, now and in the future. Thank you for your consideration.

[This statement was submitted by Amy M. York, Executive Director, Eldercare Workforce Alliance.]

PREPARED STATEMENT OF THE ENDOCRINE SOCIETY

The Endocrine Society thanks the subcommittee for the opportunity to submit the following testimony regarding Fiscal Year (FY) 2024 Federal appropriations for biomedical research and public health programs. The Endocrine Society is the world's oldest and largest professional organization of scientists devoted to hormone research and physicians who care for people with hormone-related conditions. The Society's membership includes basic and clinical scientists who receive support from the National Institutes of Health (NIH) for research on endocrine diseases that affect millions of Americans, such as diabetes, thyroid disorders, cancer, infertility, aging, obesity, and bone disease. Our membership also includes clinicians who depend on new scientific advances to better treat and cure these diseases and who value Federal prevention and treatment programs. To support necessary advances in biomedical research to improve health, the Endocrine Society recommends the following FY 2024 appropriations:

—NIH—$50.924 billion exclusive of additional funds to the Advanced Research Projects Agency for Health (ARPA–H)
—Centers for Disease Control and Prevention (CDC)—$11.58 billion
—Title X program—$512 million

Investment in NIH is Essential.—We urge the Congress to provide $50.924 billion to continue its bipartisan support for NIH, ensure consistent increases across all Institutes and Centers (ICs), and protect investigator-initiated research.

ENDOCRINE RESEARCH IMPROVES PUBLIC HEALTH AND SAVES MONEY

NIH-supported scientists are making fundamental biological discoveries and developing applied therapies that advance our understanding of how to treat diseases, often at a fraction of the cost of managing these conditions. Our members' research has led to new medical treatments, saved millions of lives, improved overall quality of life, and contributed billions to the US economy. For instance, in post-menopausal women, NIH-funded studies have found that one of the best predictors of fracture is bone mineral density of the hip. This finding resulted in a better method for identifying those at risk for osteoporosis, which in turn prevents expensive and debilitating fractures that cost $17 billion annually in direct care.[1] Despite many successes that have improved lifespan and quality of life, NIH funding is not keeping pace with inflation; its most recent appropriation is still only 0.6% above peak funding levels in FY 2003.[2] If funding for biomedical research does not keep pace with inflation, we risk the opportunity to realize future breakthroughs in medical care.

EFFECTIVE PROGRESS REQUIRES CONSISTENT SUPPORT ACROSS NIH

The endocrine system affects all areas of human health. Consequently, our members are funded by many ICs across NIH. We urge you to apply funding increases consistently to all ICs and offices at NIH to effectively advance biomedical research. We are concerned that when funding is applied disproportionally and at the expense of certain ICs, payline disparities increase and gaps in our understanding of important biological pathways emerge. Proportional increases to all NIH ICs empower endocrinologists to develop novel interdisciplinary approaches that address public health priorities. For example:

—Endocrinologists funded by the National Institute of Environmental Health Sciences (NIEHS) and National Institute for Child Health and Human Development (NICHD) are aiming to improve our understanding of how climate change

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[1] Tran O, Silverman S, Xu X, Bonafede M, Fox K, McDermott M, Gandra S. Long-term direct and indirect economic burden associated with osteoporotic fracture in US postmenopausal women. Osteoporos Int. 2021 Jun;32(6):1195–1205. doi: 10.1007/s00198–020–05769–3. Epub 2021 Jan 7. Erratum in: Osteoporos Int. 2022 Aug;33(8):1835. PMID: 33411007; PMCID: PMC8128807.

[2] 2022 Update: NIH's Role in Sustaining the U.S. Economy. United for Medical Research. https://unitedformedicalresearch.org/annual-economic-report/. Updated in 2022. Accessed March 8, 2023.

will impact fertility,[3] and how Per- and Polyfluoroalkyl Substances (PFAS) affect bone health in children.[4]

—Endocrine oncologists supported by the National Cancer Institute (NCI) and NIEHS are contributing to our knowledge of how drugs and consumer products can contribute to cancer risk.[5]

—Endocrine researchers funded by the National Institute of Mental Health (NIMH) and Office of Research on Women's Health are helping us better address gaps in understanding of how sex differences contribute to mental illness.[6]

While these examples illustrate the important interdisciplinary work being done in endocrine research, the value of consistent increases across ICs extends to every discipline.

SPECIAL PROGRAMS MUST NOT ERODE SUPPORT FOR INVESTIGATOR-INITIATED RESEARCH

The Endocrine Society is enthusiastic about the potential for ARPA–H to advance transformative public health interventions and develop new research platforms that deliver improved care to patients quickly and efficiently. Investments for ARPA–H, however, must not come at the expense of the investigator-initiated research that has been primarily responsible for the numerous NIH-supported public health achievements. This is because while complementary, the NIH and ARPA–H have distinct but critical missions and should therefore be budgeted separately. Funding for ARPA–H should supplement rather than supplant NIH funding.

Adequate Funding of CDC Programs Is Necessary to Protect the Public's Health.—We urge the Congress to support the CDC with an appropriation of at least $11.58 billion; protect the work of the Chronic Disease Center, which provides successful diabetes prevention programs; and support the work of the Environmental Health Laboratory to continue its efforts to harmonize the reporting of clinical laboratory test results.

Diabetes Prevention.—CDC plays a critical role in protecting the public's health by applying new knowledge to the promotion of health and prevention of chronic diseases, including diabetes and obesity. The Division of Diabetes Translation administers the National Diabetes Prevention Program (National DPP), which addresses the increasing burden of prediabetes and Type 2 Diabetes in the United States, creates public and private partnerships to provide evidence-based, cost-effective interventions that prevent diabetes in community-based settings. Through structured lifestyle change programs at local YMCAs or other community centers, individuals with prediabetes can reduce the risk of developing diabetes by 58% in those under 60, and by 71% in those 60 and older.[7] We urge Congress to support $40 million for the National DPP in FY 2024.

Accurate Clinical Laboratory Test Results.—CDC's Clinical Standardization Programs (in the former Center for Environmental Health) are critical to improving accurate and reliable testing of hormones, appropriate diagnosis, and treatment of disease, and reproduceable public health research. Adequate funding is critically important to ensure that CDC can ensure every patient has access to dependable and accurate clinical laboratory test results and that those results are harmonized. We recommend the CDC receive an additional $7.2 million for activities directed by its Environmental Health Laboratory.

Title X Funding Provides Necessary Services and Reduces Healthcare Costs

Title X is an important source of funding for ensuring reproductive health benefits, including both contraceptive and preventive services to low-income individuals and families. Offering affordable access to contraception can have a measurable im-

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[3] Gaskins AJ, Mínguez-Alarcón L, VoPham T, Hart JE, Chavarro JE, Schwartz J, Souter I, Laden F. Impact of ambient temperature on ovarian reserve. Fertil Steril. 2021 Oct;116(4):1052–1060. doi: 10.1016/j.fertnstert.2021.05.091. Epub 2021 Jun 9. PMID: 34116830; PMCID: PMC8478715.

[4] Kirk, A., et al., PFAS and Potential Adverse Effects on Bone and Adipose Tissue Through Interactions With PPARγ. Endocrinology. 2021 Dec; 162(12): bqab194.

[5] https://www.endocrine.org/news-and-advocacy/news-room/featured-science-from-endo-2021/drug-used-during-pregnancy-may-increase-cancer-risk-in-mothers-adult-children.

[6] Fish AM, Nadig A, Seidlitz J, Reardon PK, Mankiw C, McDermott CL, Blumenthal JD, Clasen LS, Lalonde F, Lerch JP, Chakravarty MM, Shinohara RT, Raznahan A. Sex-biased trajectories of amygdalo-hippocampal morphology change over human development. Neuroimage. 2020 Jan 1;204:116122. doi: 10.1016/j.neuroimage.2019.116122. Epub 2019 Aug 27. PMID: 31470127; PMCID: PMC7485527.

[7] The Diabetes Prevention Program (DPP) Research Group Diabetes Care. 2002 Dec;25(12):2165–71.

pact on healthcare costs. For every public dollar invested in contraception, short-term Medicaid expenditures are reduced by $7.09 for the pregnancy, delivery, and early childhood care related to births from unintended pregnancies, resulting in savings of $7 billion to Federal and State governments.[8] Title X is the main point of care for low income, under- or un-insured, adults and adolescents for affordable contraception, cancer screenings, sexually transmitted disease testing and treatment, and medically accurate information on family planning options. However, to provide these services to the over 4 million people who depend on Title X-funded centers, Title X is significantly underfunded. Therefore, we support at least $512 million for the Title X Program.

Spending Cuts Will Stunt Biomedical Research Progress and Have Long-Term Consequences on Public Health

Over the past 8 years, the NIH has secured a 57% increase in funding due to strong bipartisan support for biomedical research; investments in CDC and Title X funding have seen moderate increases as well. However, we are concerned about legislation in the House that proposes austere restrictions to spending levels for discretionary funding, which includes essential public health programs such as NIH, CDC, and Title X, to secure overall budget stability. While the exact budget cuts have not been determined, recent reports have suggested a minimum of 30% cuts to NDD (nondefense discretionary) spending can be anticipated.

Using the NIH as an example, a 30% cut to FY 2023 levels would result in a budget reduction from $47.7 billion to $33.4 billion. The current research funding landscape is already very competitive, with the success rate for grant applications hovering at ~15%. With the proposed budget cuts, this would lead to almost 7,000 fewer awarded grants per year, and the success rate of applications further shrinking to ~10%.

This would have devastating effects on the biomedical research enterprise in many ways. In part due to difficulty obtaining funding, the research pipeline is already losing early career researchers to other sectors; significant budget cuts will only exacerbate this issue and cause a reduction in the biomedical research workforce for decades to come. Without these scientists in our workforce, many medical breakthroughs will either never happen or will be realized outside of the United States, driving public health and economic activity elsewhere.

With the reduction of research projects funded by the NIH comes an incalculable impact on human health. Diseases such as obesity and diabetes are on the rise and already have enormous impacts on quality of life and overall mortality. With fewer resources to study these diseases, lifesaving treatments may never come to fruition. Moreover, because factors such as race and geographic location affect disease prevalence, people of color and those living in rural communities will be disproportionately impacted by diminished research progress and lack of treatment options.

While we have described significant consequences to cuts in NIH funding, cuts to CDC and Title X would have similarly devastating impacts on public health. These biomedical research programs need more funding, not less. Investments in these programs will save lives, save billions of dollars in health care costs, and maintain the United States' position as a global scientific leader.

PREPARED STATEMENT OF THE ENTOMOLOGICAL SOCIETY OF AMERICA

The Entomological Society of America (ESA) submits this statement for the record in support of funding for vector-borne diseases (VBD) research at the U.S. Department of Health and Human Services (HHS). ESA joins the research community by requesting at least $51 billion in fiscal year (FY) 2024 for the National Institutes of Health (NIH) base program funding; at least $2.5 billion for the Advanced Research Projects Agency for Health (ARPA–H) to supplement, rather than supplant, investment in NIH; increased support for vector-borne disease (VBD) research at the National Institute of Allergy and Infectious Diseases (NIAID); $11.581 billion for the Centers for Disease Control and Prevention (CDC) base program funding, including at least $88.603 million for VBD, global health, and core infectious diseases; and robust funding for the Institute of Museum and Library Services (IMLS), including $55 million for the Office of Museum Services.

ESA urges the subcommittee to support VBD research programs that incorporate the entomological sciences as part of a comprehensive approach to addressing infectious diseases. These efforts help mitigate the impact that insect and arthropod car-

[8] Frost JJ, et al., Publicly Funded Contraceptive Services at U.S. Clinics, 2015, New York: Guttmacher Institute, 2017.

riers of disease, like mosquitoes and ticks, have on human health. NIH, the Nation's premier biomedical research agency, advances human health by supporting research on basic human and pathogen biology and by developing prevention and treatment strategies. Cutting-edge research in the biological sciences, including in entomology, is essential for addressing societal needs related to environmental and human health. Many species of insects and arthropods, including ticks and mites, are carriers or vectors of an array of infectious diseases that threaten the health and well-being of citizens in all States and territories, as well as military personnel. The mosquitoes that carry and transmit diseases are responsible for more human deaths globally than any other animal species. VBD can be particularly challenging to manage due to insect and arthropod mobility and their propensity to develop resistance to pesticides. Further, effective preventative treatments, including vaccines, are not available for most VBDs.

Within NIH, NIAID conducts and supports research related to understanding, preventing, and treating infectious diseases. Entomological research to characterize the relationships between insect vectors and the diseases they transmit is essential to better monitor and predict outbreaks, reduce disease transmission, and diagnose and treat diseases. NIAID-funded researchers are working to understand how to increase protection after exposure to arthropod disease vectors and the pathogens they transmit that could cause Lyme disease and other tick-borne infections. With NIAID funding, researchers developed and trialed the first messenger RNA (mRNA) vaccine targeting ticks.[1] Whereas previous vaccine development efforts against tick-borne disease in humans have targeted disease-related pathogens, this new mRNA vaccine technology induces immunity against a salivary protein produced by the vector ticks themselves. This study showed the mRNA vaccine administered to guinea pigs caused blacklegged tick bites to become inflamed and ticks to fall off too quickly to transmit the pathogen that causes Lyme disease.[2] This novel research demonstrates that the new mRNA vaccine technology has the potential to protect individuals against the pathogen that causes Lyme disease and others carried by the blacklegged tick. NIAID also supports multidisciplinary studies that have already produced valuable insight into the invasive Asian longhorn tick's ability to carry and transmit pathogens.[3] Continued funding for this research will improve our understanding of the risks of further spread of the tick and support targeted interventions to prevent disease transmission.

Tick-induced red meat allergy, also known as alpha-gal syndrome (AGS), is a potentially life-threatening allergic reaction which can result in hives, severe stomach pain, and even anaphylactic shock.[4] Worldwide reports have shown that tick bites from multiple different species can induce the red meat allergy in humans, but in the United States, only the lone star tick has been linked to the allergy. Funding for research to better understand the role that this tick plays in inducing a severe allergic reaction and why only some people develop this allergy is needed to better help healthcare providers and scientists discover solutions to prevent and cure this disease. While there is still much that remains to be discovered about AGS, with funding from NIH, researchers at Kansas State University were able to demonstrate a new model system for the study of AGS to better understand the mechanisms of the red meat allergy.[5]

ESA requests at least $88.603 million per year, as is aligned with the FY 2024 President's budget request, for CDC's Division of Vector-Borne Diseases (DVBD) within the National Center for Emerging and Zoonotic Infectious Diseases (NCEZID). The DVBD supports the existing Centers of Excellence (COE) on VBD as well as the new Teaching and Evaluation Centers (TECs), which builds on the success of the COE model. ESA also requests $34.2 million in Epidemiology and Laboratory Capacity (ELC) program funding for VBD to fulfill the vision of the Kay Hagan Tick Act and help meet the needs of States across the U.S.

CDC, serving as the Nation's leading health protection agency, conducts research and provides health information to prevent and respond to infectious diseases and other global health threats. Within the core infectious diseases budget of CDC, the Division of Vector-Borne Diseases (DVBD) aims to protect the Nation from the threat of viruses, bacteria, and parasites transmitted primarily by mosquitoes, ticks,

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[1] https://www.smithsonianmag.com/smart-news/first-ever-mrna-vaccine-for-lyme-disease-shows-promise-in-guinea-pigs-180979090/.

[2] https://pubmed.ncbi.nlm.nih.gov/34788080/.

[3] https://pubmed.ncbi.nlm.nih.gov/35846754/.

[4] https://www.cdc.gov/ticks/alpha-gal/index.html#:~:text=Alpha%2Dgal%20syndrome%20(AGS),other%20products%20containing%20alpha%2Dgal.

[5] https://pubmed.ncbi.nlm.nih.gov/35309294/.

and fleas. DVBD's mission is carried out by a staff of experts in several scientific disciplines, including entomology.

CDC plays a key role in tracking new and emerging diseases, as well as in supporting health care professionals in identifying and diagnosing these diseases. Using funding appropriated during the 2016 Zika crisis, CDC awarded $50 million to five universities for 5 years to establish regional COEs to provide training for the VBD workforce; conduct applied research targeting new strategies for VBD monitoring, prevention, and control; and connect regional partners to share knowledge and resources and form collaborations in a community of practice to enable appropriate and timely local public health action for VBD throughout the U.S. The COE model requires collaboration between the research institutions and the local and regional departments of health (DOH), important relationships which have not arisen organically. This is critical given significant regional differences in vector ecology, disease transmission dynamics, and resources. Sustained funding for the COEs is critical to continue efforts to prevent and control VBD threats. Building on the success of the COE model, the CDC created an expansion of this program called TECs, which will help expand national coverage and continue to grow those relationships focused on translating and disseminating research findings to the public health community.

The Kay Hagan Tick Act also expands authorized support for the ELC program, critical to supporting State and local departments of health vector surveillance and management. In 2022 the CDC's DVBD received requests for nearly $32 million from the state DOH for VBD through the ELC program. However, the DVBD was only able to support $16.2 million, about half of the amount requested. The Kay Hagan Tick Act authorized an additional $20 million over the level in FY 2019, which was $14.2 million. The VBDN request for FY 2024 is $34.2 million in ELC funding for VBD to fulfill the vision of the Kay Hagan Tick Act and help meet the needs of States across the U.S.

ESA requests robust funding for IMLS, including no less than $55 million for the Office of Museum Services in FY 2024. The resources provided by IMLS are critical for research infrastructure, workforce development, and economic impact. IMLS provides for the expansion of collections capabilities at American museums, key for the identification, documentation of locations, and classification of entomological species. The 21st Century Museum Professionals Program provides opportunities for diverse and underrepresented populations to become museum professionals, expanding participation in an industry with an annual economic contribution of $21 billion. Museums are critical to the public understanding of science through exhibits and programs, and in so doing, support science education as an integral part of the Nation's educational infrastructure. They also make significant long-term contributions to economic development in their communities.

ESA, headquartered in Annapolis, Maryland, is the largest organization in the world serving the professional and scientific needs of entomologists and individuals in related disciplines. Founded in 1889, ESA is a non-partisan professional organization over 7,000 members affiliated with educational institutions, health agencies, private industry, and government. Members are researchers, teachers, extension service personnel, administrators, marketing representatives, research technicians, consultants, students, pest management professionals, and hobbyists. For more information about ESA, please see http://www.entsoc.org/.

[This statement was submitted by Marianne Alleyne, Ph.D., President, Entomological Society of America.]

PREPARED STATEMENT OF THE EPILEPSIES ACTION NETWORK

Chairwomen Murray and Baldwin and Vice Chairs Collins and Moore Capito, I am sharing testimony today on behalf of the Epilepsies Action Network and the millions upon millions of people touched by epilepsy.

I am Co-Founder of Decoding Developmental Epilepsies, which includes both disease-specific and broad-based epilepsy organizations (the International SCN8A Alliance and DEE–P Connections), serve on the leadership team for the Epilepsies Action Network, and work as an advocate for systemic change to improve epilepsy patient outcomes. But most importantly, I am a mom of a child with a rare and catastrophic epilepsy.

First, I thank you for your past support of research, public health, and health care programs that help increase understanding and treatment of the epilepsies as well as support for people with the epilepsies. I would like to share information on the vast impact of this neurological disease and my son's journey in order to illuminate the challenges for the committee and the public. I hope this will encourage you to

enhance your efforts to increase funding and programmatic support within the Department of Health and Human Services for the epilepsies.

To start, I'd like to share my and family's story, and then I will address the larger epilepsy challenges and opportunities for Congress to consider as you draft the FY2024 Labor, Health and Human Services, and Education Appropriations bill.

Elliott, my first, was born in late 2012. Within days, we noticed that he was making strange movements, which turned out to be a very severe type of seizure but were dismissed by the pediatrician for months before we received a referral. Our diagnostic odyssey, with a dozen doctors along the way, lasted a year and half. During that time, Elliott had hundreds of seizures and was hospitalized many times, never receiving care that was in line with his diagnosis. In 2014, Elliott was finally diagnosed as a result of genetic testing. At the time, little was known about this disorder as it was newly discovered. Nearly 10 years later, despite knowing that there are many more people living with SCN8A, it falls upon small, caregiver-led groups like the one I started with other SCN8A caregivers-the International SCN8A Alliance-to find, track and monitor those living with this disorder. In addition to caring for loved ones who require 24 hour a day care, caregivers are also left to lead organizations in order to provide support, education and resources to families all while asking their families, friends and neighbors to help finance-on bake sales and lemonade stands-the search for a cure.

Every day I fear the loss of my child. Children with SCN8A are dying at an alarming rate. We know of roughly 750 people worldwide who have been identified and in the last 6 months, 10 that we know of, have died after having lived for just a few short months or years. Parents whose children have rare epilepsies-of which there are hundreds-share these fears.

Elliott is 10 years old and his development remains intensely slow. He is still working on head control and is exclusively fed through a tube that goes to his small intestine. He cannot grasp a toy and has a severe vision impairment that means he cannot see my face. He cannot tell me if he feels happy or sad, cold or hot, hungry or full. When he cries or screams, I can only guess why and try to help him. I often cannot. He has never said he loves me or given me a hug. I know Elliott better than anyone else in the world and have learned to read his sounds and body language in order to best carry out his wishes. My husband had to quit his job as a University professor 9 years ago to become Elliott's primary caregiver. Elliott brings us so much joy but make no mistake, this life is grueling.

Our treatment odyssey continues to this day. Elliott has tried and failed nearly every approved antiseizure medication on the market. Despite currently being on four antiseizure medications (plus about a dozen other medications taken 1–3 times a day), he continues to seize.

How is it that nearly every treatment decision for those with SCN8A, like Elliott, and so many others with epilepsy is still a guess? There just isn't the data to make informed decisions for treating those with epilepsy, which is shocking and disturbing. Our foundation is taking on a massive effort to try to learn how to better diagnose and treat children with SCN8A but it is time consuming, expensive and requires massive buy-in from the entire community. We must do this because there are currently no standardized ways of tracking the number of children with epilepsy, their care or their outcomes, as the Children's Oncology Group system does. If this country never makes the effort to learn from our children with epilepsy, how can we ever expect to improve care and outcomes for them and those yet to come? We must invest in pediatric-onset data collection and sharing among clinicians, researchers, patients and their caregivers in order to truly advance epilepsy care.

The very disturbing truth is that while we have known about epilepsy for hundreds of years and there has been some major progress in research and genetics (with significant credit going to many families who when faced with epilepsy isolated and alone have organized and advocated for advancements and awareness), there has been no substantial improvement in the lives of those living with the epilepsies. In the U.S. there is still limited tracking of epilepsy, roughly one-third of those with epilepsy cannot get control of their seizures with currently available treatments and there are a wide range of poorly managed co-morbidities.

There is incredible work being done in the epilepsy community but very little of that is translating into improved quality of life and outcomes for those living with this neurological condition. One billion people worldwide have some form of epilepsy and it is estimated that 1 in 26 people will be diagnosed with epilepsy. In the United States, an estimated 3.4 million people are living with epilepsy, of which

470,000 are children or teenagers.[1] Of the more than 500 neurological conditions and disorders, epilepsy is among the top three. Neurological disorders are the leading cause of disability and the second leading cause of death worldwide.[2]

Just like cancer, there are hundreds and hundreds of epilepsies, which are disorders of the brain characterized by abnormal nerve cell signaling that leads to seizures (uncontrolled bursts of electrical activity) and often impact behavior, awareness, and muscle movements. With the rise of genetic testing, the epilepsies are increasingly comprised of an ever-growing number of rare genetic epilepsies. Beyond seizures, those with epilepsy can also experience cognitive, behavioral, and psychiatric mood disorders, as well as mobility, gastrointestinal, and respiratory issues.[3] Epilepsy can also be fatal. Sudden Unexpected Death in Epilepsy (SUDEP) can occur at any time in one's life, even among youth who are otherwise healthy. Every year, 1 in 1,000 people with epilepsy die from SUDEP and this number increases drastically to 1 in 150 for people whose seizures are not controlled by treatment.[4] Alarmingly, the mortality rate increased 47% from 2005 to 2014 overall and this increase was about twice as high among the non-Hispanic Black population.[5]

While some have thrived with epilepsy, such as singer Prince, Olympian Florence Griffith Joyner, singer Elton John, President Teddy Roosevelt, and NFL legend Alan Faneca, others have not, requiring 24/7 care or suddenly dying from SUDEP. Sadly, the cause of the disease is unknown in roughly 50% of cases and over 30% of adults and 20–25% of children do not respond to treatment—this is even higher for patients with rare, genetic epilepsies.[6] There are no biomarkers for the vast majority of the epilepsies, and there are only a few often isolated studies systematically learning from the experiences of patients living with epilepsy. Moreover, epilepsy and/or seizures impose an annual economic healthcare burden of at least $54 billion.[7]

Despite the vast number of Americans impacted by epilepsy there is so much that is still unknown and many that go untreated. Only .5% of NIH's $42 billion spent annually on medical research is dedicated to epilepsy, no consortium is bringing together clinicians, researchers and patients to share data and advance care for children, and the CDC's National Neurological Conditions Surveillance System (NNCSS) does not include epilepsies, resulting in insufficient surveillance of the epilepsies that contributes to incomplete, untimely, unrepresentative data.

That is why I am part of the Epilepsies Action Network and why I started organizations to address these gaps in the system I have been forced to deal with on a daily basis over the last decade. There are hundreds of thousands of parents like me doing everything they can to find answers, treatments, and a better quality of life for our children with epilepsy.[8] But we cannot succeed alone. We need your leadership and support.

We respectfully request that you include in the FY24 LHHS Appropriations bill $10 million for the Pediatric-Onset Epilepsies Consortium to enable a collaborative research model that enrolls patients from hospitals across the country to increase the ability to detect meaningful differences due to interventions, gain insights on best treatment protocols to establish best practices for each form of epilepsy, accelerate therapeutic development based on the data acquired through the model, and

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[1] Zack, M.M. & Kobau, R. (2017). National and State Estimates of the Numbers of Adults and Children with Active Epilepsy—United States, 2015. Morbidity and Mortality Weekly Report (MMWR), 66(31), 821–825. http://dx.doi.org/10.15585/mmwr.mm6631a1.

[2] Feigin, Valery et al (2019). The global burden of neurological disorders: translating evidence into policy, The Lancet Neurology, Vol 19, Issue 3, 255–265. https://www.thelancet.com/journals/laneur/article/PIIS1474-4422%2819%2930411-9/fulltext.

[3] Ho, N.T., Kroner, B., et al. (2018). Comorbidities of rare epilepsies: Results from the rare epilepsy network. The Journal of Pediatrics, 203, 249–258. https://doi.org/10.1016/j.jpeds.2018.07.055.

[4] Thurman, D.J., Hesdorffer, D.C. & French, J. (2014). Sudden unexpected death in epilepsy: Assessing the public health burden. Epilepsia, 55(10), 1479–1485. https://doi.org/10.1111/epi.12666. Keller, A.E., Whitney, R., et al. (2018). Incidence of sudden unexpected death in epilepsy in children is similar to adults. Neurology, 91(2), e107-e111. DOI: 10.1212/WNL.0000000000005762.

[5] Greenlund, S. F., Croft, J. B., & Kobau, R. (2017). Epilepsy by the Numbers: Epilepsy deaths by age, race/ethnicity, and gender in the United States significantly increased from 2005 to 2014. Epilepsy & behavior : E&B, 69, 28–30. https://doi.org/10.1016/j.yebeh.2017.01.016.

[6] hen, Z. et al. (2018). Treatment Outcomes in Patients with Newly Diagnosed Epilepsy Treated With Established and New Antiepileptic Drugs A 30–Year Longitudinal Cohort Study. JAMA Neurology, 75(3), 279–286. doi: 10.1001/jamaneurol.2017.3949.

[7] Moura, L.M.V.R., Karakis, I., Zack, M.M., Tian, N., Kobau, R., & Howard, D. (2022). Drivers of U.S. health care spending for persons with seizures and/or epilepsies, 2010–2018. Epilepsia, 63(8), 2144–2154. doi:10.1111/epi.17305.

[8] The Rare Epilepsy Network.

expedite translation of research findings into standard clinical care. This consortium under the direction of NINDS and NCATS, which leads the rare disease research activities, in addition to an annual report from NINDS on findings and progress resulting from the Curing Epilepsies Conferences could make significant advancements in translating knowledge into better care that improves patient outcomes. We also request that you include $5 million for the CDC's National Neurological Conditions Surveillance System (NNCSS), which should include epilepsy within its surveillance system and report on this progress.

Thank you for considering my testimony. We know we can change these systemic problems which have for too long delayed the translation of ever growing new scientific knowledge on the epilepsies into improved treatment and outcomes for all patients. Increased NIH research, the establishment of a consortium (of doctors, patients and researchers working together) to collaborate on cooperative research studies through a Pediatric-Onset Epilepsies Consortium, and improved surveillance that includes the epilepsies in the NNCSS all hold great promise to both accelerate knowledge development and rapidly advance therapeutic options.

We appreciate your support and are eager to work with Congress and the Department of Health and Human Services to advance these efforts. I and the Epilepsies Action Network look forward to working with you to make these important advancements.

[This statement was submitted by Gabi Conecker, MPH, Co-Founder and Executive Director, Decoding Developmental Epilepsies.]

PREPARED STATEMENT OF THE EPILEPSY FOUNDATION

Thank you for the opportunity to submit testimony on behalf of the Epilepsy Foundation and the 3.4 million Americans living with the epilepsies whom we serve. Chairwoman Baldwin, Ranking Member Capito, and distinguished members of the subcommittee, we deeply appreciate the robust investments in public health and research programs over recent years which are helping us better understand and treat the epilepsies and better support people with epilepsy and their families day-to-day. The Epilepsy Foundation supports robust funding for many departments and programs that support epilepsy-related research and improve the lives of people with the epilepsies such as the National Institutes of Health and the Center for Disease Control and Prevention (CDC)'s National Neurological Conditions Surveillance System. Today, we focus our testimony on two vital programs that we urge you and your colleagues to continue investing in as you work on appropriations for FY 2024 by providing: $13 Million for the CDC's National Center for Chronic Disease Prevention and Health Promotion's Epilepsy Program and $164 Million for the CDC's Safe Motherhood & Infant Health Program in order to support and help expand the Sudden Unexpected Infant Death (SUID) & Sudden Death in the Young (SDY) Case Registry.

ABOUT THE EPILEPSY FOUNDATION

The Epilepsy Foundation is the leading national voluntary health organization that speaks on behalf of the approximately 3.4 million living with epilepsy and seizures. We foster the wellbeing of children and adults affected by seizures through research programs, educational activities, advocacy, and direct services.

ABOUT THE EPILEPSIES

Epilepsy is a disease or disorder of the brain which causes reoccurring seizures affecting a variety of mental and physical functions. It is a spectrum disease comprised of many diagnoses including an ever-growing number of rare epilepsies. There are many different types of seizures and varying levels of seizure control.

3.4 million Americans live with active epilepsy including 470,000 children and teenagers. Thirty to forty percent of people with epilepsy live with uncontrolled seizures despite available treatments. Delayed recognition of seizures and inadequate treatment increase a person's risk of subsequent seizures, brain damage, disability, and death. Epilepsy and/or seizures impose an annual economic healthcare burden of at least $54 billion on the country.

Please provide $13 million for CDC's Epilepsy program.

The Institute of Medicine's (IOM) report on epilepsy, Epilepsy Across the Spectrum: Promoting Health and Understanding, identifies the Epilepsy Foundation and the CDC as leaders in addressing many of its national recommendations to eliminate stigma, improve awareness and education and better connect people with the

epilepsies to health and community services. The CDC Epilepsy program is the only public health program specifically related to epilepsy with a national scope and community programs.

Focus areas requiring continued and increased investment include:

—Training for School Staff: In FY 22, 9,587 school nurses and 225,270 school personnel were trained on seizure recognition and seizure first aid.

—Seizure First Aid Certification: In FY 22, 16,988 people were certified in seizure first aid, in partnership with multiple healthcare professional groups including those serving minority communities.

—Professional Education in Epilepsy: To improve care in rural and underserved communities, in collaboration with partner organizations, 1,243 providers have been trained across two ECHO programs: Epilepsy & Neurology for primary providers and Managing Students with Seizures for School Nurses. In addition, webinars for behavioral and mental health providers have been developed as tools for ensuring access to epilepsy knowledge and skills.

—Addressing Disparities: Racial and ethnic minorities represent more than 40% of people living with epilepsy. Social determinants of health, such as housing and food insecurities, social isolation, poverty and more, create disparities, which may lead to lower rates of surgery, higher rates of medication non-adherence, and early mortality. Epilepsy-related disparities among racial and ethnic groups, underserved populations, and rural communities are being addressed through mini-grants to increase awareness and connect people with epilepsy to services, as well as partnerships with medical associations representing and serving racial and ethnic minorities.

—Supporting Mental Health Needs: Mental health screenings have been implemented on the 24/7 Epilepsy & Seizures Helpline since people with epilepsy are at increased risk for depression, anxiety, and suicide. Several suicide interventions have been successful. In addition, people with epilepsy are being connected to self-management programs that prevent and decrease depression.

Additional funding for the CDC Epilepsy Program would allow these successful programs and activities to be available in more parts of the country, particularly rural and underserved areas.

Please provide $164 million for the CDC's Safe Motherhood & Infant Health Program in order to support and help expand the SUID & SDY Case Registry.

SUDEP is the sudden, unexpected death of someone with epilepsy, who was otherwise healthy. It is the leading cause of death in people with uncontrolled seizures. Each year, it is thought that more than 1 in 1,000 people with epilepsy die from SUDEP and this number increases drastically to 1 in 150 for people whose epilepsy is not controlled by treatment. But there are deficiencies and inconsistencies with how SUDEP-related deaths are tracked. While some strides are being made, the exact cause(s) of SUDEP are not known.

Building on child death review programs at the National Center for Fatality Review and Prevention Case's Reporting System, the SUID portion was initiated in 2009 and in 2015, the SDY Case Registry component was added to include children and adolescents. A joint collaboration of the CDC and NIH, the SDY Case Registry increases the understanding of the prevalence, causes, and risk factors for infants, children, and young adults up to age 20, who die suddenly and unexpectedly including from SUDEP-informing strategies to prevent future deaths. The registry is present in 22 States and jurisdictions but this is capturing less than half of these deaths nationwide.

Increased investment in the CDC's Safe Motherhood/Infant Health Programwhere the Registry is housed-would allow more States to participate and in turn, yield more data to improve understanding and prevention.

The Epilepsy Foundation appreciates the opportunity to provide written testimony so that people living with the epilepsies have the support they need and so that we can continue to better understand and treat the epilepsies, as well as prevent epilepsy-related deaths. Should you have any questions, please contact Laura Weidner, Vice President of Government Relations & Advocacy at lweidner@efa.org.

PREPARED STATEMENT OF THE FAMILY PLANNING COALITION

Dear Chair Baldwin and Ranking Member Moore Capito,

The 66 below organizations represent millions of providers, researchers, program administrators, community advocates, and, most importantly, people who seek publicly funded family planning services. We applaud the committee for demonstrating strong support for family planning, including introducing a bill last year that in-

cluded robust increases for the Title X family planning program, the Teen Pregnancy Prevention Program (TPPP), and sexually transmitted disease (STD) prevention, as well as language to reduce administrative burdens for STD programs that receive Federal dollars. We were disappointed that both the Title X and TPPP were flat-funded in the fiscal year (FY) 2023 omnibus, and that the STD funding increase was too limited to counter the growing epidemics. These inadequate funding levels left programs without sufficient funding to meet the needs in their communities. We urge you to adequately fund these critical programs by appropriating $512 million for the Title X family planning program (Office of Population Affairs—OPA), $150 million for the Teen Pregnancy Prevention Program (OPA), $312.5 million for the Division of STD Prevention (Centers for Disease Control and Prevention—CDC), and $200 million for a new program to support clinical services related to sexually transmitted infections (HRSA) in the FY 2024 Labor, Health and Human Services, Education, and Related Agencies (Labor-HHS) bill.

TITLE X FAMILY PLANNING PROGRAM

Title X is the only Federal program dedicated to providing family planning services for people with low incomes. Title X-funded health centers are lifelines in their communities, providing high-quality reproductive and sexual health care, including cancer screenings, testing and treatment for STDs, contraceptive services and supplies, pregnancy testing, and other essential health care services. These centers are access points for people who often face severe structural barriers to accessing quality health care, such as people with low incomes, people with no or insufficient insurance, people of color, people who live and work in rural areas, and LGBTQ people. Indeed, six in 10 women who sought contraceptive care at Title X-funded health centers in 2016 said that provider was their only source of health care for the entire year.[1] In 2021, the program served 1.7 million people through 3,284 health centers across the country.[2]

Title X is funded at $286.5 million for FY 2023, well below the $500 million proposed in last year's House bill and the $737 million that Federal researchers determined in 2016 would be needed annually just to provide family planning care to low-income women without insurance.[3] This is a significant under-estimate of the true need, especially as the program now serves more than 200,000 men and an unknown number of nonbinary individuals each year.

These services are in jeopardy as a result of chronic underfunding to the Title X Program. Just last year dozens of grantees representing hundreds of potential service sites were approved by OPA but were left unfunded due to insufficient appropriations, leaving many people who could benefit from this care without access to Title X-supported services. Therefore, we respectfully request $512 million for the Title X program in FY 2024. That funding level will bring the program halfway to the federally supported funding recommendation and allow the program to begin to meet this growing need and reach millions more Americans.

STI PREVENTION, TREATMENT, AND TESTING

For the eighth year in a row, sexually transmitted infections (STIs)[4] are at an all-time high in the United States. STIs such as chlamydia, gonorrhea, and syphilis come at a steep price, with new STIs costing more than $1 billion in direct lifetime medical costs,[5] and can lead to lifelong medical issues and death. Increasing cases of syphilis in newborns (congenital syphilis) are particularly worrisome; cases of congenital syphilis have increased 203% in the past 5 years, and deaths from congenital syphilis increased 175% in the same period. Our nation's STD programs and the sexual health clinics that test and treat STIs are our front line of defense against these epidemics, but the COVID–19 pandemic, coupled with more than 17 years of

[1] Meghan Kavanaugh, "Use of Health Insurance Among Clients Seeking Contraceptive Services at Title X-Funded Facilities in 2016," Guttmacher Institute (June 2018).

[2] Christina Fowler, Julia Gable, and Beth Lasater, "Family Planning Annual Report: 2021 National Summary," Office of Population Affairs (September 2022). https://opa.hhs.gov/sites/default/files/2022-09/2021-fpar-national-final-508.pdf.

[3] Euna August, et al, "Projecting the Unmet Need and Costs for Contraception Services After the Affordable Care Act," American Journal of Public Health (February 2016): 334–341.

[4] Sexually transmitted infection (STI) is the updated medical term for infections transmitted through sex and includes both symptomatic and asymptomatic infections. The traditional term "sexually transmitted disease (STD)" refers only to symptomatic infections. Most Federal and State government divisions dedicated to preventing STIs are still officially named 'STD programs' and are referred to as such in this letter.

[5] "Sexually Transmitted Disease Surveillance 2021," Centers for Disease Control and Prevention (April 2023). https://www.cdc.gov/std/statistics/2021/default.htm.

level funding for STD programs, has resulted in a 40% reduction in buying power, further impeding efforts to get STIs under control.

First, we request $312.5 million for the Division of STD Prevention (DSTDP).[6] DSTDP, which is funded at $174.3 million for FY 2023, directly funds all 50 State health departments and six major cities to engage in STD prevention and control. Additional funding will allow STD programs to improve contact tracing, monitor trends in STI cases throughout their jurisdictions, and quickly respond to new outbreaks. Second, we request $200 million for a new demonstration project at HRSA to award grants to public and private nonprofit clinics for STI clinical services, which will address staffing shortages and expand capacity. Testing and prompt treatment for bacterial STIs are the best tools to reduce STI rates. However, no dedicated Federal program exists to directly and comprehensively support high-quality and accessible STI clinical services. This project will provide long overdue support for patients and their public and nonprofit providers.

THE TEEN PREGNANCY PREVENTION PROGRAM

We request $150 million in funding for the Teen Pregnancy Prevention Program (TPPP) for FY 2024. Since 2010, TPPP, along with the complementary Personal Responsibility Education Program (PREP),[7] have been recognized as pioneering examples of tiered, evidence-based policymaking. Originally funded at $110 million, the program has been funded at $101 million since 2014. The first two 5-year cycles of grants and evaluations have made a vital contribution to building a body of knowledge of what works for whom and under what circumstance to prevent teen pregnancy. In fact, the September 2017 unanimously-agreed-to-report from the bipartisan Commission on Evidence-Based Policymaking highlighted TPPP as an example of a Federal program developing increasingly rigorous portfolios of evidence.[8] A new round of 5-year grants is on track to be awarded this year with FY 2023 funds, and their continuation will be contingent on FY 2024 funding.

Since the early 1990s there have been steep declines in teen pregnancy and birth rates, across all racial and ethnic groups and in all 50 States. Yet disparities persist by race, ethnicity, age, and geography. TPPP has addressed these disparities by focusing funds on communities and populations with the greatest needs. Due to limited resources, the critical sexual health information provided by TPPP is out of reach for many. Increased funding would also ensure more young people receive the evidence-based information they need to live healthy lives and attain the goals they set for themselves. After years of decreased funding for TPPP, we encourage you to provide $150 million in FY 2024.

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[6] This request includes a continuation of the funds begun in the FY 2023 appropriations bill, including $15 million to move the grant year by 1 month, and $3 million to hold harmless grantee funding levels.

[7] A 3-year extension of funding for this mandatory funding stream, which expires at the end of FY 2023, was attached to the FY 2021 Omnibus and COVID Relief and Response Act (Public Law 116–260).

[8] Nick Hart and Meron Yohannes (eds.) Evidence Works: Cases Where Evidence Meaningfully Informed Policy. Bipartisan Policy Center (2019) Retrieved from: https://bipartisanpolicy.org/wp-content/uploads/2019/06/Evidence-Works-Cases-Where-Evidence-Meaningfully-Informed-Policy.pdf.

CONCLUSION

The undersigned organizations look forward to working with you on these priorities. Amidst a reproductive health care crisis in which millions of people are unable to access critical services, these investments in family planning and the ability of qualified providers to participate in these programs are even more crucial. If you have any questions, please contact Lauren Weiss at the National Family Planning & Reproductive Health Association (lweiss@nfprha.org).

Sincerely.

Act Now: End AIDS (ANEA) Coalition
Advocates for Youth
AIDS Action Coalition DBA Thrive Alabama
AIDS Alabama
AIDS Alliance for Women, Infants, Children, Youth & Families
AIDS United
American Academy of HIV Medicine
American Academy of Nursing
American Atheists
American College of Nurse-Midwives
American College of Obstetricians and Gynecologists
American Humanist Association
American Society for Reproductive Medicine
Association of Maternal & Child Health Programs
Association of Nurses in AIDS Care
Association of Schools and Programs of Public Health
Big Cities Health Coalition
Catholics for Choice
Center for Biological Diversity
Center for Reproductive Rights
Community Access National Network
Equality California
Five Horizons Health Services
Girls Inc.
Guttmacher Institute
Healthy Teen Network
HIV Medicine Association
Housing Works, Inc.
Ibis Reproductive Health
Ipas
Jacobs Institute of Women's Health
Jewish Women International
Los Angeles LGBT Center
March of Dimes
Medical Students for Choice
NARAL Pro-Choice America
NASTAD
National Abortion Federation
National Association of Nurse Practitioners in Women's Health
National Coalition of STD Directors
National Council of Jewish Women
National Family Planning & Reproductive Health Association
National Health Law Program
National Latina Institute for Reproductive Justice
National Organization for Women
National Partnership for Women & Families
National Women's Health Network
National Women's Law Center
National Working Positive Coalition
PAI
Physicians for Reproductive Health
Planned Parenthood Federation of America
Population Connection Action Fund
Population Institute
Power to Decide
Professional Association of Social Workers in HIV/AIDS
Religious Coalition for Reproductive Choice
Reproductive Health Access Project
SIECUS: Sex Ed for Social Change
Silver State Equality-Nevada
Society for Maternal-Fetal Medicine
Treatment Action Group
Union for Reform Judaism
Upstream USA
URGE: Unite for Reproductive & Gender Equity
Women of Reform Judaism

PREPARED STATEMENT OF FEDERAL TRIO PROGRAMS

Growing up in a divorced, low-income, immigrant household with a visually impaired father can be challenging and complex. For children in this situation, financial strain and limited access to resources may make it difficult to meet basic needs such as food and clothing. They may have different opportunities to participate in extracurricular activities, attend summer camps, or pursue other experiences that could inspire or broaden their horizons. Furthermore, they may need to give up some of their childhood to take on additional responsibilities, such as helping with chores and waking up at four in the morning to work in the fields and pick cherries and apples to help make ends meet. Additionally, you learn to navigate the world differently than your peers by not having both parents' full support and comfort. That is precisely my origin story.

At a young age, I learned the value of a dollar, and I knew that nothing came easy and that there are no shortcuts to life, only hard work, dedication, and the

willingness not to give up. I grew up in the rural town of Sunnyside, Washington, where the population is just over 16,000. When I turned ten, we moved to East Wenatchee, Washington, the world's apple capital, due to the valley's many orchards. I was surrounded not only by fruit-growing agriculture regions my whole life but by hard-working farm-working immigrants. My environment motivated me to stay focused in school and pursue the dreams my parents couldn't.

In 2017 I was accepted to Washington State University, and as many first-generation students may experience, I felt pressure, worry, and significant imposter syndrome throughout my undergraduate career. However, I overcame these challenges and achieved my goals with the proper support and resources. Upon being accepted to the University and TRIO Student Support Services (SSS), I was ecstatic to have the opportunity to start building a future for myself in hopes of one day helping my family. I spent my time at WSU making positive impacts as a student leader and advocate in my community while excelling academically. I joined various on-campus organizations and held part-time work-study jobs.

Although juggling many responsibilities at once became familiar, financing my education was another hurdle I had to overcome. I was "Pell eligible" and received the most financial aid possible, but sometimes it wasn't enough. My mother filed for bankruptcy that same year, and we had no home and a broken-down car. TRIO SSS offered money management workshops where I learned for the first time about credit, loan repayment, budgeting tips, and more. At the time, I was living in my first college apartment and needed extra guidance on managing money and expenses. During my sophomore year, I had the opportunity to study abroad, but my biggest worry was leaving and not knowing if I would have enough money to support myself throughout the trip, especially given my mother's financial situation.

Fortunately, TRIO awarded me a scholarship named the TRIO SSS Participation Achievement Award which helped to alleviate the cost of my First-Generation Study Abroad program to Seville, Spain. That summer, while I was in Spain, I felt the guilt of knowing my mother was living in a farmworker cabin while I was experiencing the excitement of living and learning in a beautiful foreign country. I knew I deserved to have those experiences, and I worried less because I got the support I needed at the right time.

As the years continued, I became the TRIO Graduating Scholar of the Year. Then the Council for Opportunity in Education (COE) selected me as its 2023 Thomas R. Wolanin Congressional Intern. An opportunity to experience living in the Nation's capital, and interning for a Member of Congress, was a dream come true. But it would only be possible for me to get here because of the consistent support system that TRIO SSS offered me. Because of that support, TRIO SSS made me a successful and confident university graduate.

The program's services provided me with the necessary tools and framework I needed every step of the way. For instance, the academic advising, success workshops, leadership conferences, FAFSA application assistance, money management tool lessons, and scholarship search assistance barely scrapes the surface of what the program indeed did for me. Growing up, my mother instilled in me the desire to pursue my dreams and the desire to serve. However, she could not provide me with social capital or expose me to opportunities outside of her job as a migrant farmworker.

Throughout my educational journey, I learned to utilize available resources and pass down what I learned to others. The uncertainties, fears, and doubts of not knowing how I would find resources, connect with a supportive community, or succeed slowly vanished. I knew I had a team who guided me and believed in my abilities. To this day, COE and my TRIO family offer me support, encouragement, and reassurance that there is always hope, even when times are tough or no matter your background.

I am deeply grateful for the sacrifices and hard work of TRIO professionals and advocates, especially for their efforts to support students from marginalized backgrounds. Their unwavering dedication and commitment to serving low-income, first-generation, and disabled students have paved the way for the success that we enjoy today. However, we must remember that more work still needs to be done. Every person deserves to have an equal chance at pursuing their academic dreams. Therefore, we must strive for equity and inclusion in every community and ensure that all students have access to the resources and support they need to succeed. From the bottom of my heart, I extend my sincerest appreciation and heartfelt thanks to all those who have played a role in shaping TRIO into what it is today.

[This statement was submitted by Cristalina Ramirez, Alumna, Federal TRIO Programs.]

PREPARED STATEMENT OF THE FEDERATION OF AMERICAN SOCIETIES OF EXPERIMENTAL BIOLOGY

Founded in 1912, FASEB is a nonprofit which provides a forum for educational meetings, develop publications, and disseminate results of biological research. Now the Nation's largest biomedical coalition, it represents 27 scientific societies and more than 115,000 researchers worldwide. Our mission is to advance health and well-being by promoting research and education in biological and biomedical sciences through collaborative advocacy and service to our member societies and their members.

FASEB FY 2024 Recommendation for the National Institutes of Health (NIH) is at least $50.924 billion for NIH. Funding for ARPA–H should supplement rather than supplant the budget as intended by ARPA–H's authorization.

Federal investments in fundamental research have led to remarkable progress in the biological and biomedical sciences—an increasingly multidisciplinary team-based effort. These collaborative research efforts have enabled investigators to respond to pressing scientific challenges. Basic research was the groundwork for the speed—months instead of years—that led to the development of COVID–19 vaccines and also supports pre-clinical research involving the use of animal studies to achieve medical progress.

A major contributing factor to the success of team science is the mobilization of core facilities and shared research resources (SRRs), including the scientific technology and expertise infrastructure within research organizations. SRRs and cores work across different scientific disciplines and deliver unbiased research data in support of scientific rigor and transparency. They are essential training grounds for the next generation of skills-based scientists from diverse backgrounds.

Despite Congress' bipartisan support for investing in science, Federal funding for research has not kept pace with scientific opportunity, posing a threat to our Nation's competitiveness. We face a real threat of losing our edge in industries such as biotechnology if we do not continue to prioritize increasing investments in science, shared resource facilities, including core facilities, and building a diverse workforce.[1] The U.S. spends less on research and development (R&D) than many countries. If the U.S. is to be prepared to respond to future threats, our scientific leadership must progress. According to Science Is Us, more than 67 million workers in the U.S. are professionals in science, technology, engineering, and math (STEM) fields. STEM economic activity accounted for 40.5 percent of U.S. gross domestic product in 2021.[2]

The Federal Government should commit to robust, predictable, and sustained funding increases for science agencies such as the National Institutes of Health (NIH).

The NIH is the Nation's largest public funder of biomedical research in the world, providing competitive grants to support the work of 300,000 scientists at universities, medical centers, independent research institutions, and companies nationwide. The biomedical discoveries, innovations, and treatments that NIH supports are possible because of scientific research with animals which provide in-depth knowledge of entire biological systems and complex disorders affecting multiple organs. As required by the Food and Drug Administration, animal research is also essential during the preclinical stage of drug development to determine the safety and efficacy of potential drugs and therapies prior to human clinical trials.

A recent example of NIH's effective ability to harness animal research and maximize its public-private partnerships, NIH collaborated with industry to develop a messenger RNA (mRNA) vaccine which was quickly adapted for COVID–19.[3] The agency also accelerated the development and commercialization of COVID testing through the Radx initiative.[4]

There is also the need to keep pace with the persistently increasing costs of research. Lab supplies are 20 percent more expensive due to continued supply chain issues. Labor costs have also grown, placing additional pressure on researchers who must carefully manage their grant budgets. Additionally, there is the need to continue to support pandemic preparedness efforts where the effects of COVID–19 variants are still impacting global economic growth which has dropped from 4.1 percent in 2022 to 3.2 percent in 2023. Also U.S. life expectancy has decreased by 2.7 years for the total population due to excess deaths related to COVID and other

[1] The State of U.S. Science and Engineering 2020 | NSF—National Science Foundation.
[2] People-of-Science-Economic-Impact-Analysis-FINAL_March-2023.pdf (scienceisus.org).
[3] Coronavirus Vaccines and Prevention | NIH: National Institute of Allergy and Infectious Diseases.
[4] RADx | National Institutes of Health (NIH).

causes and even more so for certain races and ethnic groups who were disproportionally affected by the pandemic.[5,6]

Though the NIH is in a stronger position than it was a few years ago, Congress must continue to increase biomedical research funding and continue pandemic preparedness efforts while researchers face inflation of 6.4 percent.[7] Our nation is confronting public health threats, especially given global climate change, land use, and international travel, that requires an even closer understanding of One Health-the collaborative, multisector, and transdisciplinary intersection of biological science, earth sciences, and ecology to optimize health outcomes. More research will be needed to address infectious diseases, long COVID, and the more than 10,000 rare diseases with zero or few treatment options while still making progress on more common diseases.[8]

In the U.S., we must also continue to address the needs of a growing aging population and the serious disease of obesity.[9,10] NIH research is developing therapies for a whole spectrum of age-related disorders.[11] Obesity impacts 42 percent of the U.S. population and increases the likelihood of developing costly medical conditions such as diabetes, cancer, and heart disease and is a substantial obstacle to military recruitment.[12,13] Additionally, minority populations experience a higher prevalence of these diseases.[14]

Our recommendation of at least $50.92 billion is $3.4 billion (7.2 percent increase) above FY 2023. With this funding level, NIH will have the necessary resources to accelerate progress across all areas of medical science, including regenerative medicine, cancer immunotherapy, and neurological health.[15,16,17] The agency will also be able to continue its commitment to support the next generation of our biomedical research enterprise.[18]

Prepared Statement of the Federation of Associations in Behavioral and Brain Sciences

Chairman Baldwin, Ranking Member Capito, and Members of the subcommittee:

The Federation of Associations in Behavioral and Brain Sciences (FABBS) is grateful for the opportunity to submit testimony for the record in support of the National Institutes of Health (NIH), Advanced Research Projects Agency in Health (ARPA–H) and the Institute of Education Sciences (IES). FABBS represents twenty-nine scientific societies and almost sixty university departments whose members and faculty share a commitment to advancing knowledge of the mind, brain, and behavior. For fiscal year (FY) 2024, FABBS requests $50.924 billion for the NIH, aligned with the Ad Hoc Group request, provide strong funding for ARPA–H and the IES, within the Department of Education, a budget of $900 million.

NATIONAL INSTITUTES OF HEALTH

FABBS members contribute to the NIH mission of seeking fundamental knowledge about the behavior of living systems and the application of that knowledge to enhance health, lengthen life, and reduce illness and disability. FABBS thanks the subcommittee for the consistent increases to NIH in recent years. As a member of the Ad Hoc Group for Medical Research and the Coalition for Health Funding, FABBS recommends at least $51 billion for NIH in FY 2024 and suggests that any funding for other targeted programs supplement the base budget, rather than supplant the essential foundational investment in the NIH.

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[5] ARPA–H | National Institutes of Health (NIH).
[6] New Report Confirms U.S. Life Expectancy has Declined to Lowest Level Since 1996 (cdc.gov).
[7] Consumer Price Index Summary—2023 M02 Results (bls.gov).
[8] NIH study suggests people with rare diseases face significantly higher health care costs | National Institutes of Health (NIH).
[9] Older People Projected to Outnumber Children (census.gov).
[10] Overweight & Obesity Statistics—NIDDK (nih.gov).
[11] Strategic Directions 2020–2025 | National Institute on Aging (nih.gov).
[12] Adult Obesity Facts | Overweight & Obesity | CDC.
[13] Obesity in the United States and Effects on Military Recruiting (congress.gov).
[14] Special issues regarding obesity in minority populations—PubMed (nih.gov).
[15] RMI | National Institutes of Health (NIH).
[16] NCI's Role in Immunotherapy Research—NCI (cancer.gov).
[17] Brain Initiative (nih.gov).
[18] Next Generation Researchers Initiative | grants.nih.gov.

Office of Behavioral and Social Science Research (OBSSR)

FABBS members are especially supportive of the OBSSR and appreciative for the growth to the Office's baseline budget that enables consistent and reliable funding to provide essential support across NIH Institutes and Centers (ICs). OBSSR coordinates and promotes basic, clinical, and translational behavioral and social science research at NIH and plays a crucial role enhancing trans-NIH investments in longitudinal datasets, technology in support of behavior change, innovative research methodologies, and promoting the inclusion of behavioral science in initiatives in partnership with ICs. OBSSR co-funds highly rated grants that ICs cannot fund alone and efficiently leverage investments across the NIH to broadly improve the quality and effectiveness of federally funded research.

National Institute of Mental Health (NIMH)

FABBS members are particularly interested in NIMH, the premier Federal agency responsible for transforming the understanding of mental health and the treatment of mental illnesses through basic biomedical, behavioral, and clinical research, to best inform prevention, early intervention, recovery, and cures. As a founding co-chair of the Friends of NIMH, we appreciate the bipartisan commitment to mental health, and request robust funding for NIMH in FY 2024. FABBS applauds the Administration's proposal for a $200 million increase for NIMH, to a total request of $2.542 billion. The additional funds would expand research on youth mental health, precision psychiatry, and COVID–19 as a risk factor for those with serious mental illness so that the Institute can build upon the significant achievements to advance the behavioral, biomedical, and social research mission and important initiatives to provide new insights and solutions to all. Recently, NIMH-funded researchers have:

—Developed strategies to maximize the impact of digital mental health, which is particularly critical given increased demand and workforce shortages.

—Found brief cognitive training may extend the antidepressant effects of ketamine.

To fully capitalize on these bipartisan committee priorities and improve the mental health of all Americans, we recommend that the committee continue to prioritize investments in the NIMH.

Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD)

As a member of the Friends of NICHD executive committee, FABBS recommends increasing the NICHD in FY 2024 in a way that is commensurate with any increase to the overall NIH budget. NICHD has facilitated significant advances in brain and behavioral research with far reaching implications for public health, maternal, child, and family health, and learning and language development. For example, NICHD-funded researchers have recently:

—Found the "Eat, Sleep, Console" (ESC) care approach to be more effective than using the Finnegan Neonatal Abstinence Scoring Tool (FNAST) to assess and manage opioid-exposed newborns.

—Determined characteristics of the cries of preterm infants that may help predict their risk for long-term developmental and behavioral problems. The findings may lead to tools to identify babies at the highest risk for such issues, aiding early treatment or prevention efforts.

—Determined that depression may be a risk factor for problematic social media use, to the point of it interfering with daily functions of both children and adults.

NICHD needs additional funding for a range of topics including behavioral research on child developmental trajectories, across infancy, childhood, and adolescence, in both at-risk and normative environments, across diverse contexts and including underrepresented and vulnerable groups.

ADVANCED RESEARCH PROJECTS AGENCY FOR HEALTH (ARPA–H)

FABBS is pleased to see the progress at ARPA–H and encourages the subcommittee to continue to ensure that additional appropriations for the agency supplement, rather than supplant, funding for NIH. We are eager to see how this new agency will effectively take a cross-disciplinary approach to questions that are challenging to address in the current organizational approach of NIH.

INSTITUTE OF EDUCATION SCIENCES (IES), U.S. DEPARTMENT OF EDUCATION

FABBS is grateful for the subcommittee's increase for IES over the past few fiscal years. As members of the Friends of IES, FABBS encourages the subcommittee to appropriate at least $900 million to IES in FY 2024. This funding level will allow

the Institute to build on the FY 2023 enacted budget to maximize its capacity to advance innovative research, develop the methodological skills of education researchers, and continue to support high-quality and trustworthy statistics and evidence-based resources. The National Academies of Science, Engineering, and Medicine (NASEM) recommendations for the future of education research provide an exciting path forward for the agency, outlining approaches to make progress in issues of critical importance to education policy and practice and improve learner outcomes for all students. However, the report finds that "Given the breadth of what IES is expected to accomplish as mandated in ESRA [the Education Sciences Reform Act], its funding for both programmatic activities and staffing has historically been limited in comparison to other Federal science, research, and statistical agencies with similar objectives [and] in order to achieve the overarching vision presented through these recommendations, IES will require additional investments." An increase in funding for FY24 would bolster the necessary education research and data infrastructure to address emerging and persistent challenges in education.

Thank you for considering this testimony.

FABBS Member Societies:

Academy of Behavioral Medicine Research, American Educational Research Association, American Psychological Association, American Psychosomatic Society, Association for Applied Psychophysiology and Biofeedback, Association for Behavior Analysis International, Behavior Genetics Association, Cognitive Neuroscience Society, Cognitive Science Society, Flux: The Society for Developmental Cognitive Neuroscience, International Congress of Infant Studies, International Society for Developmental Psychobiology, National Academy of Neuropsychology, The Psychonomic Society, Society for Behavioral Neuroendocrinology, Society for Computation in Psychology, Society for Judgement and Decision Making, Society for Mathematical Psychology, Society for Research in Adolescence, Society for Psychophysiological Research, Society for the Psychological Study of Social Issues, Society for Research in Child Development, Society for Research in Psychopathology, Society for the Scientific Study of Reading, Society for Text & Discourse, Society of Experimental Social Psychology, Society of Multivariate Experimental Psychology, Vision Sciences Society

[This statement was submitted by Juliane Baron, Executive Director, Federation of Associations in Behavioral and Brain Sciences.]

PREPARED STATEMENT OF THE FEDERATION OF ASSOCIATIONS IN BEHAVIORAL AND BRAIN SCIENCES

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[This statement was submitted by Juliane Baron, Executive Director, Federation of Associations in Behavioral and Brain Sciences.]

PREPARED STATEMENT OF FIGHT CRIME: INVEST IN KIDS

Thank you Chairwoman Baldwin, Ranking Member Capito, and Appropriations Committee members for the opportunity to share the law enforcement perspective on addressing the child care crisis in West Virginia and nationwide. My name is Dan James, Prosecuting Attorney for Morgan County, West Virginia. Additionally, I am a member of Fight Crime: Invest in Kids, a group of over 5,000 police chiefs, sheriffs, prosecutors, and attorneys general from every State in the country advocating for evidence-based solutions that reduce crime and steer children toward success. My fellowFight Crime: Invest in Kids members and I urge Congress to protect and strengthen programs like Child Care and Development Block Grant (CCDBG), Preschool Development Grants, Birth to Five (PDG B–5), and Head Start and Early Head Start, which are essential tools in efforts to reduce juvenile involvement in the criminal justice system and guide the next generation towards positive outcomes in the long term.

Last year, Fight Crime: Invest in Kids released a research brief discussing the importance of having a solid foundation for educational success in a child's earliest years. This brief highlighted an independent cost-benefit analysis of universal preschool programs that found approximately $3 were saved in net profit for every dollar invested into preschool programs. If preschool programs were expanded to include the approximately six million additional children who are not served now, our Nation could realize a return on investment of $90 billion. In West Virginia alone, an additional 28,000 children could be served with expanded preschool programs, saving an estimated $420 million.

Our research brief shows investments in the youngest in our society can improve academic performance—including high school graduation—and reduce the risk that participants will become involved in crime later. Studies show attendance in preschool programs increases school readiness and success, reduces likelihood of behavioral infractions at all grade levels, and is linked to long term crime reduction.

From the law enforcement perspective, no police chief, sheriff, or prosecutor wants to slam the book on any child. They want to uplift them and allow them to prosper so the child benefits, the family benefits, and the community benefits. We as law enforcement leaders know that a prime way to reduce crime in the long run is strong investments in high-quality programs that allow children to develop properly and prepare them for school and life.

To leverage the return on investment we see from early childhood programs, we must increase funding for Child Care and Development Block Grant (CCDBG), Preschool Development Grants, Birth to Five (PDG B–5), and Head Start and Early Head Start for Fiscal Year (FY) 2024.

By increasing funding for programs like CCDBG, PDG B–5, and Head Start and Early Head Start, we can begin to counteract this crisis and provide children with the tools they need to steer away from crime and towards life-long success.

In West Virginia, the lack of child care and early learning programs also hurts the economy. According to a new report by the business leaders of ReadyNation, the lack of child care in West Virginia causes economic damage of $464 million per year in lost wages, productivity, and revenue, and that's just for kids under age 3. The infant-toddler child care crisis has doubled in the last 4 years, and the damage is $122 billion per year nationwide. Two thirds of West Virginians live in a child care "desert," with more than three young children for each licensed child care slot.

For FY24, Fight Crime: Invest in Kids asks to increase funding to $12.4 Billion for Child Care and Development Block Grants (CCDBG). These grants provide a flexible child care subsidy or "voucher" that parents can use at a wide variety of licensed providers. In West Virginia, CCDBG serves only 19.0 percent of eligible children due to funding constraints, leaving a lot of families without affordable options for high-quality child care. Ensuring that a child is taken care of properly and not neglected is a priority of law enforcement leaders everywhere. Beginning with infants and toddlers, the first few years of a child's life are the most important to brain development, and we must be investing in ways to ensure they can develop in a safe and secure environment to promote later in life success.

For FY24, we request that the Committee increase funding to $500 Million for Preschool Development Grants, Birth to Five (PDG B–5). PDG B–5 provides competitive grants designed to improve school readiness among children from families with low incomes, smooth transitions from early childhood programs into elementary school, and leverage new and current efforts to increase access to programs, improve program quality, and maximize parental choice. West Virginia's Department of Health and Human Resources recently won a $2 million grant from PDG B–5. Currently, West Virginia has 11,981 children enrolled in pre-K. West Virginia has a universal pre-k program that serves all 4 year olds (and some 3 year olds with special needs. The universal program meets 9 out of 10 quality standards, but additional funding would ensure more children get slots and the opportunity to benefit from quality early education. Setting up the foundation for success in school is essential to preventing behavioral issues that lead to interactions with the criminal justice system.

For FY24, we ask the Committee to increase funding to $17.47 Billion for Head Start and Early Head Start. Head Start and Early Head start are programs that support children and families by providing high-quality early learning and wraparound services to help them rise out of poverty. In West Virginia, 7,804 program slots are available with only 1,086 of those slots for Early Head Start. Only seven percent of eligible children in West Virginia are served by Early Head Start, and 29 percent of eligible children are served by Head Start. Wraparound services such as home visits, behavioral screenings, and preventative dental care are key components of this program that reduce crime by preventing child abuse and neglect which we know is linked to a child's future involvement with crime. By investing the dollars now, we prevent their interactions with me in the courtroom down the line, saving the taxpayers money. If we are serious about crime prevention, we need to create positive environments for children to thrive and break cycles of abuse and neglect.

I would like to again thank this subcommittee for the opportunity to elevate the importance of funding programs that combat the child care crisis. Children deserve the highest standards of care to ensure they stay on a path toward success. Federal funding for programs like these help ensure these children develop the tools necessary to succeed in this ever changing world.

Historically, supporting children and their development has been a bipartisan issue. This year is no different, with a record number of Republicans and Democrats supporting early childhood programs in Congress.

I look forward to seeing the bipartisanship continue as you look at critical investments for the upcoming fiscal year.

[This statement was submitted by Dan James, Prosecuting Attorney for Morgan County, West Virginia.]

PREPARED STATEMENT OF THE FLORIDA A&M UNIVERSITY

Chair Murray, Chair Baldwin, Vice Chair Collins, Ranking Member Capito, and Members of the Labor, Health and Human Services, and Education, and Related Agencies subcommittee, thank you for the opportunity to submit public testimony on the subcommittee's Fiscal Year (FY) 2024 appropriations bill. Florida A&M Uni-

versity (FAMU) is grateful for the historic support of Congress during the pandemic. Maintaining or enhancing funding is critical for programs of interest to the University and our students, including the Department of Education's Historically Black Colleges and Universities (HBCU) programs, the HBCU Capital Financing Program, and the Federal Pell Grants program. FAMU also supports two programs at the Department of Health and Human Services—the National Institutes of Health's Research Centers in Minority Institutions and the Health Resources and Services Administration's Health Careers Opportunity Program. These Federal programs provide significant support to the University, our students as well as other institutions of higher education across the Nation.

Florida A&M University, based in the State capital of Tallahassee, Florida, was founded in 1887 with only 15 students and two instructors. Today, FAMU offers 98 undergraduate, graduate, postgraduate, and professional degree programs to nearly 10,000 students. We are proud to be the highest ranked among public Historically Black Colleges and Universities (HBCU) for four consecutive years, according to the 2023 U.S. News and World Report National Public Universities. The University is a leading land-grant research institution with an increased focus on science, technology, engineering, mathematics, agriculture and health. As noted by Diverse Issues, FAMU is a top producer of African American undergraduate degrees and doctoral degrees in pharmacy and pharmaceutical sciences and Bestcolleges.com recently ranked FAMU first among HBCUs for health science majors.

Federal support is critical for institutions of higher education, particularly HBCUs, which are historically under-resourced. Robust Federal funding for programs that help to improve our institutions, broaden access for students, and enhance student success is paramount. The Department of Education HBCU programs help us achieve these goals and the Federal Pell Grant program is an imperative resource for our students as the majority of our students are Pell-eligible. Furthermore, the Department of Health and Human Services' research and career development programs that support minority students also benefit FAMU, our students, and the Nation. FAMU strongly supports the allocation of resources for these vital Federal programs.

DEPARTMENT OF EDUCATION HISTORICALLY BLACK COLLEGES AND UNIVERSITIES PROGRAMS

FAMU strongly supports robust funding for the Department of Education HBCU programs under the Higher Education, Aid for Institutional Development Programs account. These programs, authorized under Title III of the Higher Education Act, provide critical support to higher education institutions that enroll large proportions of minority and financially disadvantaged students. One of the primary missions of the Title III programs has been to support the Nation's HBCUs. The Strengthening Historically Black Colleges and Universities program and the Historically Black Graduate Institutions program provide FAMU and other HBCUs with formula grants to help sustain our academic, administrative, and fiscal capabilities.

The President's FY 2024 budget requests $402.6 million for the Strengthening Historically Black Colleges and Universities program. These formula grants provide critical support to HBCUs that help to improve our facilities, develop faculty, support academic programs, strengthen institutional management, enhance our development and recruitment activities, and provide tutoring and counseling services to students.

We support the President's FY 2024 budget request of $102.3 million for the Strengthening Historically Black Graduate Institutions as well, which funds 5-year grants to provide scholarships for disadvantaged students, academic and counseling services to improve student success, and supports infrastructure and facilities improvements.

FAMU, like other HBCUs, has a critical need for funding to support equipment upgrades and purchases, construction and renovation of our facilities, and the development of our academic programs. This includes a wide variety of projects to strengthen the University and its programs, such as expansion of our online education offerings to enhance pathways to degree attainment, upgrading our information technology infrastructure, construction of laboratories, research and education facilities, and upgrading our health sciences and technology equipment and facilities. Continued funding for these HBCU programs and other Aid for Institutional Development programs is essential to postsecondary institutions, like FAMU, that educate the Nation's minority students.

DEPARTMENT OF EDUCATION HISTORICALLY BLACK COLLEGES AND UNIVERSITIES CAPITAL FINANCING PROGRAM

FAMU supports the FY 2024 President's budget request of $20.8 million for the Department of Education's HBCU Capital Financing Program, which provides low-cost capital to finance improvements to the infrastructure of the Nation's HBCUs. Specifically, the program provides accredited HBCUs with access to capital financing or refinancing for the repair, renovation, and construction of classrooms, libraries, laboratories, dormitories, instructional equipment, and research instrumentation.

FAMU, like other HBCUs, has a critical need to upgrade and rehabilitate our aging facilities. This program makes capital available for HBCUs to improve our academic facilities, which will enhance the learning experience for our students. The funding requested would be used to pay the loan subsidy costs in guaranteed loan authority under the program. We urge the subcommittee to provide full funding for FY 2024, which will allow HBCUs to continue to refinance previous capital project loans, renovate existing facilities, or build new facilities in alignment with our peer institutions.

DEPARTMENT OF EDUCATION PELL GRANT PROGRAM

FAMU supports robust funding for the Pell Grant program under the Department of Education's Student Financial Assistance account. The Federal Pell Grant program, authorized by Title IV of the Higher Education Act, is the largest source of Federal grant aid supporting college students. The Pell Grant Program provides need-based grants to low-income undergraduate students to promote access to postsecondary education.

Nearly 60 percent of our enrolled students rely on Pell grants to attend our institution. As Pell Grants account for less than one-third of the average cost of attendance at public 4-year universities, we join many national education associations in requesting an increase in the maximum individual award to $12,990. By nearly doubling the award, Congress will provide critical support for economically disadvantaged college students as we continue to rebound from one of the most challenging periods in our Nation's history. We expect that our current and prospective students will be dependent on financial assistance, including Pell Grants, in order to continue pursuing their postsecondary education goals.

NATIONAL INSTITUTES OF HEALTH RESEARCH CENTERS IN MINORITY INSTITUTIONS

FAMU supports funding at the FY 2023 enacted level of $88.765 million for the NIH National Institute on Minority Health and Health Disparities (NIMHD), Research Centers in Minority Institutions (RCMI) Program. The RCMI Program, established in 1985, supports critical infrastructure development and scientific discovery in historically minority graduate and health professional schools. The program serves the dual purpose of bringing more racial and ethnic minority scientists into mainstream research and promoting minority health research because many of the investigators at RCMI institutions study diseases, like COVID–19, that disproportionately affect minority populations. Notably, the employees at the FAMU community testing site were selected as the Tallahassee Democrat "Person of the Year" and have provided more than 694,000 tests and almost 30,000 vaccines to the Big Bend area since April 25, 2020.

Since program inception, the FAMU RCMI Center has greatly benefited from this program, which has provided critical infrastructure to enable the College of Pharmacy and Pharmaceutical Sciences | Institute of Public Health to achieve national prominence and become a competitive biomedical research center nationally. The RCMI support of FAMU led the College to implement four doctoral tracks in pharmaceutical sciences, including pharmacology/toxicology, medicinal chemistry, pharmaceutics, and environmental toxicology. With RCMI support, our College of Pharmacy has graduated more than 60 percent of the African American doctoral recipients in the pharmaceutical sciences nationally.

DEPARTMENT OF HEALTH AND HUMAN SERVICES, HEALTH RESOURCES AND SERVICES ADMINISTRATION, HEALTH CAREERS OPPORTUNITY PROGRAM

FAMU supports the FY 2024 President's budget request of $18.5 million for HRSA's Health Careers Opportunity Program (HCOP). First authorized in 1972, the HCOP competitive grant program aims to provide individuals from disadvantaged backgrounds an opportunity to develop the skills needed to successfully compete for, enter, and graduate from a health or allied health professions school. HCOP focuses on three key milestones of education: high school completion; acceptance, retention

and graduation from college; and acceptance, retention and completion of a health professions degree program. The ultimate goal of the HCOP program is to diversify the health professions workforce by narrowing the educational achievement gaps between individuals from higher-income and lower-income households.

The Health Careers Opportunity Program (HCOP) High School Summer Institute, conducted on FAMU's campus, is designed for high school students interested in pursuing a career in a health profession. The four-week program provides a wide-range of educational and social experiences for rising 10th, 11th and 12th grade students. The entire experience is designed to enhance participants' academic abilities, social skills, and other competencies to increase their competitiveness for admission to a post-secondary health professions program.

The President's FY 2024 budget increases funding for HRSA's Health Professions Training for Diversity Programs, including the HCOP. Continued funding is critical for these programs that help address the shortage of underrepresented minorities in health professions.

We urge the subcommittee to support continued and/or enhanced funding for these critical education programs at the Departments of Education and Health and Human Services. We thank you for your continued support of Federal postsecondary initiatives that not only directly benefit the University and our students, but the region and the Nation as well. Thank you for your consideration.

[This statement was submitted by Larry Robinson, Ph.D., President, Florida A&M University.]

PREPARED STATEMENT OF THE FLORIDA AGRICULTURAL AND MECHANICAL UNIVERSITY

Chair Murray, Chair Baldwin, Vice Chair Collins, Ranking Member Capito, and Members of the Labor, Health and Human Services, and Education, and Related Agencies subcommittee, thank you for the opportunity to submit public testimony on the subcommittee's Fiscal Year (FY) 2024 appropriations bill. Florida A&M University (FAMU) is grateful for the historic support of Congress during the pandemic. Maintaining or enhancing funding is critical for programs of interest to the University and our students, including the Department of Education's Historically Black Colleges and Universities (HBCU) programs, the HBCU Capital Financing Program, and the Federal Pell Grants program. FAMU also supports two programs at the Department of Health and Human Services—the National Institutes of Health's Research Centers in Minority Institutions and the Health Resources and Services Administration's Health Careers Opportunity Program. These Federal programs provide significant support to the University, our students as well as other institutions of higher education across the Nation.

Florida A&M University, based in the State capital of Tallahassee, Florida, was founded in 1887 with only 15 students and two instructors. Today, FAMU offers 98 undergraduate, graduate, postgraduate, and professional degree programs to nearly 10,000 students. We are proud to be the highest ranked among public Historically Black Colleges and Universities (HBCU) for four consecutive years, according to the 2023 U.S. News and World Report National Public Universities. The University is a leading land-grant research institution with an increased focus on science, technology, engineering, mathematics, agriculture and health. As noted by Diverse Issues, FAMU is a top producer of African American undergraduate degrees and doctoral degrees in pharmacy and pharmaceutical sciences and Bestcolleges.com recently ranked FAMU first among HBCUs for health science majors.

Federal support is critical for institutions of higher education, particularly HBCUs, which are historically under-resourced. Robust Federal funding for programs that help to improve our institutions, broaden access for students, and enhance student success is paramount. The Department of Education HBCU programs help us achieve these goals and the Federal Pell Grant program is an imperative resource for our students as the majority of our students are Pell-eligible. Furthermore, the Department of Health and Human Services' research and career development programs that support minority students also benefit FAMU, our students, and the Nation. FAMU strongly supports the allocation of resources for these vital Federal programs.

DEPARTMENT OF EDUCATION HISTORICALLY BLACK COLLEGES AND UNIVERSITIES PROGRAMS

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account. These programs, authorized under Title III of the Higher Education Act, provide critical support to higher education institutions that enroll large proportions of minority and financially disadvantaged students. One of the primary missions of the Title III programs has been to support the Nation's HBCUs. The Strengthening Historically Black Colleges and Universities program and the Historically Black Graduate Institutions program provide FAMU and other HBCUs with formula grants to help sustain our academic, administrative, and fiscal capabilities.

The President's FY 2024 budget requests $402.6 million for the Strengthening Historically Black Colleges and Universities program. These formula grants provide critical support to HBCUs that help to improve our facilities, develop faculty, support academic programs, strengthen institutional management, enhance our development and recruitment activities, and provide tutoring and counseling services to students.

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search Centers in Minority Institutions (RCMI) Program. The RCMI Program, established in 1985, supports critical infrastructure development and scientific discovery in historically minority graduate and health professional schools. The program serves the dual purpose of bringing more racial and ethnic minority scientists into mainstream research and promoting minority health research because many of the investigators at RCMI institutions study diseases, like COVID–19, that disproportionately affect minority populations. Notably, the employees at the FAMU community testing site were selected as the Tallahassee Democrat "Person of the Year" and have provided more than 694,000 tests and almost 30,000 vaccines to the Big Bend area since April 25, 2020.

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FAMU supports the FY 2024 President's budget request of $18.5 million for HRSA's Health Careers Opportunity Program (HCOP). First authorized in 1972, the HCOP competitive grant program aims to provide individuals from disadvantaged backgrounds an opportunity to develop the skills needed to successfully compete for, enter, and graduate from a health or allied health professions school. HCOP focuses on three key milestones of education: high school completion; acceptance, retention and graduation from college; and acceptance, retention and completion of a health professions degree program. The ultimate goal of the HCOP program is to diversify the health professions workforce by narrowing the educational achievement gaps between individuals from higher-income and lower-income households.

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The President's FY 2024 budget increases funding for HRSA's Health Professions Training for Diversity Programs, including the HCOP. Continued funding is critical for these programs that help address the shortage of underrepresented minorities in health professions.

We urge the subcommittee to support continued and/or enhanced funding for these critical education programs at the Departments of Education and Health and Human Services. We thank you for your continued support of Federal postsecondary initiatives that not only directly benefit the University and our students, but the region and the Nation as well. Thank you for your consideration.

[This statement was submitted by Larry Robinson, Ph.D., President, Florida A&M University.]

PREPARED STATEMENT OF THE FRED HUTCHINSON CANCER CENTER

Fred Hutchinson Cancer Center (Fred Hutch) appreciates the robust and reliable funding Congress has provided for the National Institutes of Health (NIH) in the past, and strongly urges continued support for this vital funding moving into the future. Prioritizing NIH funding as a key national investment helps to establish the United States as a world leader in health innovation, biomedical research and scientific advancement, and empowers the education and careers of our next generation of scientific and health care leaders. Critical investments in the NIH lead to more discoveries and increased development of therapies, treatments, and cures, helping patients to live longer and healthier lives.

For fiscal year (FY) 2024, Fred Hutch urges the subcommittee to support a program level of at least $50.9 billion in base funding for the NIH.

This spring marks the 1-year anniversary of an exciting evolution for Fred Hutch. On April 1, 2022, Fred Hutchinson Cancer Research Center and Seattle Cancer

Care Alliance came together into one, independent entity, to form Fred Hutchinson Cancer Center (Fred Hutch). This opportunity to clinically integrate world-class research with one of the top cancer care hospitals in the Nation will lead to greater advances in adult oncology—bringing the research bench to the bedside. We anticipate increased numbers of clinical trials, as well as increased access to groundbreaking research and clinical care.

As the only Dedicated Cancer Center in the Pacific Northwest, serving patients in five northwestern States, Fred Hutch is actively identifying and working to fill gaps in cancer care by prioritizing an increasingly diverse patient population. It is our role to build caring relationships with all communities, and especially those experiencing disparities. Strategic outreach in traditionally underserved communities is one of the many ways Fred Hutch is developing relationships with our neighbors in all corners of our region.

Below are some examples of how NIH funding drives Fred Hutch innovation and helps shape the future generation of scientists.

Mitigating Health Inequities in Clinical Trials. History demonstrates that racial and ethnic minorities have been underrepresented in clinical trials and genetic studies. People from racial and ethnic minorities hold a heavier burden of negative health and economic impacts, and studies show these same individuals have higher rates of cancer and are more likely to die from the disease. Greater inclusion helps to further sharpen precision medicine and ultimately brings us closer to achieving our mission to find cures for cancers and diseases in all people—and there is still a lot of work to be done to improve.

While health inequities have had a disproportionate impact on racial and ethnic minorities in the United States for a long time, the COVID–19 pandemic brought these disparities into stark focus, highlighting social, political, economic, and environmental factors that play an important role in health disparities. In order to reduce these disparities and promote inclusion and participation of individuals from diverse groups in clinical trials, Fred Hutch leveraged the infrastructure already in place from coordinating the global vaccine trials for HIV for more than 20 years through the HIV Vaccine Trials Network (HVTN) to lead operations for the COVID–19 Prevention Network (CoVPN), funded by the National Institute of Allergy and Infectious Diseases. The CoVPN included five large-scale COVID–19 vaccine efficacy trials with more than 200 clinical trial sites across the world, which included more than 600,000 volunteers. As a result of this and ongoing work, the trials for CoVPN were some of the most diverse in history.

Empowering Early Career Researchers and Other Health Experts. The focus on health equity underscores all work of Fred Hutch, which includes building a more diverse and innovative scientific and clinical workforce. Robust funding for the NIH not only bolsters important research programs—it secures the future of science. Increases in NIH funding enable initiatives to reduce barriers to academia and provide training and education for young scientists, as well as encourage more culturally inclusive research.

Fred Hutch invests $2 million annually in science education programs and is currently in the process of expanding to allied health and other types of opportunities. Scientific internships at Fred Hutch range from high school and college, as well as mentorship and development resources for graduate students, postdoctoral fellows, and early-career faculty. The Science Education Partnership, which started in 1991, has paired researchers with more than 580 secondary school science teachers in Washington state through workshops and a summer professional development program.

Recruitment and Retention of Exceptional Researchers. Fred Hutch opposes provisions such as directives to reduce salary support for extramural researchers, that would harm the appeal of academic research. Policies to cut salary support would undermine Fred Hutch's ability to recruit and retain the talented researchers that keep our U.S. institutions thriving. Emphasized in the current workforce climate, there are countless desirable options for researchers and health care experts to pursue and their retention is essential to maintain our Nation's innovation ecosystem.

The partnership between the NIH and the research institutions and scientists across America is highly productive. The Federal Government has an irreplaceable role in supporting biomedical research, with no other entity willing or able to provide the broad and sustaining funding that leads to innovative breakthroughs. Fred Hutch depends on NIH funding to conduct basic, translational, clinical, public health, and infectious disease research, as well as the ability to respond rapidly and expertly to the needs of our Nation, such as during the COVID–19 pandemic. Sustained and robust funding for the NIH will contribute to our efforts to support future pandemics and numerous other global health challenges for the years ahead.

Consistent with our mission and values, Fred Hutch will continue working to increase access to the highest quality cancer treatments and services for all patients. We will continue to hone scientific innovation, such as telehealth and data science, to increase prevention efforts across entire populations and also to connect with individual patients—in ways that ultimately improve cancer outcomes for everyone.

Fred Hutch appreciates the Labor-HHS subcommittee for your continued leadership and dedication to ensuring the continued and robust funding for the NIH. Thank you for the opportunity to share our recommendation to provide at least $50.9 billion in FY 2024 for the NIH base program. As our Nation continues to rebuild and looks ahead to prepare for potentially future pandemics, now is the time to rededicate the commitment to science and support for efforts to seize upon the abundance of scientific opportunities.

[This statement was submitted by Thomas J. Lynch Jr., MD, President and Director, Fred Hutchinson Cancer Center.]

PREPARED STATEMENT OF THE FRIENDS OF THE INSTITUTE OF EDUCATION SCIENCES

Chair Baldwin, Ranking Member Capito, and Members of the subcommittee, thank you for the opportunity to submit written testimony on behalf of the Friends of IES, a coalition of scientific and professional associations, K–12 and higher education organizations, universities, and independent research organizations committed to supporting the mission of IES and the use of research and statistics. We recommend at least $900 million for the Institute of Education Sciences (IES) in the FY 2024 Labor, Health and Human Services, and Education Appropriations bill.

Our member organizations rely on IES to support vital research that addresses many of the most important issues in our Nation's schools. We are deeply thankful for the increases provided to IES in recent years to further invest in education research and statistical infrastructure and to respond to the impact of COVID–19 in exacerbating pre-existing learning gaps.

IES is an independent, nonpartisan branch of the U.S. Department of Education charged with providing information on the condition and progress of education, educational practices that support learning and improve academic achievement and access to educational opportunities for all students, and the effectiveness of Federal and other education programs. IES works collaboratively across its programs to meet this mission through producing high-quality research, trustworthy data and statistics, and developing partnerships between researchers and practitioners to inform evidence-based education policy and practice.

Research supported by IES has been incorporated in classrooms to enhance instruction and support students' academic and non-academic outcomes. Projects that received a total of nearly $100 million in funding through the FY 2022 Education Research Grant competition are directly involving 15 million students and 360,000 teachers. Recent examples being addressed in these grants range from equity in education focused on community college students and youth in foster care, to testing the effectiveness of an educational robotics program, to understanding the long-term impact of the use of a social-emotional development tool, INSIGHTS.

FY 2023 appropriations for IES represent less than one percent of the total discretionary funding for the Department of Education. Similar to the investment that the Federal Government makes in medical research at the National Institutes of Health to advance health outcomes, the investment in IES is essential to address persistent and emerging challenges in education.

IES remains constrained in its flexibility to fully fund emerging research areas and scale up promising interventions and resources. About one of every 10 grant proposals receives funding support in a typical year, limiting the ability of IES to tackle pressing questions in education. Due to limited funding, IES has been forced to curtail funding new research proposals, was unable to run competitions in education research and special education research, and delayed the administration of important statistical surveys.

With appreciation for the boost provided in FY 2023, additional funding for Research, Development, and Dissemination (RD&D) is essential to support needed research in foundational and emerging topics, including measures and assessments in career and technical education; the development and testing of education technology products that can personalize instruction; and approaches to teacher recruitment, retention, certification, assessment, and compensation. Additional funding within RD&D is critical to support research that drives the development of evidence-based education programs, that in turn complements new IES activities promoting high-reward and quick-turnaround scalable solutions to improve student outcomes. Increased investment in RD&D could also support additional work to leverage the suc-

cess of IES-funded programs that have demonstrated improvements in academic and non-academic outcomes.

The National Center for Education Statistics (NCES) is the primary Federal entity dedicated to collecting data related to education and is the only principal statistical agency dedicated to this mission. NCES works with stakeholders to provide relevant data through administrative and longitudinal surveys, but limited funding and staff resources over the past decade has resulted in constraining NCES in its capacity to meet the real-time data needs of researchers and policymakers. Additional funding for NCES would provide greater flexibility to develop surveys such as the School Pulse Panel and more quickly release important educational indicators. Expanded resources for NCES bolster the agency's capacity to analyze data on timely education issues and link administrative education data to health and employment data for evidence-based policymaking and to understand the broader context of outcomes.

NCES importantly provides the funding support and infrastructure for the Statewide Longitudinal Data Systems (SLDS) program, providing critical investment for States to link K–12, postsecondary, and workforce systems to gain a better understanding of education and workforce outcomes. This work is particularly important for questions of national interest, such as interest and persistence in STEM areas to develop needed workforce talent. IES is also emphasizing the research use of SLDS to measure the effects of interventions on long-term student outcomes and in examining the impact of State education policy actions in supporting learning recovery, such as community college persistence and completion in Tennessee. Additional resources for SLDS can support States in linking data across education and workforce systems.

In addition to the research supported by the National Center for Education Research, the Regional Educational Laboratories (RELs) conduct applied research that is directly relevant to state and district administrators, principals and teachers. RELs also ensure that research is shared widely through its deep dissemination networks. During the pandemic, the RELs have provided a wide range of evidence-based resources to guide teachers, school leaders, and State and local officials on COVID–19 response. This work is all driven by the State education agencies and other stakeholders in the regions. Additional funding is needed to research and support growing local and regional needs to respond to the impact of the pandemic on academic, social and emotional learning.

The National Center for Special Education Research (NCSER) is the only Federal agency specifically designated to develop and provide evaluations for programs for students with disabilities, but currently has a budget that still remains below its FY 2010 funding level of $70 million. NCSER also provides special educators and administrators research-based resources that support the provision of a free appropriate public education and interventions to foster self-determination in students with disabilities as they transition into adulthood.

Due to limited funding, NCSER did not run competitions in FY 2022 for its annual special education research and training grants. Yet, with funding from the American Rescue Plan, several NCSER research grants are responding to the particular challenges students with disabilities faced in the COVID–19 pandemic, in collaboration with State agencies and school districts. These grants include a virtual process for autism spectrum disorder diagnosis for more timely access to early intervention services, professional learning for teachers in small-group instruction of students with or at risk for math disabilities, and a parent-implemented preschool language program for preschoolers with developmental language disorder.

We also appreciate the inclusion of language in recent appropriations bills calling for the Department of Education to address how it will ensure adequate staffing levels, including in IES. A 2022 report from the National Academies of Science, Engineering, and Medicine (NASEM) noted the specific staffing challenges that NCES has faced, seeing the attrition of more than 30 staff positions between FYs 2010 and 2021.[1] We look forward to your continued oversight on this issue to ensure IES has the resources to employ the necessary staff to effectively carry out its mission.

To this end, we recommend that the committee provide IES at least $900 million in FY 2024. For our students to succeed and to be internationally competitive, we must make robust investments in the science of teaching and learning and we must have the necessary data to make evidenced-based decisions on allocating education

[1] National Academies of Sciences, Engineering, and Medicine. 2022. A Vision and Roadmap for Education Statistics, p. 194. Washington, DC: The National Academies Press. https://doi.org/10.17226/26392.

dollars. Failure to continue the recent trajectory of funding increases for IES would have devastating impacts on our ability to improve our schools.

[This statement was submitted by Felice J. Levine, PhD, Chair, Friends of the Institute of Education Sciences.]

PREPARED STATEMENT OF THE FRIENDS OF THE NATIONAL INSTITUTE OF MENTAL HEALTH

Chairman Baldwin, Ranking Member Capito, and Members of the subcommittee:

We write on behalf of the Friends of NIMH, a coalition of more than 35 organizations representing scientists, physicians, health care providers, individuals, families, and communities. The members of the Friends of NIMH are dedicated to supporting the mission of the National Institute of Mental Health (NIMH) to transform the understanding of mental health and the treatment of mental illnesses through basic behavioral, biomedical, and clinical research, to best inform prevention, early intervention, recovery, and cures. We encourage the committee to provide robust funding for NIMH in FY 2024 so that NIMH can build upon the significant achievements to advance the behavioral, biomedical, and social research mission and advance important initiatives to provide new insights and solutions to benefit your constituents.

Our nation is facing an unprecedented mental health crisis. For example, the proportion of mental health-related emergency department visits for teenagers in 2020 increased approximately 31 percent over 2019. In 2021, there were an estimated 57.8 million adults aged 18 or older in the United States with any mental illness. This number represented 22.8 percent of all U.S. adults. The NIMH funds critical research to improve our understanding of mental health and provide support and treatment, yet increased investment is needed. The White House Report on Mental Health Research Priorities lays the groundwork for a research agenda. To this end, the Friends of NIMH applauds the Biden Administration's proposed $200 million increase for the NIMH in FY 24, which will support further research and support mechanisms.

Our member organizations represent communities with interest across the National Institutes of Health (NIH). Individually and collectively, our members also belong to the Ad Hoc Group for Medical Research, a coalition of over 330 patient and voluntary health groups, medical and scientific societies, academic and research organizations, and industry that support enhancing the Federal investment in the behavioral and biomedical research conducted and supported by the NIH. Aligned with the Ad Hoc request, we respectfully request that the subcommittee provide at least $51 billion to NIH in Fiscal Year 2024, and also support the President's request for a $200 million increase for the NIMH.

Thank you for considering this request,
Friends of NIMH Co-Chairs

Juliane Baron
Federation of Associations in Behavioral and Brain Sciences

Pat Kobor
American Psychological Association

PREPARED STATEMENT OF THE FRIENDS OF NATIONAL INSTITUTE OF CHILD HEALTH AND HUMAN DEVELOPMENT

I write on behalf of the Friends of NICHD, a coalition of more than 100 organizations representing patients, providers, scientists, and caregivers who are united in our support for ensuring the health and well-being of women, children, families, and people with disabilities through research funded by the Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD) and the National Institutes of Health (NIH). We urge the subcommittee to provide NICHD with $1.877 billion in Fiscal Year (FY) 2024, an increase of $128 million over FY 2023. We also respectfully ask the subcommittee to maintain its commitment to increasing funding for the National Institutes of Health (NIH) by providing $51 billion in FY 2024 and give special attention to ensuring that overall funding increases for the NIH are shared evenly across the agency.

Additionally, Congress authorized the Advanced Research Projects Agency for Health (ARPA–H) in FY 2023 as an autonomous agency within the NIH, providing $1.5 billion to advance ARPA–H's unique focus on targeted research traditionally beyond what is supported by the NIH and NICHD. As ARPA–H ramps up its work

in targeted research areas and its focus on accelerating the development of commercial products, we urge the Committee to ensure any funding provided for ARPA–H funding supplement, and not supplant, the base funding for NIH and NICHD.

The Friends of NICHD are pleased to support the extraordinary work of NICHD to meet the objectives of its biomedical, social, and behavioral research mission, including research on child development before and after birth; women's health throughout the life cycle; maternal, child, and family health; learning and language development; reproductive biology; population health; and medical rehabilitation. By enacting the coalition's funding request, Congress can ensure that NICHD's base budget grows proportional to that of its counterpart institutes and the institute can build upon the initiatives detailed below to provide new insights and solutions to benefit women, children, and families in your districts and States.

COVID–19: NICHD has played a key role in understanding the impact of the COVID–19 pandemic on the institute's populations, including pregnant and postpartum women, children and adolescents, people with intellectual and developmental disabilities, and people with physical disabilities and mobility impairments. This work includes intramural research studies, collaborations with other NIH institutes and centers, and major undertakings like the Gestational Research Assessments for COVID–19 (GRAVID) study and the Predicting Viral-Associated Inflammatory Disease Severity in Children with Laboratory Diagnostics and Artificial Intelligence (PreVAIL kIds), which are advancing our knowledge of understudied COVID–19 research questions. For instance, NICHD has led research to understand long COVID in children and pregnant women and identify effective strategies to improve COVID–19 vaccine uptake. The institute also continues to advocate for inclusion of its key populations in major trans-NIH COVID–19 research programs funded by Congress.

Maternal Mortality: The Pregnancy and Perinatology Branch, through networks including the Maternal-Fetal Medicine Units (MFMU) Network, supports research to improve the health of women before, during, and after pregnancy. Maternal mortality rates remain unacceptably high in the United States and significant racial and ethnic inequities persist. In recent years, NICHD has led the Implementing a Maternal health and PRegnancy Outcomes Vision for Everyone (IMPROVE) Initiative, which seeks to eliminate disparities among populations with greater rates of maternal mortality and morbidity. With additional funding, NICHD can support much-needed research to identify ways to improve maternal and infant health. NICHD is also leading the Connecting the Community for Maternal Health Challenge to encourage community-based and advocacy organizations to develop the infrastructure needed to conduct maternal health research, as well as supporting Maternal Health Research Centers of Excellence to serve as a common data resource, implementation, and coordinating hub to reduce preventable maternal mortality and morbidity. Worldwide, an estimated 6% of people who give birth will experience postpartum PTSD related to their delivery experience. NICHD research has found that personal stories of recent birthing experiences can identify women likely to develop posttraumatic stress disorder (PTSD) related to childbirth, as well as explore racial and ethnic disparities related to childbirth-associated trauma. More research is needed with diverse populations, and additional analysis is needed to evaluate ways to further improve the accuracy of prediction.

Data on Pediatric Enrollment in NIH Trials: NIH requires investigators to submit deidentified demographic data on study participants, including age at enrollment. It is important for NIH to analyze and publicly report on this data to ensure that all populations, including children, benefit from research. This data should be used proactively NIH-wide to address recruitment issues in ongoing studies in real time and to drive forward the inclusion of individuals across the lifespan, including children. NICHD should play a leading role in the implementation of this policy vis-á-vis age.

Infant and Childhood Health: Through the Best Pharmaceuticals for Children Act (BPCA), NICHD funds the study of old, off-patent drugs important to children but inadequately studied in pediatric populations. The BPCA NIH program has been successful in accomplishing its intended purpose, leading to updated pediatric labeling in 17 drugs. However, the program has been flat funded at $25 million since it was originally authorized in 2002. This funding level is insufficient to meet needs, particularly when accounting for biomedical research inflation, and has prevented NIH from funding additional drug trials in children. Additionally, BPCA NIH has never received a direct appropriation from Congress as authorized by law but rather has been funded by contributions from NIH institutes and centers. We urge increased, dedicated support from Congress to ensure this program can fund additional studies to improve pediatric drug labeling to provide clinicians with needed guidance for drugs prescribed in children. We also strongly support NICHD's ongo-

ing research into the causes and prevention strategies for the major causes of death in infancy and childhood, including sudden unexpected infant death, accidents, and suicide.

Behavioral Health Research: NICHD supports a range of research on child development and behavior and has made great progress developing sophisticated tools to measure children's cognitive, emotional, and social functioning. To build on these successes, we encourage more integrated behavioral and biobehavioral work on child developmental trajectories, across infancy, childhood, and adolescence, in both normative and at-risk environments, across diverse contexts (school, home, and community) and including underrepresented and vulnerable groups. More research is also needed on integrated behavioral health in primary care settings and the impact of behavioral interventions on mental health, physical health, and quality of life. Child health would also benefit from additional work on the role of technology and social media to support optimal development in children, including those with disabilities, and increased access to and engagement with effective psychological and behavioral interventions for childhood conditions.

Poverty and Child Health: Poverty can be especially detrimental in childhood and adolescence, leading to adverse impacts on physical health, mental health, social well-being, cognitive and emotional development, and the acquisition of motor and language skills. NICHD is in the unique position to examine the biological, psychological, social, cultural, and environmental factors that impact the developing child in high-poverty environments—including challenges due to chronic stress, neighborhood safety, school environments, family health status, education, job instability, unstable family structures, and substandard living conditions—and to evaluate interventions aimed at improving the developmental trajectories of these children.

Reproductive Sciences: Research on the basic biological mechanisms of reproduction is a crucial foundation for all NICHD's work. Understanding reproductive biology and associated biological phenomena provides the foundation for innovative medical therapies and technologies and improves existing treatment options for gynecologic conditions. Often, this research focuses on serious conditions that are overlooked and underfunded, even though they impact many women. Future work could address infertility and the need for treatments for endometriosis, polycystic ovarian syndrome (PCOS) and uterine fibroids. For instance, uterine fibroids are the most common non-cancerous gynecologic tumor, affecting up to 80% of all American women by the age of 50, and symptoms can include life threatening anemia, pelvic, back, and leg pain, as well as pain dyspareunia.[1] Fibroids often grow rapidly during pregnancy, sometimes crowding the fetus. However, the root cause of uterine fibroids is still unknown. Additional research in this area will help to uncover the root cause of this agonizing diagnosis and allow a return of quality of life to the 26 million U.S. women and menstruators affected.

Pelvic Floor Disorders Network (PFDN): Female pelvic floor disorders, which affect 25% of American women, represent a major public health burden with high prevalence, impaired quality of life, and substantial economic costs.[2] The PFDN conducts research to improve treatment of these painful gynecological conditions. Current research aims to improve female urinary incontinence outcome measures and ensure high-quality outcomes.

PregSource: NICHD's PregSource™ Initiative has enabled pregnant women to track their health data from gestation to early infancy and access evidence-based information about healthy pregnancies. It will also allow researchers to utilize aggregated data and potentially recruit participants for clinical trials so that knowledge gaps can be eliminated and care for pregnant and post-partum women can be improved.

Task Force Specific to Research in Pregnant Women and Lactating Women (PRGLAC): In 2018, the NICHD-led PRGLAC Task Force submitted recommendations to Congress on opportunities to achieve broader inclusion of pregnant and lactating women in research and expand the workforce of clinicians and researchers with expertise in obstetric and lactation pharmacology and therapeutics. In 2020, the Task Force released a second report with a detailed plan to implement those recommendations. We encourage NICHD to continue activities to advance PRGLAC recommendations in the coming year.

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[1] Office on Women's Health. Uterine Fibroids. Available at: https://www.womenshealth.gov/a-z-topics/uterine-fibroids.

[2] Wheat, Joy E. MD*; Khan, Munziba MPH, MSHS†,‡; Banaag, Amanda MPH†,‡; Vaccaro, Christine DO*; Greer, Joy A. MD§; P. Koehlmoos, Tracey PhD, MHA†; Hamlin, Lynette PhD‖. Prevalence of Pelvic Floor Disorders in United States Active-Duty Service Women Seeking Medical Care. Female Pelvic Medicine & Reconstructive Surgery 28(6):p e195-e200, June 2022. |DOI: 10.1097/SPV.0000000000001183.

NIH Pediatric Research Consortium (N-PeRC): N-PeRC is an NICHD-led, trans-NIH initiative that aims to harmonize pediatric research and training activities across the NIH. N-PeRC capitalizes on pediatric expertise at the NIH by enabling collaboration to explore gaps in the overall pediatric research portfolio and share best practices to advance science. N-PeRC has played a vital role throughout the COVID–19 pandemic in identifying key child and adolescent research needs related to SARS–CoV–2.

Human Development, Infancy Through Adulthood: NICHD supports research on infant-through-adult development, including how father-child relationships and co-parenting positively impacts children's socio-emotional development and decreases behavior problems; children's adjustment after the birth of a sibling; pathways and outcomes associated with mothers' postseparation co-parenting relationships, with a particular focus on experiences of intimate partner violence and negative outcomes; and the health and well-being across three generations of lesbians, gay men, and bisexuals.

Intellectual and Developmental Disabilities Research Centers (IDDRC): The IDDRCs are a critical national resource for basic research into the genetic and biological basis of human brain development, greatly improving our understanding of the causes of developmental disabilities and contributing to the development and implementation of evidence-based practices by evaluating the effectiveness of biological, biochemical, and behavioral interventions. These centers have contributed to new treatments for genetic disorders through the study of intellectual and developmental disabilities, such as Everolimus for epilepsy in TSC. We must build on progress in understanding and treating this class of disorders that affect so many. We urge resources and support for the IDDRCs for research infrastructure and expansion of cores to conduct basic and translational research to develop effective prevention, treatment and intervention strategies for children and adults with developmental disabilities.

Preterm Birth: NICHD supports a comprehensive research program on the causes, prevention and treatment of preterm birth, the leading cause of infant mortality and intellectual and physical disabilities. Research shows the survival rate and neurological outcomes may be improving for very early preterm infants, but continued prioritization is needed through extramural preterm birth prevention research, the MFMU Network, the Neonatal Research Network, and intramural research program.[3] Robust funding is needed for research to determine the complex interaction of behavioral, social, environmental, genetic, and biological influences on preterm birth with the goal of developing the interventions necessary to decrease prematurity.

Population Dynamics: The NICHD Population Dynamics Branch supports research on how population change affects the health, development, and well-being of children and their families. Longitudinal surveys, such as the Fragile Families and Child Wellbeing Study, have demonstrated the role that family stability and parental involvement play in the long-term health and development of children, facilitating tremendous progress in the population sciences. NICHD also supports the Population Dynamics Centers Research Infrastructure Program, which supports research and research training in demographic or population research. These centers focus on research such as family demography and intergenerational relationships; education, work, and inequality; population health; and reproductive health. NICHD also supported a groundbreaking study showing that infants of mothers in low-income households that received monthly cash payments were more likely to show faster brain activity in a pattern associated with learning and development at later ages.

Male Infertility: Male infertility is another relevant area of inquiry that would benefit from additional NICHD-sponsored research. For instance, the biological mechanisms associated with common causes of male infertility, such as varicoceles, remain poorly understood. These research domains represent important opportunities to develop better treatments for male infertility.

[This statement was submitted by Drew Hatter, 2023 Chair, Friends of NICHD and Federal Affairs Strategist, American College of Obstetricians and Gynecologists.]

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[3] Younge et al. Survival and Neurodevelopmental Outcomes among Periviable Infants. N. Engl J Med 2017;376:617–28. DOI: 10.1056/NEJMoa1605566.

PREPARED STATEMENT OF THE FRIENDS OF THE NATIONAL INSTITUTE OF ENVIRONMENTAL HEALTH SCIENCES

The Friends of the NIEHS are pleased to submit the following testimony regarding Fiscal Year (FY) 2024 Federal appropriations for the Labor, Health and Human Services, Education, and Related Agencies in support of the vital work being carried out by the NIH/NIEHS as a result of the annual appropriation provided for this work in the subcommittee's bill. We ask you to provide at least $980.7 million for NIEHS in FY2024 as part of an overall appropriation for NIH of $50.924 billion not inclusive of other funds for the Advanced Research Projects Agency for Health (ARPA–H) or pandemic preparedness.

Our coalition of organizations represents a variety of interests, including medical and scientific professional societies, environment and public health focused organizations, children's health advocates, women's health advocates, and many others. Collectively, our community supports and calls attention to the vital work being done by the National Institute of Environmental Health Sciences. NIEHS, one of the component Institutes and Centers of the National Institutes of Health (NIH), focuses on the prevention of health problems and diseases with special emphasis on the intimate interactions between our bodies and the environments where we live, work, and play over our lifetimes.

NIEHS Plays a Unique Role in Advancing Public Health Priorities

The NIEHS plays a unique role within the NIH; it is the leading institute conducting research to prevent human illness and disability by understanding how the environment influences the development and progression of human diseases and illnesses such as cancer, autism, asthma, Parkinson's disease, autoimmune diseases, chemical intolerance or toxicant-induced loss of tolerance, and chemical sensitivities. Expert research funded by NIEHS addresses diseases across all the NIH Institutes and Centers and identifies environmental contributors to health disparities. Specific research areas with projects that address national priorities include:

Climate change and health: NIEHS leads efforts to study the impact of climate change on human health. Working with several other Institutes and Centers, NIEHS published a strategic framework to guide research as part of NIEHS' climate change and human health initiative. Emerging research has already underscored how a warming climate can affect human health through impacts on stress and reproductive health; NIEHS is well-positioned to further advance our knowledge and understanding of this complex environmental and public health crisis.

Breast cancer and health disparities: NIEHS-funded studies have been instrumental in advancing our knowledge about the causes of cancer, including the discovery of the first breast cancer susceptibility gene. In 2019, the NIEHS Sister Study, a national cohort of 50,000 sisters of women who had breast cancer, found that women who use chemical hair dye and chemical hair straighteners have an increased risk of breast cancer, particularly black women. The study results suggest that chemicals in hair products may play a role in breast carcinogenesis and illustrate how environmental factors may influence health disparities.

Maternal and children's health and environmental exposures: Pregnant women, the developing fetus, and children are uniquely vulnerable to harmful substances in their environment, and the NIEHS plays a critical role in studying these populations. Children are uniquely susceptible to toxicants due to their ongoing development, and they face higher rates of exposure than adults by virtue of how they explore and interact with their environment. To further advance our knowledge of environmental impacts on children's health, NIEHS is leading the Environmental influences on Child Health Outcomes (ECHO) program. This innovative program will leverage existing cohort studies to create efficiencies and generate new findings. Importantly, many of the ECHO cohorts recruited patients during pregnancy, enabling us to better understand how the environment affects health from conception through adolescence. Additionally, a recent NIEHS-funded study found up to a 20% lower rate of asthma and fewer new asthma cases after air quality improvements were made, including reductions in nitrogen dioxide and PM2.5, and the Southern California Children's Health Study examined new onset cases of asthma in over 4,100 children in the Los Angeles, California area before, during and after air quality improvements. NIEHS funded investigators examining wildfire smoke exposure during pregnancy in relation to adverse pregnancy outcomes including preterm birth and severe maternal morbidity found wildfire smoke is linked to preterm birth, with more effects in socially vulnerable areas. They continue to link maternal and child health effects to wildfire smoke exposures, which has exceeded levels considered safe for hundreds of thousands of pregnancies over the past several years.

Pandemic and disaster preparedness: Researchers funded by NIEHS have highly relevant expertise that has enhanced our response to COVID–19 and prepared us for future pandemics, for example by identifying interventions to protect health care workers facing occupational exposure to SARS-CoV–2 and how environmental exposures such as air pollution impact individual susceptibility to infection and severity of disease. NIEHS can also positively impact our response to and recovery from natural disasters and climate change. For example, the Disaster Research Response Resources Portal (DR2) and Climate Change and Human Health Literature Portal provide researchers and the public with resources and tools to design studies in partnership with communities and rapidly translate research results into actionable interventions.

Endocrine disrupting chemicals: NIEHS-funded research teams have led the way in advancing our understanding of how chemicals that interfere with the normal function of hormones and endocrine systems, also known as endocrine-disrupting chemicals (EDCs) can cause adverse health effects. New scientific knowledge on EDCs has established that these chemicals may have nontraditional dose response curves, developmental effects with long-term consequences, and unique effects at low doses due to the sensitive nature of the endocrine system. The decades of scientific contributions of NIEHS to this field resulted in a 2019 paper identifying key characteristics of EDCs.

Community engagement: Finally, NIEHS is recognized for its unique ability to engage societies and translate research findings to community-level interventions. The NIEHS Environmental Health Sciences Core Center Program includes Community Engagement Cores that facilitate communication between research teams and community representatives to ensure that research goals meet the needs of the people impacted by chemical exposures. The educational resources and other materials developed by these cores often are useful beyond the communities for which they were developed, helping improve knowledge at other sites with similar concerns.

Increased Funding for NIH and NIEHS is Necessary in FY 2024

In conclusion, to ensure that NIEHS-funded researchers are able to continue to advance research in support of the Nation's public health priorities, the Friends of NIEHS recommend that the subcommittee provide at least $980.7 million for NIEHS in FY2024 as part of an overall appropriation for NIH of $50.924 billion in the FY 2024 Labor, Health and Human Services, Education, and Related Agencies appropriations bill. Finally, we request that any funding for the new Advanced Research Projects Agency for Health (ARPA–H) agency complement this funding recommendation for NIH's base budget, rather than supplant the essential investment in the NIH, to ensure that NIH can continue to support and grow the investigator-initiated research programs that have provided the foundation for our collective successes in biomedical research.

[This statement was submitted by Joseph Laakso, Director of Science Policy, Endocrine Society, Friends of NIEHS.]

PREPARED STATEMENT OF THE FRIENDS OF THE NATIONAL INSTITUTE ON AGING

On behalf of the Friends of the National Institute on Aging (FoNIA), we are grateful for your leadership in advancing the mission of National Institutes of Health (NIH), and the research supported and conducted by the National Institute on Aging (NIA). FoNIA is a coalition of more than 50 academic, patient-centered and nonprofit organizations supporting NIA's mission to understand the nature of aging and the aging process, and diseases and conditions associated with growing older to extend the healthy, active years of life.

We are writing to request that Federal resources continue to be dedicated to sustaining and enhancing timely and promising aging research at NIA and across NIH.

Specifically, FoNIA requests:

—no less than $50.924 billion in fiscal year (FY) 2024 for base spending at NIH for current institutes and operations, which corresponds with the overall recommendation of the Ad Hoc Group for Medical Research;

—we ask that NIA, as a component of the NIH, receive a commensurate funding increase (7.3 percent over the FY 23 levels) in FY 2024;

—continued funding to support the Advanced Research Projects Agency for Health (ARPA–H) at NIH. However, investment in ARPA–H should not come at the cost of the existing NIH institutes and centers conducting and supporting research on aging;

—a minimum increase of $321 million above the final enacted amount for FY 2023 specific to research on Alzheimer's disease and related dementias (ADRD).

NIA is the primary Federal agency supporting and conducting Alzheimer's disease and related dementias research.

NIA sponsors and conducts the vast majority of Federal aging-related research, and this pioneering science contributes significantly to the improved care and quality of life for all of us as we age. A key NIA priority is translating research into better and more efficient care through the development of effective interventions that are disseminated to health care providers, patients, and caregivers. These interventions for the prevention, early detection, diagnosis, and treatment of disease will help reduce declines in function and increased susceptibility to disease, frailty, or disability.

In the area of dementia, NIA supports vital research where scientific investigation is working to improve AD/ADRD prevention, diagnosis, treatment and care; basic science approaches to illuminate neurodegenerative mechanisms/pathways; and computational/biological systems approaches to identify, model and predict the architecture and dynamics of the molecular interactions underlying AD/ADRD pathogenesis. Researchers have identified new genetic, behavioral, and lifestyle risks and protective factors for dementias and developed improved diagnostic tools to pinpoint the cause of a person's dementia symptoms. As the U.S. Federal Government leader in medical research, NIH has expanded dementia research initiatives and resources including platforms for data sharing and interdisciplinary collaborations, new research models and methodologies, and policies to ensure our clinical trials reflect the diversity of our population.

The Science & Technology Action Committee estimates that the U.S. should double its R&D investment by 2026 in order to remain a global competitor in science, technology, engineering, and math.[1] A recent survey from Research!America, found that most Americans (91%) agree it is important for the US to be a global leader in science and technology and a bipartisan majority (63%) support paying an additional $1 per week in taxes if they could be certain all the money would be spent on additional medical and health research.[2] As the world's premier public funder of medical research, the NIH is a critical international leadership, and robust annual growth in support for NIH will be key to achieving these objectives.

Lastly, NIH funding provides a vital economic boost to local economies. Most of NIH/NIA funding is distributed as grants to universities and other research institutions across the United States, and acts as an economic engine and multiplier in local and regional communities. According to United for Medical Research, total FY 22 NIH research spending supported more than 568,500 American jobs and generated nearly $96.84 billion in economic activity, in all 50 States.[3]

Thanks to your support, NIH/NIA is continuing to accelerate scientific discoveries which will benefit us all as we age. Only through continued, and meaningful investments in NIH/NIA will it be possible to enhance the quality of care for older adults across the Nation.

Thank you for your consideration of this funding request. Should you need additional information, feel free to contact me at pdantonio@geron.org.

Sincerely.

[This statement was submitted by Patricia M. D'Antonio, BSPharm, MS, MBA, BCGP, Chair, Friends of NIA.]

PREPARED STATEMENT OF THE FSHD SOCIETY

Honorable Chairman Baldwin, Ranking Member Moore Capito, and distinguished members of the subcommittee, thank you. We are requesting a FY2024 appropriation of $32.5 million to the agency U.S. DHHS National Institutes of Health (NIH) for facioscapulohumeral muscular dystrophy (hereafter called FSHD) research programs.

I am co-founder, Director emeritus, past -Chairman, -President & CEO, and -CSO of the FSHD Society. As a patient with FSHD, my life's work on FSHD disease and its funding spans nearly every research lab, biotechnology and pharma company

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[1] Science & Technology Action Committee. (2022 January). Briefing Paper: A Roadmap for Investment in Science and Technology. https://sciencetechaction.org/news-item/white-paper-a-roadmap-for-investment-in-science-and-technology/.

[2] Research!America. (2023) Survey of U.S. Adults conducted in partnership with Zogby Analytics. https://www.researchamerica.org/wp-content/uploads/2023/02/2023-January-National-Survey-Results-ResearchAmerica.pdf. Accessed 3/21/2023.

[3] NIH's Role in Sustaining the U.S. Economy 2023 Update. https://unitedformedicalresearch.org/wp-content/uploads/2023/03/UMR__NIHs-Role-in-Sustaining-the-U.S.-Economy-2023-Update.pdf. Accessed 3/21/2023.

working today on FSHD globally. My efforts through the FSHD Society have led to understanding how FSHD1[1] and FSHD2[2,3] work. I was a key architect of the Muscular Dystrophy Community Assistance, Research and Education Amendments of 2001 (MD–CARE Act, Public Law 107–84). I have served on the Muscular Dystrophy Coordinating Committee (MDCC) since its inception and am the longest serving member. MDCC is a Federal Advisory Committee designed to coordinate activities relating to the various forms of muscular dystrophy across the NIH and with other Federal health agencies.

FSHD is a heritable disease and one of the most common neuromuscular disorders with a prevalence of 1:8,000.[4] It affects nearly one million children and adults of both sexes worldwide. FSHD is characterized by progressive loss of skeletal muscle strength that is asymmetric in pattern and widely variable. Muscle weakness typically starts at the face, shoulder girdle and upper arms, often progressing to the legs, torso and other muscles. In addition to affecting any skeletal muscle, it can bring with it respiratory failure and breathing issues,[5-7] mild-profound hearing loss,[8] eye problems and cardiac bundle blockage and arrhythmias.[9,10] FSHD causes significant disability and death according the U.S. Centers for Disease Control and Prevention (CDC), National Center on Birth Defects and Developmental Disabilities, Atlanta, and others.[11,12]

FSHD is associated with epigenetic changes on the tip of human chromosome 4q35, in the D4Z4 DNA macrosatellite repeat array region, leading to an inappropriate gain of expression (function) of the D4Z4-embedded double homeobox 4 (DUX4) gene.[13-16] DUX4 is a transcription factor that kick starts the embryonic genome during the 2- to 8-cell stage of development.[17-19] Ectopic expression of DUX4 in skeletal muscle is associated with the disease and the disease's pathophysiology that leads to muscle death. DUX4 is never expressed in 'healthy' muscle. FSHD has had few clinical trials,[20-26,27,28] there is no cure or therapeutic options. DUX4 requires and needs to activate direct transcriptional targets for DUX4-induced gene aberration and muscle toxicity.[29-42]

Our patient community through its fundraising efforts and intensive research-integration has pioneered inroads to treating FSHD using genomic sequencing, genomic medicine, gene editing and next generation diagnostics.[43] All with the goal of reducing DUX4 in its DNA or RNA or protein state, or the effects of DUX4-driven toxicity e.g. modulating DUX4 repressive pathways, targeting DUX4 mRNA, DUX4 protein, or cellular downstream effects of DUX4 expression.[44-47]

Currently active projects listed in NIH RePORT as being applicable to FSHD are $16.961 million FY2023 (18May2023) vs. $17.507 million year-ago FY2022 (source: NIH Research Portfolio Online Reporting Tools (RePORT) 'FSHD or facioscapulohumeral or landouzy-dejerine'). The NIH is currently the principal worldwide source of funding of basic biomedical research on FSHD. Currently annual funding directly dedicated for FSHD listed in NIH RCDC is $10 million.

TABLE 1. FSHD RESEARCH DOLLARS (MILLIONS) & FSHD PERCENTAGE OF TOTAL NIH MUSCULAR DYSTROPHY FUNDING

[Dollars in millions]

Fiscal Year	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023e	2024e
All MD ($ millions) ..	$75	$76	$78	$77	$79	$81	$81	$83	$95	$82	$78	$81	83
FSHD ($ millions)	$5	$5	$7	$8	$9	$11	$11	$10	$9	$9	$10	$10	10
FSHD (% total MD)	7%	7%	9%	10%	11%	14%	14%	12%	9%	11%	13%	12%	12%

Sources: NIH/OD Budget Office & NIH OCPL & NIH RePORT/RCDC (e=estimate, a=actual vers=March 31, 2023)

Honorable Chairman, thanks to Congress' work in enacting the MD CARE Act, funding the NIH, and with communications with NIH-leadership and program/legislative staff—several dystrophies now have FDA approved treatments. NIH has been especially thoughtful with its expenditure and approach to research on muscular dystrophy. In the past year, nearly one hundred peer reviewed publications on FSHD came online. Excellent gains made in expanding basic research, better understanding of natural history and disease heterogeneity, biomarkers and outcomes assessments, therapeutic compounds/interventions and clinical trial design.[48-61] Recent publications further underscore the need for broad and combinatorial therapeutic strategies as it is possible that any single approach may not be successful or not be enough e.g. immunomodulation plus DUX4 inhibition, DUX4 inhibition plus muscle regeneration, FSHD as a myodevelopmental disease [″satellite cellopathy" a primary satellite cell disease] caused by specific stem cell epigenetically weakly repressed at the D4Z4 repeat needing early intervention.[62-67] The prospect of treating and curing FSHD in the next 12 to 24 months is very real and tangible.

More than $1 billion from investment banks, venture capital, private/philanthropic investors across more than 25 companies recently flowed into companies working on FSHD therapies. Though target DUX4 completely black and white—all are still flying blind when it comes to measuring ectopic DUX4 in human muscle. What emerges—is, on one end of the spectrum an overarching need for far more basic and mechanistic research e.g. better understanding of the fundamental mechanisms of FSHD disease, including muscle disease. Secondly, on the back-end with getting therapies to patients, is the need to eliminate projects that will never succeed in practice/clinic i.e. 'does this have a pathway to clinic?' Associated with our request for 32.5 million dollars in FY2024, we highlight top priorities, research questions in need of better answers and open-ended areas of investigation in tables 2 and 3 where NIH can improve on its FSHD research spending.

Table 2. FSHD1 and FSHD2 Broad NIH Cross-Cutting Thematic Areas

—*Better biomarkers:* we still need to improve on our non-invasive and invasive biomarkers for trial readiness;
—*Clinical variability and disease pattern:* our understanding of the causes for clinical variability in both FSHD1 and FSHD2 is too limited, let alone that we can predict progression;
—Studying the normal function of DUX4 and how it causes muscle disease can focus design of future clinical trials;
—Investigating if muscle pathology can be reversed once DUX4 expression starts the pathogenic cascade in a particular muscle?;
—Exploring if there is a systemic effect of local DUX4 expression that leads to amplification of muscle decline, either immune or some extracellular signaling. Can we intercept and control the disease process?;
—Designing new technologies and methods to track biological, chemical, mechanical and electrical aspects of muscle function for improving or declining health of FSHD permissive genotype;
—*Improving registries:* need further international integration and sustainability;
—*Prioritizing pathways:* DUX4 activates many different pathways, we don't know if there is any hierarchy in contribution to disease, or different roles;
—*Genetic heterogeneity:* not all patients are explained, population differences, etc.;
—*Molecular/tissue heterogeneity:* do we sufficiently understand the muscle involvement? Other tissues/cell types?;
—*DUX4 dynamics:* what activates DUX4 as all nuclei are (epi)genetically sensitized but only few express DUX4. Is there active silencing (can we take advantage of the 8-cell stage mechanism of DUX4 silencing)? How are the DUX4 signals propagated within fibers, between fibers?;
—*Therapy:* many different routes are being explored e.g. small molecule drugs, biologics, gene transfer/editing, cell/molecular therapies (including oligonucleotides), devices, nutritional and exercise, behavioral and combinatorial therapy. How do we handle this effort with the limited patient population that will be available for trials?;
—Improved preclinical and large animal models that accurately reflect mechanisms of disease onset and progression;
—Genetic and environmental mechanisms that determine timing of onset/rate of progression in genetically inherited disease;
—Role of the adaptive and innate immune system in disease onset and progression;
—Uniform, reliable and scalable DNA diagnostics, pre-implantation, prenatal and postnatal;
—Promoting research that helps to increase safety and efficacy of FSHD clinical trials, addressing toxicity, immune response and efficiency of uptake.

Table 3. FSHD1 and FSHD2 Inspirational Research Directions

—Individuals with FSHD1 and FSHD2 are born with DUX4 turned on from day one and it may be years/decades on non-symptomatic disease infiltrating the muscle—accelerate research efforts and ways of screening genetically and identifying and tracking non-symptomatic disease progression and infiltration;
—Developing ways to assess, stop and reverse non-symptomatic disease progression and infiltration in FSHD muscle e.g. outcome measures herein are strictly biological not clinical functional;
— Help accelerate movement of testable compounds toward clinical trials in FSHD, by the discovery and generation of tractable markers of both symptomatic and non-symptomatic disease to provide measurable outcomes;
—Understanding precisely how FSHD skeletal muscle epigenome protects from FSHD or capitulates to having active FSHD progression;

—Provide a platform for stakeholders [members of the FSHD research community, pharmaceutical and biotechnology companies interested in developing therapeutics for FSHD, and leading scientists who have successfully exploited model systems in understanding human disease writ large] to identify viable biomarkers that could be exploited in clinical trials;

—Identify and elucidate or engineer specific biomarkers and models associated with the onset, and progression of FSHD1 and FSHD2;

It is imperative to increase our efforts in the areas mentioned herein—gains in these areas will help ascertain if therapies are effective, safe and not cost-prohibitive. We request for FY2024, increasing NIH FSHD research funding/appropriation of the standard portfolio to $32.5 million.

Honorable Chairman, thank you for this opportunity to update you with this testimony.

REFERENCES

[1] Gould T, Jones TI, Jones PL. Precise Epigenetic Analysis Using Targeted Bisulfite Genomic Sequencing Distinguishes FSHD1, FSHD2, and Healthy Subjects. Diagnostics (Basel). 2021 Aug 13;11(8):1469. doi: 10.3390/diagnostics11081469. PMID: 34441403; PMCID: PMC8393475. (2021).

[2] Goossens R, Tihaya MS, van den Heuvel A, Tabot-Ndip K, Willemsen IM, Tapscott SJ, González-Prieto R, Chang JG, Vertegaal ACO, Balog J, van der Maarel SM. A proteomics study identifying interactors of the FSHD2 gene product SMCHD1 reveals RUVBL1-dependent DUX4 repression. Sci Rep. 2021 Dec 8;11(1):23642. doi: 10.1038/s41598–021–03030–3. PMID: 34880314; PMCID: PMC8654949. (2021).

[3] Wang, L. H. & Tawil, R. Facioscapulohumeral Dystrophy. Curr. Neurol. Neurosci. Rep. 16, 66 (2016).

[4] Deenen, J. C. W. et al. Population-based incidence and prevalence of facioscapulohumeral dystrophy. Neurology 83, 1056–9 (2014).

[5] Lu-Nguyen N, Malerba A, Antoni Pineda M, Dickson G, Popplewell L. Improving Molecular and Histopathology in Diaphragm Muscle of the Double Transgenic ACTA1–MCM/FLExDUX4 Mouse Model of FSHD with Systemic Antisense Therapy. Hum Gene Ther. 2022 Apr 28. doi: 5.1089/hum.2021.251. Epub ahead of print. PMID: 35078334. (2022).

[6] Teeselink S, Vincenten SCC, Voermans NC, Groothuis JT, Doorduin J, Wijkstra PJ, Horlings CGC, van Engelen BGM, Mul K. Long-term follow-up of respiratory function in facioscapulohumeral muscular dystrophy. J Neurol. 2022 Feb 11:1–8. doi: 10.1007/s00415–022–10990–7. Epub ahead of print. PMID: 35147730; PMCID: PMC8831680. (2022).

[7] Henke C, Spiesshoefer J, Kabitz HJ, Herkenrath S, Randerath W, Brix T, Görlich D, Young P, Boentert M. Respiratory muscle weakness in facioscapulohumeral muscular dystrophy. Muscle Nerve. 2019 Dec;60(6):679–686. doi: 10.1002/mus.26717. Epub 2019 Oct 23. PMID: 31566774. (2019).

[8] Fuccillo E, Frezza E, Massa R, Di Girolamo S. Response To Letter To The Editor "Auditory Dysfunction In Facioscapulohumeral Muscular Dystrophy Type 1: Beyond The Inner Ear Involvement" By Gheller et al. Otol Neurotol. 2022 Mar 1;43(3):e392-e393. doi: 10.1097/MAO.0000000000003423. PMID: 34772889. (2022).

[9] van Dijk GP, van der Kooi E, Behin A, Smeets J, Timmermans J, van der Maarel S, Padberg G, Voermans N, van Engelen B. High prevalence of incomplete right bundle branch block in facioscapulohumeral muscular dystrophy without cardiac symptoms. Funct Neurol. 2014 Jul-Sep;29(3):159–65. PMID: 25473735; PMCID: PMC4264782. (2014).

[10] Ducharme-Smith A, Nicolau S, Chahal CAA, Ducharme-Smith K, Rehman S, Jaliparthy K, Khan N, Scott CG, St Louis EK, Liewluck T, Somers VK, Lin G, Brady PA, Milone M. Cardiac Involvement in Facioscapulohumeral Muscular Dystrophy (FSHD). Front Neurol. 2021 May 24;12:668180. doi: 10.3389/fneur.2021.668180. (2021).

[11] Blokhuis AM, Deenen JCW, Voermans NC, van Engelen BGM, Kievit W, Groothuis JT. The socioeconomic burden of facioscapulohumeral muscular dystrophy. J Neurol. 2021 May 27. doi: 10.1007/s00415–021–10591-w. (2021).

[12] Wallace B, Smith KT, Thomas S, Conway KM, Westfield C, Andrews JG, Weinert RO, Do TQN, Street N; Muscular Dystrophy Surveillance, Tracking, and Research Network (MD STARnet). Characterization of individuals with selected muscular dystrophies from the expanded pilot of the Muscular Dystrophy Surveillance, Tracking and Research Network (MD STARnet) in the United States. Birth Defects Res. 2021 Apr 15;113(7):560–569. doi: 10.1002/bdr2.1764. (2020).

[13] Mocciaro E, Runfola V, Ghezzi P, Pannese M, Gabellini D. DUX4 Role in Normal Physiology and in FSHD Muscular Dystrophy. Cells. 2021 Nov 26;10(12):3322. doi: 10.3390/cells10123322. PMID: 34943834; PMCID: PMC8699294. (2021).

[14] Jagannathan S. The evolution of DUX4 gene regulation and its implication for facioscapulohumeral muscular dystrophy. Biochim Biophys Acta Mol Basis Dis. 2022 May 1;1868(5):166367. doi: 10.1016/j.bbadis.2022.166367. Epub 2022 Feb 11. PMID: 35158020. (2022).

[15] Vuoristo S, Bhagat S, Hydén-Granskog C, Yoshihara M, Gawriyski L, Jouhilahti EM, Ranga V, Tamirat M, Huhtala M, Kirjanov I, Nykänen S, Krjutškov K, Damdimopoulos A, Weltner J, Hashimoto K, Recher G, Ezer S, Paluoja P, Paloviita P, Takegami Y, Kanemaru A, Lundin K, Airenne TT, Otonkoski T, Tapanainen JS, Kawaji H, Murakawa Y, Bürglin TR, Varjosalo M, Johnson MS, Tuuri T, Katayama S, Kere J. DUX4 is a multifunctional factor priming human embryonic genome activation. iScience. 2022 Mar 22;25(4):104137. doi: 10.1016/j.isci.2022.104137. PMID: 35402882; PMCID: PMC8990217.

[16] Wong CJ, Whiddon JL, Langford AT, Belleville AE, Tapscott SJ. Canine DUXC: Implications for DUX4 retrotransposition and preclinical models of FSHD. Hum Mol Genet. 2021 Dec 9:ddab352. doi: 10.1093/hmg/ddab352. Epub ahead of print. PMID: 34888646.
[17] Hendrickson, P. G. et al. Conserved roles of mouse DUX and human DUX4 in activating cleavage-stage genes and MERVL/HERVL retrotrans. Nat. Genet. 49, 925–934 (2017).
[18] Whiddon, J. L., Langford, A. T., Wong, C.-J., Zhong, J. W. & Tapscott, S. J. Conservation and innovation in the DUX4-family gene network. Nat. Genet. 49, 935–940 (2017).
[19] De Iaco, A. et al. DUX-family transcription factors regulate zygotic genome activation in placental mammals. Nat. Genet. 49, 941–945 (2017).
[20] Tawil, R. et al. A pilot trial of prednisone in facioscapulohumeral muscular dystrophy. FSHDY Group. Neurology 48, 46–9 (1997).
[21] Passerieux, E. et al. Effects of vitamin C, vitamin E, zinc gluconate, and selenomethionine supplementation on muscle function and oxidative stress biomarkers in patients with facioscapulohumeral dystrophy: a double-blind randomized controlled clinical trial. Free Radic. Biol. Med. 81, 158–69 (2015).
[22] Kissel, J. T. et al. Randomized, double-blind, placebo-controlled trial of albuterol in facioscapulohumeral dystrophy. Neurology 57, 1434–40 (2001).
[23] Elsheikh, B. H. et al. Pilot trial of diltiazem in facioscapulohumeral muscular dystrophy. Neurology 68, 1428–9 (2007).
[24] Wagner, K. R. et al. A phase I/IItrial of MYO–029 in adult subjects with muscular dystrophy. Ann. Neurol. 63, 561–71 (2008).
[25] Statland JM, Campbell C, Desai U, Karam C, Díaz-Manera J, Guptill JT, Korngut L, Genge A, Tawil RN, Elman L, Joyce NC, Wagner KR, Manousakis G, Amato AA, Butterfield RJ, Shieh PB, Wicklund M, Gamez J, Bodkin C, Pestronk A, Johnson NE, Mathews KD, Miller B, Leneus A, Fowler M, van de Rijn M, Attie KM. Randomized phase 2 study of ACE–083, a muscle-promoting agent, in facioscapulohumeral muscular dystrophy. Muscle Nerve. 2022 Apr 15. doi: 10.1002/mus.27558. Epub ahead of print. PMID: 35428982. (2022).
[26] Mellion ML, Ronco L, Berends CL, Pagan L, Brooks S, van Esdonk MJ, van Brummelen EMJ, Odueyungbo A, Thompson LA, Hage M, Badrising UA, Raines S, Tracewell WG, van Engelen B, Cadavid D, Groeneveld GJ. Phase 1 clinical trial of losmapimod in facioscapulohumeral dystrophy: Safety, tolerability, pharmacokinetics, and target engagement. Br J Clin Pharmacol. 2021 Dec;87(12):4658–4669. doi: 10.1111/bcp.14884. Epub 2021 May 14. PMID: 33931884. (2021).
[27] Ghasemi M, Emerson CP Jr, Hayward LJ. Outcome Measures in Facioscapulohumeral Muscular Dystrophy Trials. Cells. 2022 Feb 16;11(4):687.. PMID: 35203336; PMCID: PMC8870318. (2022).
[28] Gros M, Nunes AM, Daoudlarian D, Pini J, Martinuzzi E, Barbosa S, Ramirez M, Puma A, Villa L, Cavalli M, Grecu N, Garcia J, Siciliano G, Solé G, Juntas-Morales R, Jones PL, Jones T, Glaichenhaus N, Sacconi S. Identification of Serum Interleukin 6 Levels as a Disease Severity Biomarker in Facioscapulohumeral Muscular Dystrophy. J Neuromuscul Dis. 2022;9(1):83–93.. PMID: 34459413; PMCID: PMC8842759. (2022).
[29] Rickard, A. M., Petek, L. M. & Miller, D. G. Endogenous DUX4 expression in FSHD myotubes is sufficient to cause cell death and disrupts RNA splicing and cell migration pathways. Hum. Mol. Genet. 24, 5901–14 (2015).
[30] Sandri, M. et al. Caspase 3 expression correlates with skeletal muscle apoptosis in Duchenne and facioscapulohumeral muscular dystrophy. A potential target for pharmacological treatment? J. Neuropathol. Exp. Neurol. 60, 302–12 (2001).
[31] Block, G. J. et al. Wnt/β-catenin signaling suppresses DUX4 expression and prevents apoptosis of FSHD muscle cells. Hum. Mol. Genet. 22, 4661–72 (2013).
[32] Statland, J. M. et al. Immunohistochemical Characterization of Facioscapulohumeral Muscular Dystrophy Muscle Biopsies. J. Neuromuscul. Dis. 2, 291–299 (2015).
[33] Kowaljow, V. et al. The DUX4 gene at the FSHD1A locus encodes a pro-apoptotic protein. Neuromuscul. Disord. 17, 611–23 (2007).
[34] Bosnakovski, D. et al. An isogenetic myoblast expression screen identifies DUX4-mediated FSHD-associated molecular pathologies. EMBO J. 27, 2766–79 (2008).
[35] Wallace, L. M. et al. DUX4, a candidate gene for facioscapulohumeral muscular dystrophy, causes p53-dependent myopathy in vivo. Ann. Neurol. 69, 540–52 (2011).
[36] Geng, L. N. et al. DUX4 activates germline genes, retroelements, and immune mediators: implications for facioscapulohumeral dystrophy. Dev. Cell 22, 38–51 (2012).
[37] Yao, Z. et al. DUX4-induced gene expression is the major molecular signature in FSHD skeletal muscle. Hum. Mol. Genet. 23, 5342–52 (2014).
[38] Homma, S., Beermann, M., Boyce, F. M. & Miller, J. B. Expression of FSHD-related DUX4–FL alters proteostasis and induces TDP–43. Ann. Clin. Transl. Neurol. 2, 151–66 (2015).
[39] Jagannathan, S. et al. Model systems of DUX4 expression recapitulate the transcriptional profile of FSHD cells. Hum. Mol. Genet. 25, 4419–4431 (2016).
[40] Jones, T. I. et al. Facioscapulohumeral muscular dystrophy family studies of DUX4 expression: evidence for disease modifiers and a model of pathogenesis. Hum. Mol. Genet. 21, 4419–30 (2012).
[41] Campbell AE, Shadle SC, Jagannathan S, Lim JW, Resnick R, Tawil R, van der Maarel SM, Tapscott SJ. NuRD and CAF–1-mediated silencing of the D4Z4 array is modulated by DUX4-induced MBD3L proteins. Elife. 2018 Mar 13;7. pii: e31023. doi: 10.7554/eLife.31023 (2018).
[42] Kolata, G., Reanimated 'Junk' DNA Is Found to Cause Disease. New York Times, Science. Published online: August 19, 2010 http://www.nytimes.com/2010/08/20/science/20gene.html (2010).
[43] Nurk S, Koren S, Rhie A, Rautiainen M, Bzikadze AV, Mikheenko A, Vollger MR, Altemose N, Uralsky L, Gershman A, Aganezov S, Hoyt SJ, Diekhans M, Logsdon GA, Alonge M, Antonarakis SE, Borchers M, McCoy RC, Dennis MY, Alexandrov IA, Gerton JL, O'Neill RJ,

Timp W, Zook JM, Schatz MC, Eichler EE, Miga KH, Phillippy AM. The complete sequence of a human genome. Science. 2022 Apr;376(6588):44–53. doi: 10.1126/science.abj6987. Epub 2022 Mar 31. PMID: 35357919 (2022).

[44] Jagannathan S1,2,3, Ogata Y4, Gafken PR4, Tapscott SJ3, Bradley RK1. Quantitative proteomics reveals key roles for post-transcriptional gene regulation in the molecular pathology of facioscapulohumeral muscular dystrophy. Elife. 2019 Jan 15;8. pii: e41740. doi: 10.7554/eLife.41740 (2019).

[45] Bouwman LF, den Hamer B, van den Heuvel A, , Tapscott SJ, Rigo F, van der Maarel SM, de Greef JC. Systemic delivery of a DUX4-targeting antisense oligonucleotide to treat facioscapulohumeral muscular dystrophy. Mol Ther Nucleic Acids. 2021 Sep 27;26:813–827. doi: 10.1016/j.omtn.2021.09.010. PMID: 34729250; PMCID: PMC8526479. (2021).

[46] Soliman HAN, Toso EA, Darwish IE, Ali SM, Kyba M. Antiapoptotic Protein FAIM2 is targeted by miR–3202, and DUX4 via TRIM21, leading to cell death and defective myogenesis. Cell Death Dis. 2022 Apr 25;13(4):405. doi: 10.1038/s41419–022–04804-x. PMID: 35468884; PMCID: PMC9038730. (2022).

[47] Guo D, Daman K, Chen JJ, Shi MJ, Yan J, Matijasevic Z, Zhou H, Bang AG, Wagner KR, Maehr R, King OD, Hayward LJ, Emerson CP Jr. iMyoblasts for ex vivo and in vivo investigations of human myogenesis and disease modeling. Elife. 2022 Jan 25;11:e70341. doi: 10.7554/eLife.70341. PMID: 35076017; PMCID: PMC8789283. (2022).

[48] Jagannathan S. The evolution of DUX4 gene regulation and its implication for facioscapulohumeral muscular dystrophy. Biochim Biophys Acta Mol Basis Dis. 2022 May 1;1868(5):166367. doi: 10.1016/j.bbadis.2022.166367. Epub 2022 Feb 11. PMID: 35158020; PMCID: PMC9173005. (2022)

[49] Masteika IF, Sathya A, Homma S, Miller BM, Boyce FM, Miller JB. Downstream events initiated by expression of FSHD-associated DUX4: Studies of nucleocytoplasmic transport, ?H2AX accumulation, and Bax/Bak-dependence. Biol Open. 2022 Feb 15;11(2):: 10.1242/bio.059145. Epub 2022 Feb 22. PMID: 35191484; PMCID: PMC8890089. (2022)

[50] Williams K, Yokomori K, Mortazavi A. Heterogeneous Skeletal Muscle Cell and Nucleus Populations Identified by Single-Cell and Single-Nucleus Resolution Transcriptome Assays. Front Genet. 2022 May 13;13:835099. doi: 10.3389/fgene.2022.835099. PMID: 35646075; PMCID: PMC9136090. (2022)

[51] Himeda CL, Jones PL. FSHD Therapeutic Strategies: What Will It Take to Get to Clinic? J Pers Med. 2022 May 25;12(6):865.. PMID: 35743650; PMCID: PMC9225474. (2022)

[52] Lu-Nguyen N, Dickson G, Malerba A, Popplewell L. Long-Term Systemic Treatment of a Mouse Model Displaying Chronic FSHD-like Pathology with Antisense Therapeutics That Inhibit DUX4 Expression. Biomedicines. 2022 Jul 7;10(7):1623. doi: 10.3390/biomedicines10071623. PMID: 35884928; PMCID: PMC9313434. (2022)

[53] Mariot V, Dumonceaux J. Gene Editing to Tackle Facioscapulohumeral Muscular Dystrophy. Front Genome Ed. 2022 Jul 15;4:937879. doi: 10.3389/fgeed.2022.937879. PMID: 35910413; PMCID: PMC9334676. (2022)

[54] Azzag K, Bosnakovski D, Tungtur S, Salama P, Kyba M, Perlingeiro RCR. Transplantation of PSC-derived myogenic progenitors counteracts disease phenotypes in FSHD mice. NPJ Regen Med. 2022 Sep 2;7(1):43. doi: 10.1038/s41536–022–00249–0. PMID: 36056021; PMCID: PMC9440030. (2022)

[55] Hiramuki Y, Kure Y, Saito Y, Ogawa M, Ishikawa K, Mori-Yoshimura M, Oya Y, Takahashi Y, Kim DS, Arai N, Mori C, Matsumura T, Hamano T, Nakamura K, Ikezoe K, Hayashi S, Goto Y, Noguchi S, Nishino I. Simultaneous measurement of the size and methylation of chromosome 4qA–D4Z4 repeats in facioscapulohumeral muscular dystrophy by long-read sequencing. J Transl Med. 2022 Nov 8;20(1):517. doi: 10.1186/s12967–022–03743–7. PMID: 36348371; PMCID: PMC9644496. (2022)

[56] Lim KRQ, Yokota T. Knocking Down DUX4 in Immortalized Facioscapulohumeral Muscular Dystrophy Patient-Derived Muscle Cells. Methods Mol Biol. 2023;2587:197–208. doi: 10.1007/978–1–0716–2772–3__12. PMID: 36401032. (2023)

[57] Heskamp L, Ogier A, Bendahan D, Heerschap A. Whole-muscle fat analysis identifies distal muscle end as disease initiation site in facioscapulohumeral muscular dystrophy. Commun Med (Lond). 2022 Dec 1;2(1):155. doi: 10.1038/s43856–022–00217–1. Erratum in: Commun Med (Lond). 2023 Jan 12;3(1):6. PMID: 36450865; PMCID: PMC9712512. (2023)

[58] Bosnakovski D, Toso EA, Ener ET, Gearhart MD, Yin L, Lüttmann FF, Magli A, Shi K, Kim J, Aihara H, Kyba M. Antagonism among DUX family members evolved from an ancestral toxic single homeodomain protein. bioRxiv [Preprint]. 2023 Jan 22:2023.01.21.524976. doi: 10.1101/2023.01.21.524976. PMID: 36711898; PMCID: PMC9882399. (2023)

[59] Nip Y, Bennett SR, Smith AA, Jones TI, Jones PL, Tapscott SJ. Human DUX4 and porcine DUXC activate similar early embryonic programs in pig muscle cells: implications for preclinical models of FSHD. Hum Mol Genet. 2023 Feb 2:ddad021. doi: 10.1093/hmg/ddad021. Epub ahead of print. PMID: 36728804. (2023)

[60] Wong CJ, Friedman SD, Snider L, Bennett SR, Jones TI, Jones PL, Shaw DWW, Blemker SS, Riem L, DuCharme O, Lemmers RJFL, van der Maarel SRM, Wang LH, Tawil R, Statland JM, Tapscott SJ. Validation of the association between MRI and gene signatures in facioscapulohumeral dystrophy muscle: implications for clinical trial design. bioRxiv [Preprint]. 2023 Feb 20:2023.02.20.529303. doi: 10.1101/2023.02.20.529303. PMID: 36865168; PMCID: PMC9980042. (2023)

[61] Claus C, Slavin M, Ansseau E, Lancelot C, Bah K, Lassche S, Fiévet M, Greco A, Tomaiuolo S, Tassin A, Dudome V, Kusters B, Declèves AE, Laoudj-Chenivesse D, van Engelen BGM, Nonclercq D, Belayew A, Kalisman N, Coppée F. The double homeodomain protein DUX4c is associated with regenerating muscle fibers and RNA-binding proteins. Skelet Muscle. 2023 Mar 7;13(1):5. doi: 10.1186/s13395–022–00310-y. PMID: 36882853; PMCID: PMC9990282. (2023)

[62] Padberg GW, van Engelen BGM, Voermans NC. Facioscapulohumeral Disease as a myodevelopmental disease: Applying Ockham's razor to its various features. J Neuromuscul Dis. 2023;10(3):411–425. doi: 10.3233/JND–221624. PMID: 36872787. (2023)
[63] Mocciaro E, Giambruno R, Micheloni S, Cernilogar FM, Andolfo A, Consonni C, Pannese M, Ferri G, Runfola V, Schotta G, Gabellini D. WDR5 is required for DUX4 expression and its pathological effects in FSHD muscular dystrophy. Nucleic Acids Res. 2023 Apr 6:gkad230. doi: 10.1093/nar/gkad230. Epub ahead of print. PMID: 37021550. (2023)
[64] Spens AE, Sutliff NA, Bennett SR, Campbell AE, Tapscott SJ. Human DUX4 and mouse Dux interact with STAT1 and broadly inhibit interferon-stimulated gene induction. Elife. 2023 Apr 24;12:e82057. doi: 10.7554/eLife.82057. PMID: 37092726. (2023)
[65] Knox RN, Eidahl JO, Wallace L, Choudury S, Rashnonejad A, Daman K, Guggenbiller M, Saad N, Hoover ME, Zhang L, Branson OE, Emerson CP Jr, Freitas MA, Harper SQ. Posttranslational modifications of the DUX4 protein impact toxic function. Ann Neurol. 2023 Apr 26. doi: 10.1002/ana.26668. Epub ahead of print. PMID: 37186119. (2023)
[66] Ganassi M, Zammit PS. Involvement of muscle satellite cell dysfunction in neuromuscular disorders: Expanding the portfolio of satellite cell-opathies. Eur J Transl Myol. 2022 Mar 18;32(1):10064. doi: 10.4081/ejtm.2022.10064. PMID: 35302338; PMCID: PMC8992676. (2022)
[67] Cowley MV, Pruller J, Ganassi M, Zammit PS, Banerji CRS. An in silico FSHD muscle fibre for modelling DUX4 dynamics and predicting the impact of therapy. Elife. 2023 May 15;12:e88345. doi: 10.7554/eLife.88345. Epub ahead of print. PMID: 37184373. (2023)
[1] U.S. Department of Education. (2023). Higher Education Fiscal Year 2024 Budget Request. https://www2.ed.gov/about/overview/budget/budget24/justifications/u-highered.pdf.
[2] South Bend-Elkhart Regional Development Authority and South Bend-Elkhart Regional Partnership. (2018). Ensuring Prosperity for the South Bend-Elkhart Region 47 Smart, Connected Communities in North Central Indiana and Southwest Michigan. https://southbendelkhart.org/wp-content/uploads/2018/02/REDS-PLAN-013118.pdf.
[1] Science & Technology Action Committee. (2022 January). Briefing Paper: A Roadmap for Investment in Science and Technology. https://sciencetechaction.org/news-item/white-paper-a-roadmap-for-investment-in-science-and-technology/.
[2] Research!America. (2023) Survey of U.S. Adults conducted in partnership with Zogby Analytics. https://www.researchamerica.org/wp-content/uploads/2023/02/2023-January-National-Survey-Results-ResearchAmerica.pdf. Accessed 3/21/2023.
[3] NIH's Role in Sustaining the U.S. Economy 2023 Update. https://unitedformedicalresearch.org/wp-content/uploads/2023/03/UMR__NIHs-Role-in-Sustaining-the-U.S.-Economy-2023-Update.pdf. Accessed 3/21/2023.

[This statement was submitted by Daniel Paul Perez, Co-Founder & Director Emeritus, FSHD Society.]

PREPARED STATEMENT OF THE GAINING EARLY AWARENESS AND READINESS FOR UNDERGRADUATE PROGRAMS

I appreciate the opportunity to submit testimony about the Gaining Early Awareness and Readiness for Undergraduate Programs (GEAR UP) initiative administered by the U.S. Department of Education. The U.S. Department of Education reports that in 2022, 81.6 percent of GEAR UP high school graduates enrolled immediately into postsecondary education,[1] an outcome that dramatically exceeds low-income students nationally. Considering this return on investment, and on behalf of the 508,000 GEAR UP students across the country, I urge the subcommittee to appropriate $410,000,000 for GEAR UP in fiscal year 2024 so that we can foster opportunity for an additional 40,000 students.

My name is Chad Addie and I have spent my professional life serving young people in one form or another, whether it be as a youth pastor, a school counselor, or as an administrator in K12 schools and on regional workforce boards. I currently serve as the Assistant Superintendent of College and Workforce Readiness at South Bend Community School Corporation, one of Indiana's largest school districts, where we serve approximately 16,000 students.

In 2011, Newsweek described my town of South Bend, Indiana as a "dying city."

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[1] U.S. Department of Education. (2023). Higher Education Fiscal Year 2024 Budget Request. https://www2.ed.gov/about/overview/budget/budget24/justifications/u-highered.pdf.
[2] South Bend-Elkhart Regional Development Authority and South Bend-Elkhart Regional Partnership. (2018). Ensuring Prosperity for the South Bend-Elkhart Region 47 Smart, Connected Communities in North Central Indiana and Southwest Michigan. https://southbendelkhart.org/wp-content/uploads/2018/02/REDS-PLAN-013118.pdf.

from low-income families. At South Bend Schools, we believe that you don't wait for talent, you must mine for it and relentlessly develop it. GEAR UP is changing the face of education in South Bend.

As a first-time grantee, we viewed the GEAR UP opportunity as a powerful vehicle for aligning our educational practices to the needs and interests of our community. GEAR UP South Bend! serves approximately 2,300 students enrolled in seven middle schools, ultimately enrolling into five high schools. Seventy three percent of our students are eligible for free and reduced-price lunch, and our targeted neighborhoods are among the most impoverished in the region, with high unemployment, poverty, below-average educational attainment, and are under resourced at the school-level.

As a seven-year grant, GEAR UP allows us to not only strengthen pathways to success, but to change individual student life trajectories by bridging middle school, high school, and postsecondary education for entire grade levels of students. Recognizing that some form of postsecondary education is imperative for helping young people earn good jobs, GEAR UP introduces early and sustained interventions to ensure that students are successful in rigorous courses, are knowledgeable about the steps necessary to prepare for life beyond high school, and ultimately enroll and succeed in a high-quality certificate, associate, or bachelor's degree program that fully equips and unleashes their potential.

Beginning in 2024, our students will be subject to more challenging high school graduation requirements, which not only requires them to meet credit and curricular expectations, but they must also demonstrate employability skills and postsecondary-ready competencies. GEAR UP allows us to improve education and career outcomes for students from low-income backgrounds by creating a postsecondary pathway for every GEAR UP student. Through GEAR UP, we have established a comprehensive strategy to fill programming gaps in our target schools through three evidence-driven strategies.

Our first strategy centers on academic preparation, supports, and enrichment. Here, we deploy GEAR UP resources to infuse our curriculum with STEM, Advanced Placement, and expand our early college high school approach, called IVY Academy, to provide our students with access to in-person and on-line early college and dual enrollment. Through our partnership with our technical colleges, we are providing our students with summer, weekend, and afterschool opportunities to complete career credentials in a diverse array of professional fields. Our students receive access to tutoring, mentoring, and a range of academic supports and technologies to help them accelerate their learning in effective and engaging ways. We complement these interventions by investing in the professional development of our teachers, ensuring our work has a lasting impact on school-level practices.

Our second strategy is focused on making our students college ready. Here we have introduced new academic assessments, provided our students with personalized guidance and support from graduation coaches, and deployed new technologies, which are designed to help students, families, and educators engage, plan, and monitor key academic and postsecondary planning steps. We have established resource centers where students and families can access workshops, personalized support, and technologies to help them navigate the financial aid process. Lastly, we seek to inspire students from every ZIP code and shape their sense of belonging by providing educational campus visits to a wide variety of postsecondary institutions.

Our third strategy is ensuring our students are career ready. We enable our students to identify and develop their unique skills, talents, and interests specific to their personalized career path. Through our partnership with business, industry, and workforce development partners, we bring a wealth of career exploration resources, skills training, and help our students earn a wide range of certifications in high-demand fields. Our partners work closely with our teachers, counselors, and administrators to help us better align career and college readiness in practice.

Through the generous matching contributions of our partners and the Federal GEAR UP investment in our work, we are able to implement this suite of interventions at a per-student cost of only $3.33 per school day. The GEAR UP investment is an efficient one that pays dividends.

I want to close by sharing what, at the local level, we have learned as a collaboration of leaders from education, community, industry, and workforce development leaders. First, if we share a common vision centered on improving the prosperity of our families, communities, and nation, we must do it together. None of what I have described would be possible if our state and community leaders remained in our operational silos or steeped ourselves in partisanship.

Second, it's not about prioritizing a career-technical or a traditional college prep experience; it's about ensuring that our students have equitable access to the full continuum of options. The truth is—whether one of our students is on a CTE path

to pursue an industry-recognized credential, or a student is taking advantage of dual enrollment to earn an associate's degree, or they are taking on an advanced course load to prepare for the University of Notre Dame—all of these outcomes are important and transformational successes. The most effective approach we can take—and GEAR UP can be a catalyst here—is to work towards a more integrated system where all students have early access to the tools and support to forge their unique path after high school.

Lastly, while we have an enormous challenge ahead of us, let me reiterate that our local, regional, and national economic goals will fail if we don't attend to the needs of our students from low-income backgrounds. In South Bend, we recognize how fortunate we are to benefit from the investment that Congress has made in our GEAR UP program and the matching funds provided by community partners. Yet the needs of communities across the Nation are far greater than what the GEAR UP appropriation can currently meet. We have the systems and leadership to get the work done. If we value people and our future talent, we need to ensure that GEAR UP remains a national priority and I urge the committee to support us in this shared pursuit by increasing the Federal investment in GEAR UP for fiscal year 2024.

[This statement was submitted by Chad J. Addie, Assistant Superintendent of College and Workforce Readiness.]

PREPARED STATEMENT OF THE GBS|CIDP Foundation International

SUMMARY OF RECOMMENDATIONS FOR FISCAL YEAR 2024

—Provide $50 billion for the National Institutes of Health (NIH) and proportional increases across its Institutes and Centers
—Continue expanding GBS research supported by NIH with proportional funding increases for the National Institute of Neurological Disorders and Stroke (NINDS), and the National Institute of Allergy and Infectious Diseases (NIAID)
—Provide $11 billion for the Centers for Disease Control and Prevention (CDC) and $6 million for the Chronic Disease Education and Awareness Program

Chairwoman Baldwin, Ranking Member Capito thank you for your time and your consideration of the priorities of the community of individuals impacted by Guillain-Barré Syndrome (GBS), Chronic Inflammatory Demyelinating Polyneuropathy (CIDP), and related conditions as you work to craft the FY2024 L–HHS Appropriations Bill.

ABOUT GBS, CIDP, VARIANTS, AND RELATED CONDITIONS

Guillain-Barré Syndrome

GBS is an inflammatory disorder of the peripheral nerves outside the brain and spinal cord. GBS is characterized by the rapid onset of numbness, weakness, and often paralysis of the legs, arms, breathing muscles, and face. Paralysis is ascending, meaning that it travels up the limbs from fingers and toes towards the torso. Loss of reflexes, such as the knee jerk, are usually found. Usually, a new case of GBS is admitted to ICU (Intensive Care) to monitor breathing and other body functions until the disease is stabilized. Plasma exchange (a blood "cleansing" procedure) or high dose intravenous immune globulins are often helpful to shorten the course of GBS. The acute phase of GBS typically varies in length from a few days to months. Patient care involves the coordinated efforts of a team such as a neurologist, physiatrist (rehabilitation physician), internist, family physician, physical therapist, occupational therapist, social worker, nurse, and psychologist or psychiatrist. Recovery may occur over 6 months to 2 years or longer. A particularly frustrating consequence of GBS is long-term recurrences of fatigue and/or exhaustion as well as abnormal sensations including pain and muscle aches.

Chronic Inflammatory Demyelinating Polyneuropathy

CIDP is a rare disorder of the peripheral nerves characterized by gradually increasing weakness of the legs and, arms. It is the gradual onset as well as the chronic nature of CIDP that differentiates it from GBS. Like GBS, CIDP is caused by damage to the covering of the nerves, called myelin. It can start at any age and in both genders. Weakness occurs over two or more months. Unlike GBS, CIDP is chronic, with symptoms constantly waxing and waning. Left untreated, 30% of CIDP patients will progress to wheelchair dependence. Early recognition and treatment

can avoid a significant amount of disability. Post-treatment life depends on whether the disease was caught early enough to benefit from treatment options. The gradual onset of CIDP can delay diagnosis by several months or even years, resulting in significant nerve damage that may take several courses of treatment before benefits are seen. The chronic nature of CIDP differentiates long-term care from GBS patients. Adjustments inside the home may need to be made to facilitate a return to normal life.

Multifocal Motor Neuropathy

MMN is a rare disorder in which focal areas of multiple motor nerves are attacked by one's own immune system. Typically, MMN is slowly progressive, resulting in asymmetrical weakness of a patient's limbs. Patients frequently develop weakness in their hand(s), resulting in dropping of objects or sometimes inability to turn a key in a lock. The weakness associated with MMN can be recognized as fitting a specific nerve territory. MMN has many features similar to CIDP in that its onset is progressive over time, causing increased disability that reflects the greater number of nerve sites involved. However, unlike CIDP, MMN is asymmetric and affects the right and left side of the body differently. The clinical course of MMN is chronically progressive without remission.

ABOUT THE FOUNDATION

The Foundation's vision is that every person afflicted with GBS, CIDP, MMN, or variants of these conditions has convenient access to early and accurate diagnosis, appropriate and affordable treatments, and dependable support services.

The Foundation's mission is to improve the quality of life for individuals and families across America affected by GBS, CIDP, and their variants by:

—Providing a network for all patients, their caregivers and families so that GBS or CIDP patients can depend on the Foundation for support, and reliable up-to-date information.

—Providing public and professional educational programs worldwide designed to heighten awareness and improve the understanding and treatment of GBS, CIDP and variants.

—Expanding the Foundation's role in sponsoring research and engaging in patient advocacy.

CENTERS FOR DISEASE CONTROL AND PREVENTION

CDC and the National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) have resources that could be brought to bear to improve public awareness and recognition of GBS, CIDP and related conditions. The Foundation supports a meaningful increase to the Centers for Disease Control and Prevention as well as continued support of the Chronic Disease Education and Awareness Program. This program seeks to provide collaborative opportunities for chronic disease communities such as ours that lack dedicated funding from ongoing CDC activities. Such a mechanism allows public health experts at the CDC to review project proposals on an annual basis and direct resources to high impact efforts in a flexible fashion.

NATIONAL INSTITUTES OF HEALTH

NIH hosts a modest research portfolio focused on GBS, CIDP, variants, and related conditions. This research has led to important scientific breakthroughs and is well positioned to vastly improve our understanding of the mechanism behind these conditions. We ask that resources continue to be used to support the important collaboration between NIAID, NINDS and the GBS|CIDP community. Four years ago, we participated in a conference with NINDS that discussed how intramural and extramural researchers can develop a roadmap that would lead research into these conditions into the next decade and encourage younger investigators to apply for grants that lead to sustained research activities. This however was not the size and scope of the original planned meeting. We continue to have conversations with the leadership of both institutes to facilitate follow up and plan for a more robust agenda and list of goals for a future in person conference. In our meetings with the leadership, we also spoke about the possibilities of cross-institute work between NINDS and NIAID to expand the research and understanding of the link between emerging viral threats and GBS. While such a conference would not require additional appropriations, the Foundation urges you to provide NIH with meaningful funding increases to facilitate growth in the GBS, CIDP, MMN, and related conditions research portfolio.

PATIENT ACCESS

As we have seen from communities that currently have access to home infusion, the ability to choose the home as the preferred site of care has tremendous benefit in terms of health outcomes and overall convenience for patients. Individuals with CIDP and MMN often face mobility issues as limbs suffer nerve damage. Traveling to receive an infusion presents a tremendous hardship to many patients and their families. This hardship greatly affects rural patients who have to travel hundreds of miles to major cities in order to receive treatment, which can be both inconvenient and costly. The Foundation has seen that when there are obstacles to receiving regular infusions, patients tend to skip scheduled infusions, which leads to progressive disability. Many CIDP and MMN patients have access to IVIG home infusion through private insurance, which allows them to lead productive and active lives. When these individuals age on to Medicare, they can face disruption in their routine and suboptimal circumstances when managing their condition. Further, because the body's immune system is depressed at the end of an infusion cycle, CIDP and MMN patients face an elevated risk of contracting illness from visiting well-traveled sites of care for infusions. Most importantly, patients and physicians should have the authority to choose their preferred site of care. We hope that members of this subcommittee and Congress as a whole support legislation that will grant our patients this important access.

Thank you for the opportunity to present the view of the GBS|CIDP and MMN communities.

[This statement was submitted by Lisa Butler, Executive Director, GBS|CIDP Foundation International.]

PREPARED STATEMENT OF THE GERALD J. AND DOROTHY R. FRIEDMAN SCHOOL OF NUTRITION SCIENCE AND POLICY, TUFTS UNIVERSITY

The Gerald J. and Dorothy R. Friedman School of Nutrition Science and Policy at Tufts University respectfully requests that the subcommittee allocate $121,000,000 to the National Institutes of Health's (NIH) Office of Nutrition Research (ONR) in Fiscal Year 2024, in line with the administration's FY24 budget request. ONR is situated within the NIH Office of the Director, Division of Program Coordination, Planning and Strategic Initiatives (DPCPSI) within NIH at the U.S. Department of Health and Human Services. This investment will accelerate discoveries across numerous critical areas and positively impact public health (namely, food and nutrition security), economic and national security, and equity, and simultaneously bolster the Nation's resilience to current and future threats such as COVID–19.

Key background and Context:

In January 2021, NIH transferred ONR from the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), where it had been established in 2015, into the NIH Office of the Director. This reorganization clarified ONR's position and role as a trans-NIH program and enabled it to better coordinate and lead research functions across NIH institutes and centers, and to develop new collaborations and relationships for nutrition research within and outside of NIH.

Poor nutrition is a driver of diet-related diseases including heart disease, type 2 diabetes, obesity, hypertension, and some cancers—all of which have staggering costs to society. Diet-related diseases are the number one cause of death and disability in the United States. Nearly three in four U.S. adults are overweight or obese and one in two have diabetes or prediabetes. The Federal and State governments spend more than $160 billion each year on diabetes care alone, an increase of 25% from 5 years ago. The combined health care spending and lost productivity from suboptimal diets costs the economy $1.1 trillion each year. Diet-related illness also undermines our country's military readiness: a striking 77% of young adults are ineligible for military service, with obesity as the largest disqualifier.

A 2019 NIH analysis compared the amount of dedicated NIH funding for risk factors of death and disability, and concluded that large disparities exist between the top causes of poor health and the research funding allocated to address them—with the largest gap existing for nutrition. Despite this pressing need for more investment, funding levels for nutrition research and training (as a percentage of total NIH spending) have been flat at approximately 5% since FY2015. Recently, due to inflation and other factors, support for nutrition research has declined—even as diet-related diseases have persistently increased in prevalence.

Within this context, the concept of nutrition security has emerged and gained momentum in recent years. A recently proposed definition of nutrition security is "consistent access, availability, and affordability of foods and beverages that promote well-being and prevent and if needed, treat disease." Improving nutrition security is a critical pathway to improve health equity, in light of the impact of poor nutrition on chronic disease prevalence. Ongoing research will continue to establish optimal types of intervention, duration, dose, educational supports, and patient populations for nutrition security interventions.

Purpose and Impact:

In recent years, NIH has made exciting strides in refocusing its nutrition research strategy. An interdisciplinary task force released the NIH 2020–2030 Strategic Plan for Nutrition Research and the agency has begun implementation of the NIH Common Fund Nutrition for Precision Health initiative. With robust resources, ONR will have the capacity to fulfill the 2020–2030 Strategic Plan and coordinate and accelerate research between and within NIH centers.

Funding at the requested level of at least $121,000,000 would enable ONR to secure the leadership, organizational structure, and resources to effectively fulfill its important mission—which will be especially significant with the expected confirmation of a new NIH director this year. Within the total, Congress should also include at least $20,000,000 to award grants for selected Centers of Excellence to build infrastructure, develop and test new programs, curricula, and Food is Medicine patient services, design and seek IRB approvals for planned research studies, and identify and engage community partners. These investments would expand and accelerate scientific discoveries that positively impact public health, health care costs, equity, the economy, national security, and the Nation's resilience to new threats.

Specifically, the requested funding level of at least $121,000,000 will allow ONR and NIH to establish a strong foundation and increased capacity to:

—Attain scientific breakthroughs in the prevention and treatment of priority disease conditions that have strong links to diet and nutrition but require much more research, such as mental illness, Alzheimer's disease, cancer, and maternal and child health, as well as the role of the microbiome in these and other diseases and conditions;

—Build and coordinate new and enhanced collaborative relationships and synergies within the NIH, with other Federal departments and agencies (e.g., USDA, DOD, VA, CMS, CDC, FDA), and with external stakeholders (including public-private partnerships) to drive nutrition research and innovation;

—Drive groundbreaking science within Food Is Medicine, a rapidly expanding model of integrating food-based intervention into health care, including treatment of chronic disease;

—Strengthen existing close communication and coordination with the NIH Director, other divisions and offices within the NIH Office of the Director, and nutrition activities across all NIH institutes and centers;

—Ensure successful implementation of the 2020–2030 Strategic Plan for NIH Nutrition Research and NIH Common Fund's Nutrition for Precision Health initiative;

—Examine structural and social determinants that affect access to healthy food and contribute to disparities in diet-related diseases (namely, through the Community Partnerships to Advance Science for Society [ComPASS] program);

—Provide guidance on rigorous research methodology;

—Provide trainings to build the next generation of diverse scientists capable of addressing diet-related diseases and health disparities;

—Increase the impact, visibility, and dissemination of nutrition science findings;

—Structure a more formalized approach to engage strong external advisory mechanisms and strengthen input from other Federal departments and agencies, academic institutions, advocacy groups, State and local governments, community members, and other stakeholders; and

—Address health disparities by State, zip code, and other factors; and

—Strengthen military readiness.

It is past time that we close the gap between our investment in nutrition research and the toll of diet-related diseases and health disparities on our Nation. Full funding for ONR is a critical investment in correcting that balance, driving future discovery, supporting health equity, and overall, saving lives.

PREPARED STATEMENT OF GLOBAL HEALTH COUNCIL

Global Health Council (GHC) is the leading member organization devoted to advancing global health priorities by uniting advocates, implementers, policy makers, and other stakeholders. Using the power of our community's collective voice, we work across disease areas to drive sustainable funding and equitable policies that improve global health and well-being for all. We work with more than 120 organizations-including associations and coalitions, corporations, foundations, NGOs, academic institutions and think tanks-that are implementing programs across 150 countries and focusing on a broad range of global health issues.

We live in an undeniably global environment where every year, more than 500 million people cross borders in planes, and with them the potential for infectious diseases to enter the U.S., demanding more attention from our public health officials and health workforce. The Centers for Disease Control and Prevention (CDC) leads global disease surveillance, health system and workforce capacity building, and research in the development of new tools and technologies to identify global diseases, including Ebola and flu variants. Additionally, the National Institutes of Health (NIH) serves as a beacon of American ingenuity in health research and science. Robust funding of these institutions is critical to advancing and protecting health at home and across the globe.

For Fiscal Year (FY) 2024, GHC urges continued support for global health within the Function 550 account at a minimum of FY23 levels enacted by Congress. However, in order to achieve U.S. global health goals and live up to our commitments, we ask that you support a greater investment in global health programs for FY24, including a minimum of: $7,120,000,000 for the National Institute of Allergy and Infectious Disease (NIAID), $3,875,000,000 for the Office of AIDS Research, and $116,100,000 for the Fogarty International Center at the NIH; an investment of $900,000,000 for the Center for Emerging Zoonotic and Infectious Diseases, $300,000,000 for the Infectious Diseases Rapid Response Fund, and no less than $1,002,300,000 for the Global Health Center at the CDC.

As we move out of the acute phase of the COVID–19 pandemic, we have seen significant declines across global health programs in their capacity to reach the same or more people for preventative care, as well as ongoing care for diseases ranging from HIV/AIDS, tuberculosis, non-communicable diseases, malaria, and more. U.S.-supported global health programs play a crucial role in mitigating the threat posed by these diseases to populations at home and abroad, and in helping to achieve a healthier and more equitable world.

For example, CDC serves as the lead implementer of the Global Health Security Agenda (GHSA), a partnership of over 60 nations that works to build capacity in low- and middle-income countries to detect global health risks rapidly, prevent them when possible, and respond effectively when they occur. By fully funding CDC and its global health work, we can also support their efforts to bolster health systems globally through programs such as the Field Epidemiology Training Program, which has trained more than 18,000 disease detectives in 80 countries to detect and rapidly respond to infectious disease outbreaks.

CDC's global programs have significant impact. In FY22, CDC's efforts supported treatment for 484,000 HIV-positive pregnant women, reducing the risk of mother-to-child transmission through the work of the President's Emergency Plan for AIDS Relief (PEPFAR). As CDC learns from the past 3 years of the COVID–19 pandemic and implements reforms across the agency, there are multiple opportunities for improvement and growth in the global health sector crucial to protecting American health and working towards a healthier and equitable world.

Not only do we know that the programs enumerated above work, they have also secured their place as some of the most critical and successful tools of U.S.-supported global health aid. By investing in these programs, the U.S. continues to build healthier and more self-reliant communities, which ultimately become more economically and politically stable. These investments see long-term gains that benefit a myriad of U.S. goals and aims abroad, as well as at home. For example, these investments result in life changing therapeutics and medical developments for American citizens. While the NIH is known to have played a crucial role in the development of COVID–19 diagnostics, therapeutics, and vaccines, NIH-funded research has also led to the development of new and improved HIV/AIDS interventions, including the use of HIV/AIDS drugs as a form of prevention, as well as treatment. These developments have critically benefited American citizens.

While the past few years have highlighted some of the inefficiencies and weak points in healthcare systems around the world, programs such as the Fogarty International Center (FIC), are helping to improve these conditions. FIC, in particular, acts as a critical link between U.S. researchers and those in the Global South. It

strengthens international research and laboratory capacity, facilitates global research partnerships, improves surveillance of emerging infectious diseases, and trains scientists who make invaluable contributions to global public health challenges, such as HIV/AIDS, COVID–19, Zika, and Ebola. It is through programs such as FIC that we can continue to maintain progress and prevent the rollback of decades worth of investment in global health.

Finally, we must continue to build upon the hard work and achievements of previous years' investments in order to prevent the persistent global health challenges of our time and mitigate further backsliding. By maintaining strong U.S. support for global health programs, we will continue to build upon the hard work and achievements of previous years in order to ensure a healthy future for Americans and people around the world.

GHC thanks the subcommittee for the opportunity to submit written testimony. For more information on U.S. investments in global health, please visit http://ghbb.globalhealth.org.

Thank you for your consideration of this request.

[This statement was submitted by Elisha Dunn-Georgiou, President and CEO, Global Health Council.]

PREPARED STATEMENT OF THE GLOBAL HEALTH TECHNOLOGIES COALITION

I am providing testimony on fiscal year 2024 (FY24) appropriations for the National Institutes of Health (NIH), the Centers for Disease Control and Prevention (CDC), and the Biomedical Advanced Research and Development Authority (BARDA) on behalf of the Global Health Technologies Coalition (GHTC), a group of 45 nonprofit organizations, universities, and aligned businesses advancing the development of new drugs, vaccines, diagnostics, and other tools for global health and global health security.

I am testifying today because we still do not have the technologies that we need to achieve a future where pandemics are prevented, and health is within reach for everyone. In 2019, at least 1.27 million people were killed by antibacterial resistance. In 2021, 1.6 million people were killed by tuberculosis, 1.5 million people were newly diagnosed with HIV, and 247 million people were infected by malaria. Today, more than 1 billion people worldwide are still affected by neglected tropical diseases (NTDs). Unfortunately, it is women and children who are often the most vulnerable. And as we look toward the future, we cannot afford to sit idle and wait for future pandemic threats with the potential to match or exceed the disruption of COVID–19.

To develop the technologies that we need to defeat these diseases and to prevent future pandemics, the US government needs to sustainably increase its investments in global health research programs. Public funding is critical for this sector because companies have little commercial incentive to invest in health areas that impact people in poverty. As the world's leader in biomedical research, the United States has both a responsibility and an opportunity: with relatively small public investments, we have the power to save and improve millions of lives.

Three agencies that support global health research are NIH, CDC, and BARDA, and we thank the Committee for its past support of these agencies. Still, there is a large hill ahead of us. To continue our progress toward developing lifesaving tools, we respectfully request:

—Increased funding for NIH, including an additional US$21 million for the Fogarty International Center (FIC) to a total of $116.1 million and the National Institute of Allergy and Infectious Diseases.

—Increased funding for CDC to maintain its capabilities in global health and global health security research, especially for the Global Health Center (GHC) and the National Center for Emerging and Zoonotic Infectious Diseases (NCEZID).

—An additional $775 million in new funding for the Pandemic Preparedness and Biodefense program under the Administration for Strategic Preparedness and Response for BARDA ($400 million in the President's Budget Request).

In addition to funding, we urge the Committee to request that leaders in the Department of Health and Human Services coordinate across the department's agencies and with the State Department to ensure that US investments in global health research are efficient, coordinated, and streamlined.

NIH is a global leader in biomedical research. Within NIH, Fogarty accelerates science through international partnerships, technical assistance, and researcher trainings. The agency delivers significant scientific results and foreign goodwill with

less than one-quarter of one percent of the total NIH budget. Many FIC-trained scientists have led their countries' responses to COVID–19, Zika, and Ebola, as well as to long-standing challenges such as HIV/AIDS. Fogarty is positioned to expand its role in pandemic preparedness and global health research capacity-building. With additional funding, the center could improve global disease surveillance, coordination, and training of scientists in fields that strengthen pandemic preparedness, such as disease transmission modeling. We urge appropriators to increase FIC's relatively modest budget by $21 million in FY24. Also within NIH, the National Institute of Allergy and Infectious Diseases is the single largest funder of research on neglected and emerging infectious diseases in the world. As it undergoes a historic leadership change, we urge Congress to include report language that emphasizes the importance of the institute's support for global health research.

CDC tracks the spread of diseases and supports the development of new global health technologies, including diagnostics and vaccines. This research happens across several centers including GHC and NCEZID. CDC has recently appointed a new deputy director for global health who will connect and oversee global health programs across the agency. CDC's GHC leads CDC's global health security efforts; provides technical support to the President's Emergency Plan for AIDS Relief, the President's Malaria Initiative, and the US Agency for International Development's NTDs Program; and develops and validates tools such as insecticides to prevent malaria. GHC also hosts a gold-standard parasitic diseases laboratory that serves as a reference for scientists around the world. GHC needs additional funding to maintain and expand its laboratory services, expand its public health workforce, and improve its global health security efforts. Also at CDC, NCEZID develops diagnostics for global health threats and is an international reference hub for identifying and tracking known and unknown viral and bacterial diseases. The center has a leading role in the National Strategy for Combating Antibiotic-Resistant Bacteria to prevent, detect, and control outbreaks of antibiotic-resistant pathogens.

BARDA sponsors the late-stage development of vaccines, drugs, diagnostics, and other medical devices for naturally occurring biothreats that lack a commercial market-including emerging infectious diseases, pandemic influenza, and antimicrobial resistance. To date, however, BARDA's work in advancing tools for emerging infectious diseases has mostly been funded through emergency supplemental appropriations. This pattern produces a delayed response with every new outbreak of emerging or reemerging diseases like Ebola, Zika, and COVID–19. We urge Congress to break this cycle by creating a new, dedicated funding line of at least $775 million to support BARDA's efforts against emerging infectious diseases. Such funding will enable the agency to prepare for-rather than react to-future pandemic threats.

Global health research and development is unique as a foreign policy goal in that it also supports researchers in the United States. From 2007 to 2020, more than $18 billion in Federal funding went to US-based institutions for research on neglected diseases, supporting estimated hundreds of thousands of jobs and generating billions more in economic growth. In addition, many of the tools and technologies developed from this funding benefit people living in the United States either directly or indirectly by strengthening national health security and global prosperity.

As we emerge from a global pandemic subdued by publicly supported science, it is clearer than ever what we can achieve with sustained funding and attention. With increased public funding for global health research, we can achieve a world that is healthier and safer for everyone.

[This statement was submitted by Jamie Bay Nishi, Executive Director, Global Health Technologies Coalition.]

PREPARED STATEMENT OF TIMOTHY GRANFIELD

TRIO has had a profound impact on the trajectory of my life. In giving this testimony, I can't help but think of where I started, where I've gotten, and how life might have been different if not for Upward Bound, the TRIO program I was most involved in.

Where I started was a bit rough. When I was 7 years old, I became homeless with my mother and two younger brothers. Eventually, we ended up in public housing in a tough neighborhood full of violence, drugs, poverty, and hunger but short on hope. It was a step up from homelessness but not an inspirational environment with ample opportunity. There was no vision for any of us for what a better life might even look like; we could only see what was right in front of us: life in that neighborhood.

In my peer group at the time, the thing to do to fit in and feel included was to pretend not to care. What was the point? Most people were multi-generation resi-

dents of public housing, and the expectation of us was that we weren't going anywhere. I was wasting potential because I had nothing to strive for.

Then in ninth grade, I remember getting a note from guidance telling me to go to this presentation in the auditorium. When I showed up, Dan Gordon, a longtime TRIO director, started talking about a program called TRIO Upward Bound. What Dan pitched that day intrigued me. I could get away from the neighborhood for the summer. Meet new people, learn about this college, and do some fun stuff. I had to take some classes, but I would get a stipend, which sounded like a good deal to a kid like me.

What I got out of Upward Bound was much more than my expectations. The first time I stepped on a college campus was when I went to the University of NH for the summer program. It, indeed, was a whole new world. It gave me an insight or epiphany that there was a broader world for me, one where I could be successful and have things I never thought I could have, like a car, a house, and a good-paying job. Maybe I didn't have to live in public housing. All I had to do was what led me to Upward Bound in the first place: I needed to start taking advantage of educational opportunities.

I learned new things, academically and socially. I met amazing people. We drew hope and inspiration from each other and the staff and used that momentum when we returned to school-success built on success. A great summer led to academic success during the school year, and I remember getting recommended into the honors curriculum, which led to great school opportunities. I found out my senior year that the United States Military Academy at West Point offered me admission and several other great schools. I couldn't have been happier, and I finally saw a path to success and moving up in life.

Five days after my acceptance letter from West Point came, my mom died of an overdose. I remember every detail of that morning. I knocked on the door when she wasn't up and then went in to wake her up. I sent my two younger brothers to school and tried CPR until medics arrived. I was trying to piece everything together from the chaos that had just descended on us. I was responsible for my little brothers, but you cannot have dependents as a cadet. I had a choice: go to West Point, and my brothers would move across the State to a family we weren't close with or forego college and become my brothers' legal guardian.

I talked to many people: friends and their families, my track coach and teachers, and Dan Gordon. They helped guide me to a great decision: to go to school and get myself to a place where I could ultimately truly help my brothers. I learned an all-important lesson; that educational opportunities are essential to future success. My brothers moved away, and I graduated from high school as the twelfth in my class and then attended West Point.

A little bit into my first summer at West Point, tragedy struck again. I broke my foot badly and was medically discharged. Sitting across from the army surgeon with the x-rays between us, I told him I could not continue there. Everything I had worked for had suddenly fallen apart again. And again, I turned to the people I trusted most, and another educational opportunity became available, enrolling at the University of New Hampshire.

I committed to my studies and worked my way into the business school. As I learned from my Upward Bound experience, I worked hard, took advantage of opportunities, and built momentum. I graduated fifth in my class at the business school and got competitive offers from great companies. Having a secure job gave me the financial means to buy the first house I ever lived in. I worked on and completed my MBA, finishing first in my class, and that program allowed me to meet people from different companies and backgrounds.

I leveraged this network to take a great offer to work at my current company, and I worked my way up there, taking advantage of educational and diverse work opportunities, just like I had learned at Upward Bound. I completed my chartered property casualty underwriter designation and my associate in general insurance, personal insurance, and associate in claims designations. These led to more significant roles and titles. It also put me in a position to give back to the community and those who supported me.

Today I am a proud father to three incredible kids, married to a fantastic woman who is an accomplished member of our community in her own right, I'm a vice president at a Fortune 100 company, chairman of the board for the Dover Housing Authority where I grew up as a resident and I'm chairman of the board for the Seymour Osman Community Center where I used to participate in programs that helped low-income kids and families. I never thought this life would have been possible, and sometimes I still wonder how this happened to a kid like me from where I started.

And every time I start reminiscing about where I came from and try to determine what was different about my path from so many I grew up with who are now dead, in jail, or are tenants in the same place we grew up, it comes down to two things; the educational opportunities I have been afforded and taken advantage of and the amazing people in my life that have inspired me to be more than I ever thought possible. This is what TRIO does, and with the requested funding, TRIO would serve more students like me. It can break the generational cycle of poverty and the inaccessibility of educational opportunities for students who need to see that "more" is indeed possible for them. This in turn creates more upstanding contributing citizens in our community, able to drive our economy better and return the opportunities afforded to them. Please consider making this investment; you will be more than satisfied with the return.

PREPARED STATEMENT OF GRANTMAKERS COUNCIL OF RHODE ISLAND

Nonprofit organizations are anchors in their communities, providing essential services, strengthening neighborhoods, and growing the economy. Over 10% of America's workforce is employed by nonprofit organizations.

In some States, like Rhode Island, the nonprofit workforce is even more important—16.5% of the State's private workforce is employed by nonprofit organizations. Unfortunately, nonprofit employees are increasingly leaving the sector because of pandemic burnout and low wages. According to a 2022 survey of about 300 Rhode Island nonprofit organizations, almost 90% have some or all staff experiencing burnout, 49% have staff who have left the sector, and 59% have staff who are considering doing so. These vacancies have been extremely difficult to fill—47% have remained open for longer than 3 months, and 16 % have remained vacant over 6 months.

Staffing shortages in a small business may increase wait times for goods or services, but staffing shortages at nonprofit organizations can result in vulnerable Americans being unable to access essential services like Early Intervention, Home Visiting, support for families in crisis, access to food and shelter, and disaster relief. The nation's economic recovery is also dependent on fully staffed nonprofits to provide childcare, senior care, and workforce development necessary to enable America's workers to return to the workforce.

It is critically important that the Nation have timely, accurate data on workforce trends, current wages, and workforce pipeline and staffing level issues in the nonprofit sector, so that policymakers and nonprofit leaders can respond proactively to protect essential services and our economic recovery.

Currently, the Bureau of Labor Statistics (BLS) only provides nonprofit wage and employment data every 5 years, so nonprofits have been forced to use estimates based on 2017 data; pre-pandemic, pre-inflation, pre-hybrid work data is obviously not useful in understanding and responding to current employment challenges.

Therefore, we strongly urge the subcommittee to support Senator Reed and Senator Whitehouse's FY24 program requests for $4 million to enable the Bureau of Labor Statistics to include nonprofit organizations as a distinct category of employer in its Quarterly Census of Employment and Wages and related reports and ensure its inclusion in the final bill.

The purpose of the QCEW is to provide "a quarterly count of employment and wages reported by employers covering more than 95 percent of U.S. jobs, available at the county, MSA, state and national levels by industry." This mission is incomplete without data on the third largest industry in the country, and the inclusion of nonprofit data in the QCEW is long overdue.

BLS has shown that it is able to produce the necessary data, and has stated that with adequate resources, it is willing and able to incorporate nonprofit data into the QCEW. The requested funding allocation will allow BLS to fulfill its mission, and will enable nonprofit leaders and policymakers to understand and address the current nonprofit workforce crisis. It will also ensure the availability of essential services and continued economic growth, so it is critically important that this program request be included in the final bill, and be implemented in a timely manner.

If you have any questions, about these issues, I'm happy to talk further. My contact information is listed at the top of this letter. Thank you for your attention to this important issue, and for ensuring that this program request is included in the final bill.

[This statement was submitted by Nancy Wolanski, Executive Director, Grantmakers Council of Rhode Island.]

PREPARED STATEMENT OF THE HEALTH CARE WITHOUT HARM AND AMERICAN GEOPHYSICAL UNION

As organizations representing public and environmental health, and the medical and scientific communities, Health Care Without Harm (HCWH) and the American Geophysical Union (AGU) appreciate the opportunity to submit testimony regarding the fiscal year 2024 (FY24) budget request for the Department of Health and Human Services (HHS) Office of Climate Change and Health Equity (OCCHE). HCWH and AGU respectively request that the 118th Congress appropriate $5 million for OCCHE in FY24, so that it can fulfill its commitment to addressing the effects of climate change on the health of the American people and on the health care sector.

The climate is changing more rapidly than has been typical in Earth's history, exacerbating many existing challenges to public health. Across the country, record-breaking heat waves, floods, droughts, and wildfires, increasingly severe storms, and increased distribution of and prolonged exposure to the insects that spread vector-borne diseases have caused direct and extensive harm. Emerging evidence suggests that some of these events have implications for the incidence and severity of chronic disease and are linked to increased mortality for some people, such as those with cardiovascular and metabolic diseases. The effects of climate change have also been linked to increased psychological stress and negative mental health issues, such as anxiety and depression. Certain populations, such as those with lower-income or who have otherwise been marginalized, are likely to experience disproportionately severe impacts and have less capacity to adapt to such changes, worsening pre-existing health disparities. For example, while pregnant women and their babies are already at especially high risk from climate change impacts, women from underserved and under-represented populations face even greater dangers.

Climate-related extreme weather and wildfire events are also causing short- and long-term effects on health care facilities and public health infrastructure, such as suspended services, postponed procedures, facility closures and an inability to treat patients. The impacts are especially acute in communities of color, low-income communities and rural communities and can exacerbate health risks and worsen health and resource inequality. As such, prompt action must be taken to build public health resilience to climate change related health threats and ensure that our health care systems are prepared for extreme weather events and other climate related impacts.

HHS has a crucial role to play in confronting the climate crisis. One critical action HHS has already taken is establishing the Office of Climate Change and Health Equity (OCCHE), which can take the lead in improving the agency's climate preparedness and response measures. Specifically, OCCHE can work with other divisions of HHS, most of which lack dedicated climate staff or expertise, to ensure climate change health and health care issues are incorporated into their missions and programs. OCCHE's leadership is vital to ensuring department wide coordination, policy development and review, and the vetting of HHS's climate action plan.

As the health effects of climate change continue to grow, the importance of OCCHE's role cannot be overstated. Without an appropriate climate change response and mitigation plan, the U.S. will continue to be underprepared, and we run the risk that many of the Nation's public health gains of the past century will be reversed. Only with proper investment can OCCHE fulfill its mission to help HHS respond to the climate health crisis. We ask for your leadership in ensuring that HHS's Office of Climate Change and Health Equity receives $5 million in Fiscal Year 2024, to help address the effect of climate change on the American people, mitigate health care emissions, and prepare our health care system to become climate resilient. Thank you for your thoughtful consideration of this request and for the opportunity to submit this testimony.

[This statement was submitted by Antonia Herzog, Associate Director, Climate Policy & Advocacy, Health Care Without Harm and Michael Villafranca, Senior Specialist, Science Policy & Government Relations, American Geophysical Union.]

PREPARED STATEMENT OF THE HEALTH PROFESSIONS AND NURSING EDUCATION COALITION

The Health Professions and Nursing Education Coalition (HPNEC) is an alliance of more than 90 national organizations representing schools, students, health professionals, and communities dedicated to ensuring that the health workforce is trained to meet the varied needs of our diverse population. Together, the members of HPNEC advocate for continued support for the health professions and nursing work-

force development programs authorized under Titles VII and VIII of the Public Health Service Act and administered by the Health Resources and Services Administration (HRSA). For fiscal year (FY) 2024, HPNEC encourages the subcommittee to adopt at least $1.51 billion for HRSA Titles VII and VIII programs.

Health provider shortages have led to widening gaps in care for our most vulnerable patients, including an aging population that requires more health care services. HRSA estimates that 99 million Americans currently live in federally designated primary care Health Professional Shortage Areas (HPSAs), 70 million live in dental health HPSAs, and 160 million live in mental health HPSAs. At least 17,000 primary care practitioners, 12,000 dental health practitioners, and 8,000 mental health practitioners are needed to serve these areas.

The HRSA Title VII and VIII programs successfully recruit, train, and support physicians, physician assistants, nurses, geriatricians, mental health providers, public health practitioners, and other frontline health care workers. These programs educate current and future providers, train providers in underserved areas, and advance new delivery systems and interprofessional and integrated models of care. Additional investment is needed in the Title VII and Title VIII programs to ensure that our health workforce is equipped to serve the Nation's ever-growing needs and prepared for the health care demands of tomorrow.

Diversity Pathway Programs.—The Title VII and Title VIII programs play a crucial role in improving the diversity of the health workforce and connecting students from rural and disadvantaged backgrounds to health careers by supporting recruitment, education, training, and mentorship opportunities.

Diversity programs include the Health Careers Opportunity Program (HCOP), Centers of Excellence (COE), Faculty Loan Repayment, Nursing Workforce Diversity, and Scholarships for Disadvantaged Students (SDS). Studies have demonstrated the effectiveness of such pathway programs in strengthening students' academic records, improving test scores, and helping disadvantaged students pursue careers in the health professions. Title VII diversity programs reached more than 11,000 students in the 2021–2022 academic year (AY), with 56% of HCOP graduates and 49% of COE graduates accepted into a health professions training program, and 54% of SDS alumni working in medically underserved communities.

Title VIII's Nursing Workforce Diversity Program increases nursing education opportunities for individuals from disadvantaged backgrounds through stipends, scholarships, and pre-entry and advanced education preparation. In AY 2021–2022, the program supported nearly 11,000 students, all of whom were from underrepresented or disadvantaged backgrounds.

Primary Care Workforce.—The Primary Care Medicine Programs fortify our Nation's primary care workforce by training future clinicians, teachers, and researchers who practice as general pediatricians, general internists, family medicine practitioners, and physician assistants through the following programs: Primary Care Training and Enhancement (PCTE) and Primary Care Medicine and Dentistry Career Development. The Primary Care programs encourage health professionals to work in underserved areas. In AY 2021–2022, 32% of PCTE programs were in medically underserved communities.

The Medical Student Education program, which supports the health care workforce by expanding training for medical students to become primary care clinicians, targets higher education institutions in States with the highest primary care workforce shortages. Through grants, the program develops partnerships among institutions, federally recognized Tribes, and community-based organizations to train medical students to provide care that improves health outcomes for those living on Tribal reservations or in rural and underserved communities. In AY 2021–2022, awardees of this program trained 2,553 students and provided nearly 5,000 clinical training experiences, with 68% of sites in medically underserved or rural communities.

Interdisciplinary, Community-Based Linkages.—By assessing the needs of the local communities they serve, Title VII programs can fill gaps in the workforce and increase access to care for all populations. The programs emphasize interprofessional education and training, bringing together knowledge and skills across disciplines to provide effective, efficient, and coordinated care.

Programs such as Graduate Psychology Education (GPE); Opioid Workforce Enhancement Program; Mental and Behavioral Health, and Behavioral Health Workforce Education and Training (BHWET), respond to changing delivery systems and models of care, and address emerging health issues in their communities. The BHWET and Mental and Behavioral Health programs, which include GPE, provides training to expand access to mental and behavioral health services for vulnerable and underserved populations. In AY 2021–2022, BHWET grantees trained over 4,000 behavioral health professionals, and GPE grantees trained nearly 400 grad-

uate-level students, many of whom continued to work in medically underserved communities and/or primary care settings after graduation.

Area Health Education Centers (AHEC) support the recruitment and training of future physicians in rural areas, respond to local health needs, and serve as a crucial link between academic training programs and community-based outreach programs. In AY 2021–2022, AHECs supported over 280,000 pathway program participants, provided over 28,000 clinical training rotations for health professions trainees, 70% of which were in underserved communities.

Title VII Geriatric Workforce programs integrate geriatrics and primary care to provide coordinated and comprehensive care for older adults. These programs offer training across the provider continuum, focusing on interprofessional and team-based care and academic community partnerships to address gaps in health care for older adults. To advance the training of the current workforce, the Geriatrics Workforce Enhancement Program (GWEP) provided 1,889 unique continuing education courses to over 500,000 health care professionals, students, patients, and caregivers in AY 2021–2022, including 673 courses on dementia-related diseases.

Nursing Workforce Development.—Title VIII nursing workforce development programs provide Federal support to address all aspects of nursing workforce demands, including education, practice, recruitment, and retention, with a focus on rural and medically underserved communities. These programs include Advanced Nursing Education; Nursing Workforce Diversity; Nurse Education, Practice, Quality, and Retention; NURSE Corps; and Nurse Faculty Loan Program. In AY 2021–2022, the Title VIII Advanced Nursing Education Workforce (ANEW) program supported nearly 4,000 nursing students and partnered with clinical training sites in primary care, underserved communities and/or rural settings. These grantees are part of the more than 8,800 nursing students and practitioners who are supported through the broader Advanced Nursing Education programs.

Oral Health.—The Primary Care Dentistry program invests in expanding programs in primary dental care for pediatric, public health, and general dentistry. The Pre- and Post-doctoral Training, Residency Training, Faculty Development, and Faculty Loan Repayment programs encourage integrating dentistry into primary care.

Public Health.—Public Health Workforce Development programs support education and training in public health and preventive medicine through different initiatives, including the only funding for physicians to work in State and local health departments. In AY 2021–2022, the program's students accumulated nearly 50,000 contact hours in underserved communities.

Workforce Information and Analysis.—The Workforce Information and Analysis program provides funding for the National Center for Health Workforce Analysis as well as grants to nine Health Workforce Research Centers across the country that perform and disseminate research and data analysis on health workforce issues of national importance.

Supporting the Mental Health of the Health Professions Workforce.—The Supporting the Mental Health of the Health Professions Workforce program provides funding to establish or expand evidence-based programs that promote wellness and well-being among health care workers and staff on the front lines of the pandemic response.

While HPNEC's members acknowledge the increasing demands and fiscal challenges facing appropriators, funding for HRSA's workforce development programs is critical in bolstering a workforce that can respond to future health threats and challenges facing all Americans. Therefore, HPNEC encourages the subcommittee to provide at least $1.51 billion in the FY 2024 appropriations bill for HRSA's Title VII and VIII programs to continue the Nation's investment in our health workforce.

PREPARED STATEMENT OF THE HIV MEDICINE ASSOCIATION

Chairwoman Murray, Vice Chair Collins and members of the subcommittee, my name is Michelle Simone Cespedes, MD, MS, chair of the HIV Medicine Association (HIVMA). I am a professor of medicine at the Icahn School of Medicine at Mount Sinai in New York, New York, and serve as co-director of the Clinical and Translational Research Center at Mount Sinai and co-director of the ID Fellowship Research Curriculum at the Icahn School of Medicine at Mount Sinai. I am pleased to submit testimony on behalf of HIVMA, which represents nearly 6,000 physicians, scientists and other health care professionals around the country on the front lines of the HIV epidemic. Our members provide care and treatment to people with HIV, lead HIV prevention programs and conduct research in communities nationwide.

HIVMA was pleased to see investments in the President's Fiscal Year 2024 Budget, including bold new initiatives to eliminate hepatitis C and to launch a national

pre-exposure prophylaxis (PrEP) program. We urge Congress to fund these initiatives and provide necessary investments in HIV-related Federal discretionary programs.

For the FY2024 appropriations process, in addition to supporting the Ending the HIV Epidemic (EHE) initiative, we urge support for much needed increases in the Ryan White HIV/AIDS Program (RWP) to keep pace with demand and inflation. We also strongly urge dedicated funding for a national PrEP program and for the Bio-Preparedness Workforce Pilot Program. Additional funding requests in our testimony largely reflect the consensus of the Federal AIDS Policy Partnership (FAPP), a coalition of HIV organizations nationwide. For a chart of current and historical funding levels and coalition requests for each program, please see FAPP's FY2024 Appropriations for Federal HIV/AIDS Programs.

Ending the HIV Epidemic Initiative—U.S. Department of Health and Human Services:

The EHE currently focuses on 57 jurisdictions that account for more than half of new HIV diagnoses. The initiative provides additional resources, technology and expertise to expand HIV prevention and treatment activities. We urge funding the EHE initiative at least at the President's budget request for $850 million across the Centers for Disease Control and Prevention (CDC), the Health Resources and Services Administration (HRSA) and the National Institutes of Health (NIH) for FY2024, to be used for expanded access to antiretroviral treatment and PrEP to prevent HIV transmissions as well as improve access to routine and critical health services.

National PrEP Program—Centers for Disease Control and Prevention:

For the second year, the President's budget calls for establishing a national PrEP program to dramatically reduce new HIV cases and address significant PrEP access disparities among communities heavily impacted by HIV. The August 2022 HIV Surveillance supplemental report estimated that 1.2 million people in the U.S. were eligible for PrEP, but only 25% were prescribed PrEP in 2020, resulting in a 75% gap in access to this effective HIV prevention medication. CDC's National HIV Surveillance System also reported that during the first half of 2022, just 30% of males and 9% of females eligible for PrEP were prescribed PrEP.

Low access and uptake of PrEP prevents the Nation from realizing its full benefit, including the prevention of thousands of new HIV cases each year, as well as the substantial lifetime costs associated with each new case. A recent article published in the Journal of Law Medicine and Ethics estimated that every 1,000 monthly PrEP prescriptions would cost $80,000. Six thousand monthly prescriptions would cost less than $500,000, the lifetime value of just one prevented case of HIV.

This new program would significantly improve PrEP access by supporting PrEP medications, recommended screenings and laboratory monitoring, essential support services, outreach and educational activities, and PrEP provider capacity building. We urge Congress to provide for a $275 million increase for CDC's EHE initiative, $495 million total, of which $200 million would go toward establishing the foundation for a national PrEP program.

Bio-Preparedness Workforce Pilot Program—Health Resources and Services Administration:

The Bio-Preparedness Workforce pilot program was authorized as part of the PREVENT Pandemics Act passed in the final FY23 Consolidated Appropriations Act. We thank Sens. Murray and Collins and the Senate HELP committee for their leadership in passing the bipartisan PREVENT Pandemics Act, demonstrating the Nation's commitment to public health and pandemic preparedness systems. The pilot program will help to ensure the U.S. has the workforce with the experience and expertise necessary to address infectious diseases (ID) such as HIV and viral hepatitis; meet ID needs associated with cancer chemotherapy, organ transplants, opioid use and other complex care; and promote equitable outbreak and epidemic response.

Nearly 80% of counties have no ID physician, especially in rural, Southern parts of the U.S. The pilot program will provide loan repayment that will serve as a significant incentive to enter the ID and HIV workforce and will ensure a more equitable distribution of HIV experts across the country. The loan repayment will be available to health care professionals providing ID services who work in health professional shortage areas, medically underserved areas, certain Federal health facilities (e.g., VA facilities) or an RWP clinic. We urge Congress to fund HRSA's new Bio-Preparedness Workforce Pilot Program at $50 million.

HIV/AIDS Bureau—Health Resources and Services Administration:

For more than 30 years, HRSA's RWP has saved lives by ensuring that individuals with HIV are linked to care, retained in care, have medical adherence and achieve viral suppression. The RWP annually provides medical care and support to more than 560,000 individuals living with HIV and has played a critical role in stabilizing the HIV epidemic by engaging and keeping people in care. We urge Congress to fund the RWP at $3.058 billion in FY2024, an increase of $487.3 million over FY2023. In addition, we strongly recommend providing at least $330 million in EHE funding for the RWP, a $165 million increase over FY2023.

It is critical to ensure that clinics in all jurisdictions nationwide receive additional funding to increase access to HIV care and treatment to keep pace with increased demand, inflation and to help end the HIV epidemic. Approximately half of Part C providers serve rural communities, making the clinics the primary source for delivering HIV care to rural jurisdictions. We urge an allocation of $231 million, a $22 million increase over FY2023, for Ryan White Part C programs.

National Center for HIV, Viral Hepatitis, Sexually Transmitted Diseases and Tuberculosis Prevention—Centers for Disease Control and Prevention:

CDC is a critical national and global expert resource and response center. Yet years of level-funding and modest increases can negatively impact CDC's efforts to address persistent public health epidemics and threats, such as HIV, STIs and viral hepatitis. To meaningfully address these epidemics and the co-occurring crisis of opioid and other substance use disorders, we request a $926.2 million overall increase above FY2023 levels for a total of $2.317 billion. Additionally, we request the following:

—For the Division of HIV Prevention (DHP), we request a total of $1.417 billion, which is a $404 million increase over FY2023 levels.
—For CDC to fund surveillance and programming to monitor and prevent injection-related infectious diseases as well as expand access to syringe services programs, harm reduction and overdose prevention, we request the appropriation of $150 million—a $127 million increase above FY2023 for CDC's opioid-related infections program.
—For the Division of Viral Hepatitis (DVH), we request a total of $150 million, which is a $107 million increase over FY2023 levels.
—For the Division of STD Prevention (DSTDP), we request a total of $312.5 million, a $138.2 million increase over FY2023.

Office of AIDS Research—National Institutes of Health:

Decades of medical research supported by NIH are the foundation for diagnostic, treatment and preventive interventions available today, and building on this research will be vital in finding a cure and vaccine for HIV. To advance these and other scientific discoveries, we ask that at least $3.673 billion be allocated for HIV research in FY2024, an increase of $379 million over FY2023.

National Hepatitis C Elimination Program:

The President's budget calls for an important new mandatory national hepatitis C elimination program to provide rapid diagnostic testing; expand access to proven treatment for patients covered by Medicaid, Medicare and commercial insurance; and to implement public health strategies to catch, cure and prevent illness. The program seeks to end hepatitis C nationwide by 2030, with a focus on high-risk populations. We urge Congress to fund the National hepatitis C elimination program at $11.3 billion over 5 years.

CONCLUSION

Thank you for considering this request to support lifesaving investments in HIV programs in the FY2024 (LHHS) appropriations bill. Fully funding these programs will ensure progress in ending the HIV epidemic. Please contact HIVMA's associate director of public policy and advocacy, Jose A. Rodriguez, at JRodriguez@hivma.org with questions.

[This statement was submitted by Michelle S. Cespedes, MD, MS, Chair, HIV Medicine Association.]

PREPARED STATEMENT OF THE HIV + HEPATITIS POLICY INSTITUTE

Our nation can eliminate both HIV and viral hepatitis, but without an infusion of new resources to accelerate our efforts, we will continue to fall short of these ambitious goals. Current discussions involving budget caps that reduce non-defense dis-

cretionary appropriations would have devastating impacts on our Nation's public health system and our ability to respond to these two infectious diseases.

We must continue to fund the Nation's response to HIV and hepatitis to both make up for diverted attention to COVID–19 and to accelerate our efforts. Increased investment in surveillance, education, prevention, and care and treatment will ensure we continue to address HIV and viral hepatitis, including taking a syndemic approach to achieve maximum impact. The programs and funding increases detailed below are pivotal to our Nation's ability to end both these potentially deadly infectious diseases.

ENDING THE HIV EPIDEMIC IN THE U.S.

Over the past 4 years, since it was first proposed by President Trump and continued under President Biden, Congress has appropriated funding for the Ending the HIV Epidemic in the U.S. initiative, which sets the goal of reducing new HIV infections 90 percent by 2030. Unfortunately, this funding has fallen far short of what is necessary. The initiative, which is currently focused on jurisdictions representing about 50 percent of HIV diagnoses, has shown success with the money appropriated to date. The Health Resources and Services Administration's HIV/AIDS Bureau reports that as a result of this funding in FY 2021, the Ryan White Program served 22,400 new or re-engaged clients. Since the initiative began, the CDC has distributed 100,000 free HIV self-test kits and health departments conducted almost 250,000 HIV tests in the first year and 1,000 people received a new diagnosis of HIV. In addition, over 200 clusters of HIV transmission were identified allowing the CDC, along with State and local health departments and community partners, to disrupt transmissions and avert additional infections. The 302 community health centers funded through EHE successfully conducted 1.7 million HIV tests, provided PrEP (HIV prevention medication) to 52,477 patients, and linked 86 percent of newly diagnosed patients to care within 30 days.

In FY 2024, we urge Congress to fund EHE activities at the levels outlined below to accelerate our efforts to end HIV in the prioritized jurisdictions.

—$495 million for the CDC Division of HIV/AIDS Prevention for testing, linkage to care, and prevention services, including pre-exposure prophylaxis (PrEP) (+$275 million);

—$330 million for the HRSA Ryan White HIV/AIDS Program to expand comprehensive care and treatment for people living with HIV (+$165 million);

—$207 million for the HRSA Community Health Centers to increase access to prevention services, particularly PrEP (+$50 million); and

—$52 million for the Indian Health Service (IHS) to address the disparate impact of HIV and hepatitis C on American Indian/Alaska Native populations (+$47 million).

PREP

It is estimated that only 25 percent of people who could benefit from PrEP have received a prescription. PrEP coverage is highest among White people, at 66percent, yet only 9 percent of Black people and 16 percent of Hispanic/Latino people who could benefit from PrEP have a prescription. PrEP coverage among women is only at 10.4 percent. Reducing these disparities must be a priority as we work to expand PrEP use. The president's FY 2024 budget request includes a proposal for a mandatory funding program to expand PrEP. As the HIV community, relevant stakeholders, and Congress consider this proposal, we urge you to support $495 million, an increase of $275 million, for the CDC's Division of HIV Prevention EHE efforts, which includes funding to initiate a national PrEP program. Additionally, we urge you to support the $207 million (+$50 m) for PrEP in community health centers, which will increase the number of centers doing PrEP from around 450 to over 600.

HIV

The success of the EHE initiative and PrEP delivery rests upon our underlying public health prevention, care, and treatment programs at the CDC, HRSA, and other agencies. Congress must ensure that they are also funded to provide services in all areas of the country.

The Ryan White HIV/AIDS Program at the Health Resources and Services Administration provides medical care, medications, and essential wrap-around services to over 567,000 low-income, uninsured, or underinsured individuals with HIV. Nearly 61 percent of clients live at or below 100 percent of the Federal poverty level and nearly three-quarters are from racial and ethnic minority populations. For over 30 years, the Ryan White program has pioneered innovative models of care, which has

resulted in over 89 percent of clients achieving viral suppression. The program is facing increased demand as people live longer and as inflation continues to rise, but funding has remained stagnant.

This program is especially important in many States, particularly in the South, where there are large healthcare coverage gaps because they have not expanded Medicaid. There are approximately 400,000 people living with HIV who are not engaged in care and treatment. The Ryan White Program can play a large role in bringing this population into care and treatment. Successful HIV treatment ensures that the virus is undetectable, which makes it untransmittable (U=U).

We urge Congress to fund the Ryan White HIV/AIDS Program at a total of $3.058 billion in FY2024, an increase of $487 million over FY2023, of which $165 million is for the EHE initiative and $68 million is for AIDS Drug Assistance Programs.

There has been incredible progress in the fight against HIV over the last forty years, but that progress has stalled with new infections plateauing since 2013. Increasing funding for high- impact, community-focused HIV prevention services through the CDC's Division of HIV Prevention has proven to result in a strong return on investment. HIV continues to disproportionately impact Black and Latino gay men, Black heterosexual women, people who inject drugs, and those in the South. There is no single way to prevent HIV, but jurisdictions use a combination of effective evidence-based approaches including testing, linkage to care, condoms, syringe service programs, and PrEP to meet the needs of these populations.

In 2020, as a result of CDC funding, health departments conducted 1,255,895 HIV tests, which resulted in finding 12,376 people to be living with HIV. Seventy-five percent of them were linked to care within 30 days. 106,931 of the persons tested for HIV were found to be eligible for PrEP and 44,743 (or 43 percent) were referred to PrEP providers. We urge you to fund the CDC Division of HIV Prevention at $822.7 million in FY2024.

A holistic response to the HIV epidemic also depends on fully funding other priority programs at HHS, including the CDC's Eliminating Opioid-Related Infectious Diseases Program and Division of School and Adolescent Health, the Minority HIV/AIDS Initiative, AIDS Research at the NIH, the Title X Family Planning Program, and the Teen Pregnancy Prevention Program (TPPP).

VIRAL HEPATITIS

We urge you to provide increased funding for viral hepatitis programs at the CDC. The CDC estimates that nearly 5 million people in the United States live with hepatitis B (HBV) or hepatitis C (HCV), and as many as 65 percent are unaware they are living with the disease. Viral hepatitis kills more Americans than any other infectious disease, and, left untreated, results in significant costs to public programs through liver cancer and liver transplants. The opioid epidemic has significantly increased the number of viral hepatitis cases. There are several curative treatments available for HCV, but individuals must have access to screening and linkage to care. The president's budget request includes a proposal for a 5-year National Hepatitis C Elimination Program. As Congress considers this program, we must shore up public health funding focused on hepatitis. The viral hepatitis programs at the CDC are severely underfunded, receiving only $43 million-far short of what is needed to build and strengthen our public health response to hepatitis.

The Viral Hepatitis National Strategic Plan for the United States: A Roadmap to Elimination (2021–2025) lays out an ambitious plan to end the hepatitis epidemic. Increased investment would allow the CDC to enhance testing and screening programs, conduct additional provider education, enhance clinical services specific to hepatitis at sites serving vulnerable populations, and increase services related to hepatitis outbreaks and injection drug use. While we are pleased that the president's budget has prioritized viral hepatitis in its FY23 budget with an increase of $11.5 million, we urge you to provide the CDC Division of Viral Hepatitis with $150 million, an increase of $107 million over FY 2023 enacted levels.

FEDERAL HIV & HEPATITIS COORDINATION

Two important offices which coordinate the implementation of the NHAS and EHE activities need resources to bolster their ability to coordinate HIV and viral hepatitis activities across the Federal Government. We urge you to provide a total of $20 million for the HHS Office of Infectious Disease and HIV/AIDS Policy and $3 million for the White House Office of National AIDS Policy in FY 2024.

SAMHSA HIV BLOCK GRANT

We urge you to include language, as was proposed in the president's budget, that would modernize the way in which States qualify to be eligible for the HIV set-aside

of the Substance Abuse Block Grant (SABG). Instead of using the outdated measurement of AIDS cases in order for a State to qualify for the 5 percent HIV setaside, the number of HIV cases should be used. Due to the current language, only two States now qualify. With the update, up to 20 would be able to.

In conclusion, we urge the committee to continue its investment in our Nation's public health infrastructure specifically as it relates to addressing the ongoing HIV and hepatitis epidemics.

[This statement was submitted by Carl Schmid, Executive Director, HIV + Hepatitis Policy Institute.]

PREPARED STATEMENT OF HOPE CHARITIES

SUMMARY OF FISCAL YEAR 2024 RECOMMENDATIONS

—Provide NIH with at least a $3.5 billion increase in discretionary funding for FY 2024 to bring overall agency funding up to a minimum of $50.9 billion annually.
  —Please provide proportional funding increases for NIH's various Institutes and Centers, such as the National Institute of Allergy and Infectious Diseases (NIAID) and the National Heart, Lung, and Blood Institute (NHLBI).
  —Please provide separate, additional funding to continue to advance implementation of the Advanced Research Projects Agency for Health (ARPA–H) to ensure this important initiative does not compete with (and ultimately compliments) ongoing NIH research efforts.
—Provide the Centers for Disease Control and Prevention (CDC) with at least a $2.4 billion increase in discretionary funding for FY 2024 to bring overall agency funding up to a minimum of $11.6 billion annually.
  —Please provide established CDC Centers and Programs, such as the National Center for Chronic Disease Prevention and Health Promotion, with proportional funding increases.
  —Please provide the emerging CDC Chronic Disease Education and Awareness (CDEA) program with $6 million for FY 2024, an increase of $1.5 million over FY 2023.
—Provide the Health Resources and Services Administration (HRSA) with a funding level of at least $10.5 billion for FY 2023, an increase of roughly $750 million over FY 2022.
—Continue to support committee recommendations resisting discriminatory practices that block access for patients with rare and chronic illness and work with your authorizing colleagues to advance much-need PBM reform to establish a more patient-centered system.

Chairwoman Baldwin, Ranking Member Capito, and distinguished senators of the subcommittee, thank you for the opportunity to present the views of Hope Charities and the patient communities that we serve. Primarily, we thank you for your continued support for medical research and public health programs that serve blood disorders and rare disease patients through the FY 2023 omnibus package. For FY 2024, Hope joins the broader medical research and public health community in asking that the investment in NIH, CDC, and HRSA be maintained and responsibly increased.

ABOUT HOPE CHARITIES

Hope Charities is a national nonprofit organization, founded in 2009, based in Louisiana. The mission of Hope Charities is to act as a conduit of hope, strength, and resources to families in a crisis caused by a chronic illness. We accomplish our mission through several programs including our Resource Connection Program; direct patient assistance, which helps families by subsidizing the cost of utilities, food, housing, transportation, and medical equipment; access to care through health insurance premium assistance as well as educational programs.

COMPLIMENTING PUBLIC HEALTH PROGRAMS

The Louisiana Department of Health classifies 63% (40 of 64) parishes as "rural." The CDC reports that residents in rural areas have higher rates of poverty, less access to healthcare, and are less likely to have health insurance. Hope Charities works with Americans by increasing access to medical care for rural, underserved,

and vulnerable populations. Our mission is to improve healthcare outcomes, which in turn decreases work absences, reduces the negative impact of chronic illness on mental health, and can lower the overall cost of healthcare.

NIH conducts important research into many rare and chronic conditions, such as hemophilia, that incrementally improves care and options for affected individuals. This work is essential to advancing innovative research, improving outcomes, and lowering healthcare costs. The CDC and HRSA also support hemophilia treatment centers and have a variety of line-item programs that assist with public health and care delivery for patients affected by a variety of conditions. These programs, particularly at CDC's National Center for Chronic Disease Prevention and Health Promotion, have only seen modest increases in recent years, but much more can be done with an infusion of timely resources.

Please note, as a safety net program, Hope Charities is pursuing a congressionally directed spending request to bolster efforts that support the work of hemophilia treatment centers and community health centers, in addition to requesting discretionary funding increases for Federal programs.

ABOUT THE PATIENTS THAT WE SERVE

Hope recently received a request from Van, a 31-year-old male who lives in Louisiana and has hemophilia. He was scheduled to have surgery at 5:30 a.m. on his right knee as a result of hemophilia-related injuries. He lives two hours away from his Hemophilia Treatment Center and the hospital where the surgery was to occur. He is on Medicaid and could not afford to travel to the hospital. Hope helped him with travel expenses and paid for a hotel room for him to stay the night before his surgery.

Anna resides in Illinois and lives 8 hours from her nearest Hemophilia Treatment Center. Her minor son has hemophilia B. She requested funding from Hope for travel to an appointment. We paid for a hotel room for Anna and her son the night before their appointment. They attended their appointment early the next day, then traveled home.

FY 2024 RECOMMENDED REPORT LANGUAGE

RECOMMENDED REPORT LANGUAGE

LABOR-HHS-EDUCATION APPROPRIATIONS BILL

CENTERS FOR DISEASE CONTROL AND PREVENTION

HEMOPHILIA TREATMENT CENTERS PROGRAM

Hemophilia Treatment Centers and Underserved Populations.—The Committee provides $XX million for the Hemophilia Treatment Centers program and encourages CDC to utilize additional resources to pursue partnerships with additional community stakeholders that can enhance program activities and access in rural and underserved communities.

[This statement was submitted by Jonathan James, CEO, Hope Charities.]

PREPARED STATEMENT OF THE HUMAN FACTORS AND ERGONOMICS SOCIETY

On behalf of the Human Factors and Ergonomics Society (HFES), we are pleased to provide this written testimony to the Senate subcommittee on Labor, Health and Human Services, Education, and Related Agencies for the official record. HFES urges the subcommittee to provide no less than $500 million for the Agency for Healthcare Research and Quality (AHRQ). HFES also strongly urges the subcommittee to provide $375.3 million for the National Institute for Occupational Safety and Health (NIOSH), including $33 million for the Education and Research Centers (ERCs) in fiscal year (FY) 2024. Additionally, HFES supports a baseline funding level of $50.9 billion for the National Institutes of Health (NIH) and that additional funding for the Advanced Research Projects Agency for Health (ARPA–H) should supplement, not supplant, this baseline funding in FY 2024.

AHRQ supports research to improve health care quality, reduce costs, advance patient safety, decrease medical errors, and broaden access to essential services. As the lead Federal agency for funding health services research (HSR) and primary care research (PCR), AHRQ is the bridge between cures and care, and ensures that Americans get the best health care at the best value. The RAND Corporation released a report in 2021 as called for by the Consolidated Appropriations Act of 2018, which identified AHRQ as "the only agency that has statutory authorizations to gen-

erate HSR and be the home for Federal PCR, and the unique focus of its research portfolio on systems-based outcomes (e.g., making health care safer, higher quality, more accessible, equitable, and affordable) and approaches to implementing improvement across health care settings and populations in the United States."

HFES requests a minimum of $500 million for AHRQ, which is consistent with the FY 2010 level adjusted for inflation and reflects the demonstrated needs of pandemic response. This funding level will allow AHRQ to rebuild portfolios terminated after years of cuts. AHRQ is the Federal vehicle for studying and improving the United States healthcare system, and it needs the resources to meet its mission and this moment. Through this appropriation level, AHRQ will be better able to fund the "last mile" of research from cure to care.

Additionally, HFES requests $375.3 million for NIOSH, including $33 million for the Education and Research Centers (ERCs). NIOSH supports education and research in occupational health through academic degree programs and research opportunities. With an aging occupational safety and health workforce, ERCs are essential for training the next generation of professionals. The Centers establish academic, labor, and industry research partnerships to achieve these goals. Currently, ERCs are responsible for supplying many of the country's OSH graduates who will go on to fill professional roles.

Additionally, HFES advocates for $50.9 billion for baseline NIH funding to ensure that the agency is keeping pace with the levels of inflation and that additional supplemental funding to expand ARPA–H does not detract from this funding. HFES supports ARPA–H's role in promoting high-risk, high-reward research that targets biomedical and health breakthroughs, while considering outcomes and the impact on healthcare and quality of life. These advancements will range from how to prevent, treat, and cure diseases that affect many Americans.

HFES strongly believes that investment in scientific research serves as an important driver for innovation and the economy as well as for protecting and promoting the health, safety, and well-being of Americans. We thank the subcommittee for its longtime recognition of the value of scientific and engineering research and its contribution to innovation and public health in the U.S.

THE VALUE OF HUMAN FACTORS AND ERGONOMICS SCIENCE

HFES is a multidisciplinary professional association with over 3,000 individual members worldwide, including psychologists and other scientists, engineers, and designers, all with a common interest in designing safe and effective systems and equipment that maximize and adapt to human capabilities.

For over 50 years, the U.S. Federal Government has funded scientists and engineers to explore and better understand the relationship between humans, technology, and the environment. Originally stemming from urgent needs to improve the performance of humans using complex systems such as aircraft during World War II, the field of human factors and ergonomics (HF/E) works to develop safe, effective, and practical human use of technology. HF/E does this by developing scientific approaches for understanding this complex interface, also known as "human-systems integration." Today, HF/E is applied to fields as diverse as transportation, architecture, environmental design, consumer products, electronics and computers, energy systems, medical devices, manufacturing, office automation, organizational design and management, aging, farming, health, sports and recreation, oil field operations, mining, forensics, and education.

With increasing reliance by Federal agencies and the private sector on technology-aided decision-making, HF/E is vital to effectively achieving our National objectives. While a large proportion of HF/E research exists at the intersection of science and practice-that is, HF/E is often viewed more at the "applied" end of the science continuum-the field also contributes to advancing "fundamental" scientific understanding of the interface between human decision-making, engineering, design, technology, and the world around us. The reach of HF/E is profound, touching nearly all aspects of human life from the health care sector to the ways we travel and to the hand-held devices we use every day.

CONCLUSION

HFES urges the subcommittee to provide $500 million for AHRQ; $375.3 million for NIOSH, including $33 million for the Education and Research Centers (ERCs); and a topline funding level of $50.9 billion for NIH that is supplemented and not supplanted by any new funding for ARPA–H. These investments fund important research studies, enabling an evidence base, methodology, and measurements for improving healthcare, safety, and public health for Americans.

On behalf of the HFES, we would like to thank you for the opportunity to provide this testimony. Please do not hesitate to contact us should you have any questions about HFES or HF/E research. HFES truly appreciates the subcommittee's long history of support for scientific research and innovation.

[This statement was submitted by Steven C. Kemp, CAE, Executive Director, Human Factors and Ergonomics Society.]

PREPARED STATEMENT OF I AM ALS

Chair Baldwin and Ranking Member Capito, thank you for the opportunity to submit testimony. My name is Brian Wallach, I have been living with ALS for five and a half years and I am a Co-Founder of I AM ALS, along with my wife, Sandra Abrevaya. It is my honor to again submit testimony to your subcommittee. Each year, I wonder whether it will be my last because most people living with ALS live only two to 5 years post-diagnosis. I want to express my gratitude to the subcommittee for the bipartisan support to accelerate treatments and cures for ALS and other neurodegenerative diseases and urge you to keep pressing forward with changes that can transform ALS from fatal to chronic.

ALS is a disease that is 160 years old. Let me repeat that: For 160 years, ALS has killed everyone diagnosed with it. That is simply unacceptable. ALS is a relentless and progressive neurodegenerative disorder that takes away your ability to talk, to walk, to care for yourself and, ultimately, to breathe. For those who have not been diagnosed, it is hard to imagine what living with ALS is like.

When I first came to this subcommittee to ask for your help, I asked you to rewrite the ALS story. Over the last 4 years, you have answered this call. You have heard us, seen us, and taken action that has created hope.

You have included ALS as one of the named diseases that ARPA–H is meant to fight. The inclusion of ALS in ARPA–H opens the door to innovative ways to attack ALS and other rare diseases. It has the possibility to dramatically accelerate research and treatments for ALS and countless other diseases.

You also have allocated a previously unprecedented amount to fund the historic ACT for ALS. As you know, ACT for ALS establishes a public-private partnership with NIH and FDA, requires FDA to publish a 5-year plan for how to accelerate research and treatments for ALS, boosts funding for the FDA's rare neurodegenerative program and, most importantly, establishes an expanded access program at NIH for treatments that have successfully completed a Phase 2 trial. As a result of the expanded access program, the 90% of ALS patients, like me, who are excluded from clinical trials can now have access to promising treatments while they are alive. In addition, we are able to finally do research on this population to see what the effect of a treatment is at different stages of ALS, which is critical to understanding changes in ALS over time and to helping ensure we have enough data to support approval of a treatment if it is merited.

The expanded access program under Section 2 of ACT for ALS was and is a revolutionary idea. People with this fatal disease are finally getting access to promising, investigational treatments while we are still alive, and critical, previously unfunded research is now funded. We commend NIH and NINDS for standing up the expanded access research program expeditiously. We also commend FDA for the grants it has awarded already to fund ALS research.

As the Agencies move into the second full year of building the expanded access grant program mandated by ACT for ALS, we ask for your help to build a stronger collaboration between FDA, NINDS, and the ALS community. As an example of the need for better collaboration, FDA released a 5-year action plan for ALS without any meaningful patient input. And as of my last communication with FDA, they are not letting patients serve on the one new task force, the ARC task force, created by that 5-year plan. In addition, after the first year of the expanded access program, NIH wrote to Congress seeking to eliminate the expanded access program and instead use the funding for basic research. This request was thankfully denied by Congress and Congress gave NINDS clear direction about how the funding is to be used.

These examples should not happen and will not happen if FDA and NIH start to incorporate patients into every aspect of ACT for ALS implementation. We are better served when research and regulatory innovation are done with the ALS community rather than keeping it at arm's length. For example, the NINDS Strategic Plan for ALS incorporated many members of the ALS community and is a clear example of how to work together to create a plan with the community. If we work together on all aspects of ACT for ALS, it will help fund new clinical trials, discover new treatments, and drive regulatory advancements for everyone living with ALS and

other neurodegenerative diseases today and those who will be diagnosed in the future.

As you focus on our Nation's priorities and we know there are many, I ask you to again fully fund the ACT for ALS in FY 2024 and to continue to recognize that ALS should be part of the ARPA–H mission.

I also want to thank this Committee's Defense Appropriations subcommittee for funding the Congressionally Directed Medical Research (CDMRP) ALS research program at historic levels. Veterans are more than twice as likely to be diagnosed with ALS than those who did not serve in the U.S. military. We still don't know why, but the correlation between military service and ALS is well established. ALS is broadly designated by the U.S. Department of Veterans Affairs as a service-connected disability no matter the time of diagnosis. No other disease in the CDMRP research program has this specific designation. The CDMRP–ALS research program has been able to fund promising treatments and research, as well as clinical trials that would not have been possible without Congress increasing the funding for this program. Given this success, we are requesting additional funds this fiscal year to meet the needs of our veterans living with ALS and further accelerate clinical research that will unlock treatments for veterans and the entire ALS community.

I never thought I would still be here to submit testimony to this subcommittee. I am weakened, I need a translator to speak, and I am in a wheelchair. But I am still here, and I still have hope that I will be among the first generation of ALS survivors thanks to you. The members of this subcommittee and your colleagues on the Appropriations Committee have taken action that makes it possible to rewrite the ALS story. On behalf of the ALS community, I want to say a perfuse thank you to you and to others like Representatives Mike Quigley, Kay Granger, Ken Calvert, Betty McCollum, Tom Cole, Jason Crow, Terri Sewell, Brian Fitzpatrick, Mike Gallagher, and Senators Dick Durbin, Chris Coons, Lisa Murkowski, Mike Braun, Patty Murray, Jon Tester, and Susan Collins, to name a few more of our incredible ALS leaders in Congress.

As a result of your collective work, the ALS story is changing. Thank you for everything you've done for the ALS community to provide the critical resources needed to push forward this fight and for the opportunity I have to still be with you, here, today.

[This statement was submitted by Brian Wallach, Co-Founder, I AM ALS.]

PREPARED STATEMENT OF THE INFECTIOUS DISEASES AND THE OPIOID EPIDEMIC PROGRAM

Chair Murray, Ranking Member Blunt, and members of the subcommittee, my name is Brad Finegood and I work for King County (WA) as a Strategic Adviser addressing for Public Health-Seattle & King County in Seattle, WA. In this role it is my responsibility to lead the overdose prevention work for the community.

I am pleased to submit testimony on behalf of King County, WA to urge Congress to appropriate $150 million for the Infectious Diseases and the Opioid Epidemic program at the Centers for Disease Control and Prevention (CDC) at the Department of Health and Human Services (HHS) to save lives and address the overdose crisis by supporting and expanding access to harm reduction and syringe services programs (SSPs). We additionally support $50 million for the new Community Harm Reduction and Engagement Initiative program for the continuation of the Community Based Funding for Local Substance Use Disorder Services at the Substance Abuse and Mental Health Services Administration (SAMHSA).

The United States is experiencing an urgent and unprecedented drug overdose crisis, with numbers continuing to surge beyond 100,000 overdose deaths from 2022–2023. Like the rest of the Nation, King County, WA continues to experience record overdose deaths each year. There have been significant increases in the county over the past decade, from 248 deaths in 2010 to 1,000 deaths in 2022. The recent influx of fentanyl in the local drug supply has contributed significantly. Fentanyl is increasingly involved in overdose deaths, from 3 deaths in 2015 to 360 in 2021- a nearly 12,000% increase in just 6 years. More alarming is that fentanyl-involved overdose deaths nearly doubled in King County last year from 360 in 2021 to 712 in 2022. Already marginalized demographic groups are disproportionately impacted. In King County, age-adjusted death rates (numbers per 100,000) in 2022 were 294 for American Indians/Alaskan Natives, 101 for Blacks, and 48 for Hispanics, compared to 37 for Whites.

It is imperative that congress respond to this overdose crisis with the urgency it deserves and requires. We know that a public health approach is the most humane and effective approach to tackling this crisis. SSPs are an essential, evidence based

public health intervention and a vital component of overdose prevention. The CDC has documented over 30 years of evidence that shows that SSPs reduce overdose deaths and infectious diseases transmission rates as well as increase the number of individuals entering substance use disorder treatment. These studies also confirm that SSPs do not increase illicit drug use or crime, but they do reduce the amount of improperly discarded syringes and save money.

The King County Needle Exchange proudly serves clients by providing health education, naloxone training and distribution, safer sex supplies, and referrals for addiction treatment and other medical services, in addition to exchanging injection supplies. Our staff attempts to meet people where they are and help them address their needs in the safest and healthiest way possible, free of judgement and stigma. SSPs are among the only health care services trusted and used by people who use drugs, so SSP programs can effectively engage this highly stigmatized population.

Unfortunately, the Nation has insufficient access to SSPs, and the COVID–19 pandemic has decreased access to these life-saving services during a time when the need for services has increased dramatically. In January 2021, Drug Policy Alliance conducted a survey of SSPs that showed that 91% of respondents experienced an increase in clients in 2020. During this time of skyrocketing need, 42% of respondents experienced funding cuts and were forced to lay off staff and reduce services, limiting access to life saving interventions. Increased Federal funding in needed to expand access to these critical and effective programs. Tacoma, WA's NASEN's statistics show that there are only approximately 400 SSPs operating nationwide. Experts estimate that to sufficiently expand access to SSP programs, the U.S. would require at least 2,000 programs—5 times the number in existence now.

Finally, expanding access to harm reduction services and SSPs will reduce health care costs, including for infectious diseases treatment. Hepatitis C treatment can cost more than $30,000 per person, while HIV treatment can cost upwards of $560,000 per person. Averting even a small number of cases would save millions of dollars in treatment costs in a single year.

With additional FY24 funding, CDC could expand SSPs at this critical time to help prevent overdose deaths, the spread of HIV and viral hepatitis and connect people to life-saving medical care.

On a personal note—in addition to leading the overdose prevention work for King County, I am the brother of overdose victim. Every single person who counts as a fatal overdose is a family member to someone and an individual that could have been saved. We have the tools; we just need the funding to help implement.

I want to thank the subcommittee for its past funding of the CDC Infectious Diseases and Opioid Epidemic program and urge Congress to provide $150 million for the program along with $50 million for the new Community Harm Reduction and Engagement Initiative program for the continuation of the Community Based Funding for Local Substance Use Disorder Services at the Substance Abuse and Mental Health Services Administration (SAMHSA) in FY24. Thank you also for your time and consideration of my testimony, and please do not hesitate to contact me at brad.finegood@kingcounty.gov if you have questions or need additional information.

Sincerely.

[This statement was submitted by Brad Finegood, Strategic Adviser, Public Health-Seattle & King Co., King County, WA.]

PREPARED STATEMENT OF THE INFECTIOUS DISEASES SOCIETY OF AMERICA

On behalf of the Infectious Diseases Society of America (IDSA), which represents more than 12,000 physicians, scientists, public health practitioners and other clinicians specializing in infectious diseases prevention, care, research and education, I urge the subcommittee to provide robust FY2024 funding for public health and biomedical research activities that save lives, contain health care costs and promote economic growth. IDSA asks the subcommittee to provide $50 million for the Biopreparedness Workforce Pilot Program at the Health Resources and Services Administration (HRSA), $400 million for the Antibiotic Resistance Solutions Initiative (ARSI) at the Centers for Disease Control and Prevention (CDC), $7.060 billion for the National Institute of Allergy and Infectious Diseases (NIAID), and $330 million for the Biomedical Advanced Research and Development Authority (BARDA) Broad Spectrum Antimicrobials and CARB–X programs.

HEALTH RESOURCES AND SERVICES ADMINISTRATION

Bio-Preparedness Workforce Pilot Program

IDSA urges you to include $50 million in FY2024 to launch the new Bio-preparedness Workforce Pilot Program. Authorized in the Consolidated Appropriations Act, 2023 (Division FF, Chapter 3—Sec. 2221(h)), within the Public Health Loan Repayment Program, the Pilot Program complements the Public Health Loan Repayment Program by ensuring the public health workforce has strong ID partners in community health care settings by incentivizing more health care professionals to enter the field of infectious diseases (ID) and work in underserved areas.

Nearly 80% of U.S. counties nationwide do not have a single ID physician. The distribution of ID physicians is geographically skewed with rural Americans being less likely to have access to ID physicians. In 2022, ID filled only 56% of our training programs, while most other medical specialties filled 90% or more of their training programs. An average medical student educational debt of more than $250,000 drives many physicians away from ID—the fifth lowest paid medical specialty, even below general internal medicine—and toward more lucrative specialties. Similar shortages persist among other ID experts, including clinical laboratory staff, infection preventionists, nurses and physician assistants—all of whom would be eligible for the Pilot.

Despite the deep gaps in the ID workforce, no Federal programs offered loan repayment for providing ID care or conducting emergency preparedness activities in health care facilities prior to the establishment of the Pilot. This program fills a discreet but critical need without duplication of Federal resources. The Pilot Program is intended to encourage early career health care professionals to enter the field of ID and expand access to ID care, targeting resources where they are needed the most. Funding in FY2024 will help ensure the U.S. has the workforce with the experience and expertise necessary to improve preparedness for future public health emergencies, limiting deaths and disruption, ensure that we have ID health professional experts to address infectious diseases such as HIV and viral hepatitis, and meet ID needs associated with cancer chemotherapy, organ transplants, opioid use, and other complex care.

$50 million for the pilot program will provide up to $50,000 in loan repayment to as many as 1,000 infectious diseases (ID) professionals who work in health professional shortage areas, Federal health facility such as VA clinics, Ryan White HIV/AIDS Program clinics or Tribal health facilities. Importantly, this funding will impact the decisions of medical students, residents and other trainees in this year's recruitment processes.

$50 million in FY2024 will impact health professional decision-making in the upcoming educational and recruitment cycle and will allow us to better leverage the investments the Committee has made to end the HIV epidemic, improve pandemic preparedness, eliminate viral hepatitis, control sexually transmitted infections and combat antimicrobial resistance.

CENTERS FOR DISEASE CONTROL AND PREVENTION

Antibiotic Resistance Solutions Initiative (ARSI)

We urge $400 million in funding for the Antibiotic Resistance Solutions Initiative in FY2024, the cornerstone of the Nation's efforts to detect, prevent and respond to AMR. Rates of antimicrobial-resistant infections and deaths in U.S. hospitals rose 15% in 2020 due to the COVID–19 pandemic, wiping out progress made in 2012–2017. At least 35,000 people die of resistant infections in the U.S. every year. The burden of resistance is likely much higher, but our surveillance is unable to capture the full picture and the pandemic worsened data gaps. Antibiotic resistance accounts for direct healthcare costs of at least $20 billion. Infections are a primary or associated cause of death in 50% of patients with cancer, as AMR can make these infections difficult or impossible to treat. AMR has a disproportionate impact on certain communities due to variance in risk of exposure, susceptibility to infection or treatment received. Rates of several serious antibiotic-resistant infections, including community-associated methicillin-resistant Staphylococcus aureus (MRSA) infections, are higher incidence in Black populations. Globally, resistant infections directly caused 1.27 million deaths in 2019 and played a role in 4.95 million deaths. If we do not act now, antibiotic-resistant infections will be the leading cause of death by 2050 and could cost the world $100 trillion.

Recommended funding is needed to expand antibiotic stewardship across the continuum of care; double State and local grant awards; expand the AR Laboratory Network globally and domestically to strengthen the identification; tracking and containment of deadly pathogens; support AMR research and epicenters; and in-

crease public and health care professional education and awareness. The program is also a critical building block of CDC's public health infrastructure that directly supports broader agency activities, foodborne illness pathogen detection, global AMR prevention and surveillance, and responses to sexually transmitted infections and health care-associated infections. Since FY2016, funding for the initiative has improved antibiotic use, increased state and regional laboratory capacity to rapidly detect resistant infections and enhanced tracking of health care-associated infections. However, many state laboratories still do not monitor and report resistance data on pathogens of importance, and the program will be unable to effectively address current and newly emerging threats and prepare for future challenges without a significant increase in funding in FY2024.

Elimination of Opioid-Related Infectious Diseases

$150 million in funding for the Opioid-Related Infectious Diseases program would allow CDC to address the significant and growing burden of the opioid epidemic by expanding surveillance for infectious diseases commonly associated with injection drug use, including HIV, viral hepatitis, endocarditis, skin and soft tissue infections, and bone and joint infections.. CDC has found steep increases in multiple viral, bacterial and fungal infections due to injection drug use, and CDC estimates that individuals who inject drugs are 16 times more likely to develop an invasive MRSA infection. Support systems for individuals with substance use disorders suffered disruptions due to the COVID–19 pandemic and additional investments are needed to address needs that went unmet during the pandemic.

National Healthcare Safety Network (NHSN)

FY2024 funding of $100 million is needed to modernize NHSN to alleviate reporting burden and speed access to data, bolster data collection on antibiotic use and resistance in healthcare facilities, and technical support for more than 65,000 users of NHSN. These data are critical to track emerging resistance patterns and evaluate the impacts of efforts to optimize antibiotic use and prevent health care associated infections.

Advanced Molecular Detection Initiative

$175 million in FY2024 funding would spur the innovation needed to detect and respond to deadly pathogens. Funding would enable Federal, State, and local public health laboratories to expand the use of pathogen genomics and other advanced laboratory technologies, bolster integration of genomics into ID surveillance and response, and improve antimicrobial stewardship.

CDC Center for Global Health

IDSA urges the subcommittee to provide increased funding in FY2024, including funding for CDC's Division of Global Health Protection. Public health experts address more than 400 diseases and health threats in 60 countries. An emerging infection in any part of the world is just a plane ride away from the U.S.. As highlighted by the COVID–19 pandemic, increased resources for this vital CDC program are needed to improve global capacity to prevent, detect and respond to health threats at their source before international spread. As a key implementor of the Global Health Security Agenda, the division works to improve health emergency preparedness and response, enhance infectious disease surveillance, strengthen laboratory capacity, train health care workers, and build and support emergency operations centers in countries with limited public health capacities. The program also works to address AMR by providing technical assistance to 30 countries, working to detect resistant threats; prevent and contain resistant pathogens; and improve antibiotic use. Other divisions in the CDC Center for Global Health are instrumental in providing technical assistance on HIV, tuberculosis (TB), malaria and other parasitic diseases, and also ensuring access to essential routine immunization services for children in low- and middle-income countries.

ASSISTANT SECRETARY FOR PREPAREDNESS AND RESPONSE (ASPR)

Biomedical Advanced Research and Development Authority (BARDA)

The BARDA Broad Spectrum Antimicrobials program and CARB–X leverage public/private partnerships to develop products that directly support the government-wide National Action Plan for Combating Antibiotic-Resistant Bacteria and have been successful in developing new FDA-approved antimicrobials. Despite this progress, the pipeline of new antimicrobials development is insufficient to meet patient needs, and $330 million in funding is needed to accelerate basic and applied research for developing new products. Additional funding will help prevent a post-

antibiotic era in which we lose many modern medical advances that depend upon the availability of antibiotics.

NATIONAL INSTITUTES OF HEALTH

National Institute of Allergy and Infectious Diseases (NIAID)

$7.060 billion for NIAID, including $608 million for AMR research, would allow NIAID to address AMR while conducting its broader role in supporting infectious diseases research, including emerging infectious diseases, HIV, TB and influenza. Increased FY2024 funding would strengthen investment in the biomedical research workforce, including training and efforts to support early-career physician-scientists and promote diversity, and update the National clinical trials infrastructure to include community hospitals and enable access for underserved populations.

With regard to AMR specifically, increased funding would support research on mechanisms of resistance, therapeutics, vaccines and diagnostics; development of a clinical trials network to reduce barriers to research on emerging and difficult-to-treat resistant infections; and support for training more physician scientists and clinical investigators to improve AMR research capacity, as outlined in the 2020–2025 National Action Plan to Combat Antibiotic-Resistant Bacteria.

In 2022, only 56% of ID physician training programs filled their slots, leaving us with an inadequate pipeline of ID physician-scientists necessary to lead clinical trials and additional research to strengthen our prevention and responses to ID threats. IDSA was dismayed to see the reduction in the new payline announced on April 5, 2023 for NIAID K awards to just 20 (except for K22 and K99). Such a low payline is likely to result in rejections of highly qualified applicants, further shrinking the already inadequate pipeline of ID physician-scientists. Despite having a higher total budget than many other institutes at NIH, NIAID only funded 80 K grants FY2022, in the most recent fiscal year for which data is available. Other institutes with smaller overall budgets awarded the same number or more K grants.

Increased funding is needed to enable strong NIAID support for career development of a larger and more diverse pipeline of ID physician-scientists. NIAID should use increased resources to increase pay lines for K, T, and F awards to expand the number of early career physician-scientist who would benefit from these grants. NIAID should also provide Early Investigator Awards, as well as new opportunities for community-based ID physicians to participate in clinical trials and other research to enhance recruitment, training and diversity of the physician-scientist workforce.

CONCLUSION

Thank you for the opportunity to submit this statement. The nation's infectious diseases physicians and scientists rely on strong Federal partnerships to keep Americans healthy and urge you to support these efforts. Please forward any questions to Lisa Cox at lcox@idsociety.org.

[This statement was submitted by Carlos del Rio, MD, FIDSA, President, Infectious Diseases Society of America.]

PREPARED STATEMENT OF THE INSTITUTE OF EDUCATION SCIENCES

The pandemic and persistent social justice issues have laid bare our Nation's inequalities, and the country will need a responsive, rigorous, and relevant Federal research enterprise to tackle the racial and socioeconomic disparities that plague our early childhood, K–12, and higher education systems nationwide.

As outlined in the National Academies Report on the Future of Education Research at IES (NASEM Report) the U.S Department of Education (ED) has the potential to launch a new era of equity-centered and evidence-informed policymaking by ensuring that families, communities, and practitioners help shape the research priorities of the Institute of Education Sciences (IES), have access to the research findings produced using Federal funds, and are equipped to put that research into action.

It is within this context that I am pleased submit recommendations on two important funding strategies for the Institute of Education Sciences at the U.S. Department of Education:

—Provide support for the implementation the recommendations in the NASEM Report

—Encourage the reinstatement of the IES Research-Practition Partnerships in Education funding program (RPP).

Implement NASEM Report recommendations

I was pleased to see in the report language for the 2023 Omnibus Appropriations Act directing IES to describe its implementation plan for the recommendations in the NASEM Report. This has been helpful in elevating the importance of the NASEM report and ensuring action will be undertaken by the IES leadership.

For FY 2024 I recommend taking several steps further along the implementation path by taking up several of the funding-related recommendations including increasing the funding levels for both the National Center for Education Research and the National Center Special Education Research as well as for a second series of grant competitions each year. I fully endorse the overall increase for IES to $900 million recommended by the Friends of IES in its letter of March 15, 2023.

I also recommend that, in support of the NASEM Report, additional investments be made in studying the various components of knowledge mobilization and use including promising practices, essential characteristics, and enabling conditions. This could be accomplished with report language relating to the Research, Development, and Dissemination (RD&D) line item. Here is some sample report language:

> Given the importance of knowledge mobilization in education decision making, the knowledge base needs to be expanded through a variety of studies about how, why, and under what conditions research-based knowledge is used in informing policy and practice and ways to improve research use. This should include a) descriptive studies of when, how, and under what conditions research evidence is used in policy and practice, b) intervention studies to improve the use, usefulness, or impact of research evidence in policy and practice, and c) measurement studies to develop reliable and valid assessments of the use of research evidence.

Reinstate the RPP program

RPPs are long-term collaborative partnerships between researchers in universities and research organizations and education stakeholders (educators, State and local education administrators, parents and community members, professional educator associations, government and business leaders, and others) to tackle important local challenges. RPPs are currently working on a variety of issues, such as strengthening the educator workforce, promoting college and career readiness and success, bolstering early childhood education, improving math and science instruction, and creating equitable learning environments.

These partnerships are built on the common-sense observation that education stakeholders are more likely to value and use research if they are involved in identifying which local educational challenges should be studied, playing a role in designing the research, and participating in communicating and engaging with education stakeholders in the use of the evidence produced. RPPs do more than produce research, they also facilitate the application of evidence in decision-making by creating engaging videos, webinars and activities that help evidence come to life.

In recent years more than 250 publicly or privately funded research-practice partnerships (RPPs) have operated at the local and State levels across the country. Among them were the 53 funded through the IES program that was eliminated in 2019 and, additionally, more than 80 partnerships through the Regional Educational Laboratory program.

The elimination of the RPP program denied communities across the country the opportunity to generate valuable evidence that can be used to address local educational challenges. That decision signaled IES leadership's unwillingness to fund research-practice partnerships as a strategy to provide education stakeholders the usable information they say they want and need.

I urge you to include language in the appropriation report directing IES to "express support for research-practice partnerships (RPPs) and to reinstate the RPP program or some variation thereof that will advance the use of research in partnerships that include educators, policymakers, education research organizations, and others committed to applying evidence to improve education."

I appreciate the opportunity to provide testimony on these two important matters. Please feel free to contact me with additional questions and comments.

Sincerely.

[This statement was submitted by Jim Kohlmoos, Principal, EDGE Partners, LLC.]

PREPARED STATEMENT OF THE INTERNATIONAL FOUNDATION FOR GASTROINTESTINAL DISORDERS

FISCAL YEAR 2024 L–HHS APPROPRIATIONS RECOMMENDATIONS:

—At least $50 billion in program level funding for the National Institutes of Health (NIH).
—Proportional funding increase for the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK).
—Please provide $11 billion for the Centers for Disease Control and Prevention (CDC).
—Please provide $6 million for the Chronic Disease Education and Awareness Program.

Chairwoman Baldwin, Ranking Member Capito, and distinguished members of the subcommittee, as you work with your colleagues to develop the FY2024 Labor-Health and Human Services (L–HHS) appropriations bill, please keep in mind the needs and concerns of the gastrointestinal illness community. Nearly two decades ago, I was diagnosed with one of these diseases, irritable bowel syndrome (IBS). As a young adult, I underwent extensive testing and workups over many years in a difficult effort to discover what was causing my symptoms and how best to treat them. I often relied on self-treatment as best as I could, but this was not sustainable. Unfortunately, I am not alone in these experiences. As President of IFFGD, I have heard my story echoed back to me by thousands of others. Patients affected by these disorders often face similar delays in diagnosis, frequent misdiagnosis, and inappropriate treatments including unnecessary and costly surgery. These are common concerns for our community, and they underscore the need for increased research, improved provider education, and greater public awareness.

ABOUT THE FOUNDATION

The International Foundation for Gastrointestinal Disorders (IFFGD) is a registered nonprofit education and research organization dedicated to informing, assisting, and supporting people affected by gastrointestinal (GI) disorders. IFFGD works with patients, families, physicians, nurses, practitioners, investigators, regulators, employers, and others to broaden understanding about GI disorders, support and encourage research, and improve digestive health in adults and children.

ABOUT FUNCTIONAL GASTROINTESTINAL AND MOTILITY DISORDERS (FGIMDS)

Anong the vast array of gastrointestinal disorders, functional GI and motility disorders are the most common digestive disorders in the general population. These disorders are classified by symptoms related to any combination of the following: motility disturbance, visceral hypersensitivity, altered mucosal and immune function, altered gut microbiota, and altered central nervous system (CNS) processing. Some examples of functional GI and motility disorders are: dyspepsia, gastroparesis, irritable bowel syndrome (IBS), gastroesophageal reflux disease (GERD), bowel incontinence, and cyclic vomiting syndrome. The costs associated with these diseases range from $25–$30 billion annually; economic costs are also reflected in work absenteeism and lost productivity.

CENTERS FOR DISEASE CONTROL AND PREVENTION

We greatly appreciate the support from the subcommittee in continuing to support the Chronic Disease Education and Awareness Program in FY2024. Patients with FGIMDs frequently suffer for years before receiving an accurate diagnosis, exposing them to unnecessary and costly tests and procedures including surgeries, as well as needless suffering and expense. Functional GI and motility disorders are among the most common digestive disorders in the general population. They affect an estimated 1 in 4 people in the U.S. and account for 40% of GI problems seen by medical providers. A CDC program focused on surveillance, provider education, and public awareness would increase diagnoses and improve patient outcomes. We ask that the subcommittee provide $6 million for the Chronic Disease Education and Awareness Program in FY2024.

NATIONAL INSTITUTES OF HEALTH

Strengthening the Nation's biomedical research enterprise through NIH fosters economic growth and sustains innovations that enhance the health and well-being

of the American people. Functional GI disorders are prevalent in about 1 in 4 people in the U.S., accounting for 40% of GI problems seen by medical providers. NIDDK supports basic, clinical, and translational research on aspects of gut physiology regulating motility and supports clinical trials through the Motility and Functional GI Disorders Program.

Several of NIH's crosscutting initiatives are currently advancing science in meaningful ways for patients with gastrointestinal disorders. The Stimulating Peripheral Activity to Relieve Conditions (SPARC) Initiative supports research on the role that nerves play in regulating organ function. Methods and medical devices that modulate these nerve signals are a potentially powerful way to treat many chronic conditions, including gastrointestinal and inflammatory disorders. The Human Microbiome Project is also unlocking important discoveries that will help to inform and advance emerging treatment options for many in the community.

Patient Perspective—Jacqui's Story

I got sick after an emergency appendectomy on Thanksgiving 2010 while I was in Army basic training. I was able to fight off the inevitable and did 4 years in the Army during which I did a tour in Afghanistan. When I got back, my health really started declining.

I fought and fought and fought for an answer, but it took just over 7 years to be diagnosed with gastroparesis. My main symptoms were nausea, vomiting and pain. It got so bad that I had to give up my dream career and was medically retired from the service.

Because we had tried pretty much every conservative treatment, they told me I would just have to live with it. It got to the point where I was going weeks without eating and was in and out of the ER getting fluids, because anything that went in my stomach came back up. My hair thinned, so I shaved it, and I was having memory problems and confusion, which got so bad that my neuropsych tests came back with my score being in the range of dementia.

My gastroenterologist even told me at one point that she couldn't do anything "drastic" to help me until my blood work was "bad enough."

Thank you for the opportunity to submit our community's perspective, as you consider appropriations priorities for FY 2024. We look forward to continuing to work with you on these critical issues.

Informing, assisting, and supporting people affected by gastrointestinal disorders.

[This statement was submitted by Ceciel T. Rooker, President and Executive Director, International Foundation for Gastrointestinal Disorders.]

PREPARED STATEMENT OF THE INTERSTITIAL CYSTITIS ASSOCIATION

SUMMARY OF RECOMMENDATIONS FOR FISCAL YEAR 2024

—Provide $1.5 million for the IC Education and Awareness Program and the IC Epidemiology Study at the Centers for Disease Control and Prevention (CDC)
—Provide $50 billion for the National Institutes of Health (NIH) and Proportional Increases Across all Institutes and Centers
—Support NIH Research on IC, Including the Multidisciplinary Approach to the Study of Chronic Pelvic Pain (MAPP) Research Network and Chronic Pain

Thank you for the opportunity to present the views of the Interstitial Cystitis Association (ICA) regarding interstitial cystitis (IC) public awareness and research. ICA was founded in 1984 and is the only nonprofit organization dedicated to improving the lives of those affected by IC. The Association provides an important avenue for advocacy, research, and education. Since its founding, ICA has acted as a voice for those living with IC, enabling support groups and empowering patients. ICA advocates for the expansion of the IC knowledge-base and the development of new treatments. ICA also works to educate patients, healthcare providers, and the public at large about IC.

IC is a condition that consists of recurring pelvic pain, pressure, or discomfort in the bladder and pelvic region. It is often associated with urinary frequency and urgency. This condition may also be referred to as painful bladder syndrome (PBS), bladder pain syndrome (BPS), and chronic pelvic pain (CPP). It is estimated that as many as 12 million Americans have IC symptoms. Approximately two-thirds of these patients are women, though this condition does severely impact the lives of as many as 4 million men. IC has been seen in children and many adults with IC

report having experienced urinary problems during childhood. However, little is known about IC in children, and information on statistics, diagnostic tools and treatments specific to children with IC is limited.

The exact cause of IC is unknown and there are few treatment options available. There is no diagnostic test for IC and diagnosis is made only after excluding other urinary/bladder conditions. It is not uncommon for patients to experience one or more years delay between the onset of symptoms and a diagnosis of IC. This is exacerbated when healthcare providers are not properly educated about IC.

The effects of IC are pervasive and insidious, damaging work life, psychological well-being, personal relationships, and general health. The impact of IC on quality of life is equally as severe as rheumatoid arthritis and end-stage renal disease. Health-related quality of life in women with IC is worse than in women with endometriosis, vulvodynia, and overactive bladder. IC patients have significantly more sleep dysfunction, and higher rates of depression, anxiety, and sexual dysfunction.

Some studies suggest that certain conditions occur more commonly in people with IC than in the general population. These conditions include allergies, irritable bowel syndrome, endometriosis, vulvodynia, fibromyalgia, and migraine headaches. Chronic fatigue syndrome, pelvic floor dysfunction, and Sjogren's syndrome have also been reported.

IC PUBLIC AWARENESS AND EDUCATION THROUGH CDC

ICA recommends a specific appropriation of $1.5 million in fiscal year 2024 (FY2024) for the CDC IC Program. This will allow CDC to fund the Education and Awareness Program, per ongoing congressional intent, as well as the IC Epidemiology Study.

CDC had previously shifted the focus of the IC program to an epidemiology study and away from education and awareness, but thanks to the subcommittee the ICA and IC community have been able to open discussions with CDC to ensure a renewed focus on education and awareness activities. The IC community had been concerned that focusing solely on an epidemiology study instead of on education and awareness activities was detrimental to patients and their families. There has been some improvement but there is more dedicated funding needed for education and awareness activities. We know that CDC has not received as generous increases as NIH over the past few fiscal years, but it is important the CDC continue supporting both critical components of the IC Program. The CDC IC Education and Awareness Program is the only Federal program dedicated to improving public and provider awareness of this devastating disease, reducing the time to diagnosis for patients, and disseminating information on pain management and IC treatment options. ICA urges Congress to provide funding for IC education and awareness in FY2024.

The IC Education and Awareness program has utilized opportunities with charitable organizations to leverage funds and maximize public outreach. Such outreach includes public service announcements in major markets and the internet, as well as a billboard campaign along major highways across the country. The IC program has also made information on IC available to patients and the public though videos, booklets, publications, presentations, educational kits, websites, self-management tools, webinars, blogs, and social media communities such as Facebook, YouTube, and Instagram For healthcare providers, this program has included the development of a continuing medical education module, targeted mailings, and exhibits at national medical conferences.

The CDC IC Education and Awareness Program also provided patient support that empowers patients to self-advocate for their care. Many physicians are hesitant to treat IC patients because of the time it takes to treat the condition and the lack of answers available. Further, IC patients may try numerous potential therapies, including alternative and complementary medicine, before finding an approach that works for them. For this reason, it is especially critical for the IC program to provide patients with information about what they can do to manage this painful condition and lead a normal life. With the recent developments in our conversations with the CDC we are confident that we will continue to provide key education and awareness that will continue to benefit the IC community.

IC RESEARCH THROUGH THE NATIONAL INSTITUTES OF HEALTH

ICA recommends a funding level of $50 billion for NIH in FY2024. ICA also recommends continued support for IC research including the MAPP Study administered by NIDDK.

The National Institutes of Health (NIH) maintains a robust research portfolio on IC with the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) serving as the primary Institute for IC research. The NIDDK Multidisci-

plinary Approach to the Study of Chronic Pelvic Pain (MAPP) Research Network has continued to include cross-cutting researchers who are currently identifying different phenotypes of the disease. Phenotype information will allow physicians to prescribe treatments with more specificity. Research on chronic pain that is significant to the community is also supported by the National Institute of Neurological Disorders and Stroke (NINDS) as well as the National Center for Complementary and Integrative Health (NCCIH). The vast majority of IC patients often suffer major and multiple quality of life issues due to this condition. Many IC patients are unable to work full time because pain affects their mobility, sleep, cognition, and mood. These are people that simply want to lead productive lives, and need pain medication to do so. Due to the fact that IC is categorized as a non-cancer pain condition, IC patients already have a difficult time obtaining pain meds. IC doctors do not have time nor the inclination to effectively prescribe or monitor the distribution of the opioid class of medication. They often refer their patients to Pain Management Specialists, many who have never heard of IC, who often refuse to treat them. In addition, antidepressants and benzodiazepines are often used to treat both mood and sleeping disorders for IC patients. Additionally, the NIH investigator-initiated research portfolio continues to be an important mechanism for IC researchers to create new avenues for interdisciplinary research.

Patient Perspective

IC is a tough disease to diagnose, and it is one of the most challenging things to deal with, finding a doctor that specializes in IC that can help diagnose and treat. I can't stress enough how important finding the right doctor is. IC patients need a doctor who understands and is willing to go along with them on this long, frustrating, painful and confusing road. I have found strength through having this that I never knew I had, strength to keep going when all treatments so far have failed me.

There are a small number of treatments available for managing IC symptoms, but they only work on a small percentage of patients. I have tried those treatments and some drugs that "might" help. I manage my diet, take lots of supplements and have to see all kinds of doctors now. I have six! That includes holistic medicine doctors, physical therapists, and acupuncturist. That's along with my regular MD, urologist and two different gynecologists. This is what my life has become. The life of an IC patient. I deal with one or more symptoms of IC EVERY SINGLE DAY. Some days definitely better than others, but every single day. It affects my life in so many ways. Work, social, travel and my intimate relationships. I never know how I'm going to feel from one day to the next. anxiety and fear included.

Thank you for the opportunity to present the views of the interstitial cystitis community.

[This statement was submitted by Lee Lowery, Executive Director, Interstitial Cystitis Association.]

PREPARED STATEMENT OF THE JAMESTOWN S'KLALLAM TRIBE

Chairwoman Baldwin, Ranking Member Moore Capito, and distinguished members of this subcommittee, on behalf of the Jamestown S'Klallam Tribe, I would like to thank you for this opportunity to submit written testimony on our funding priorities and recommendations for the FY2024 appropriations process for the Department of Health and Human Services, Labor, Education and Related Agencies.

A. Tribal Specific Health Appropriation Priorities

1. Expansion of Self-Governance within the Department of Health and Human Services
2. Permanently Exempt Tribal Healthcare Programs from Sequestration, Budgetary Cuts and Rescissions
3. Invest in Tribal Healthcare Base Funding as Opposed to Grants to Eliminate Health Disparities and Build Health Equity
4. Ensure Funding for Medicaid Outreach and Education

B. Tribal Priorities Administration for Children and Families & the Administration for Community Living

1. Child Welfare Programs Tribal Allocations Subpart 1, $350 million; Subpart 2, $120 million $3.6 million Tribal Set Aside
2. Promoting Safe and Stable Families $650 million for mandatory programs and $120 million for discretionary programs

3. Fund Long Term Care
4. Older American act Title VI, part A,B Native American Nutrition and Supportive Services- $55.5 million Title VI, $43 Million Nutrition and Support Services.

A. TRIBAL SPECIFIC HEALTH APPROPRIATIONS PRIORITIES

1. Expansion of Self-Governance within the Department of Health and Human Services—In Title VI of the Indian Self-Determination and Education Assistance Act (ISDEAA), Congress required HHS to conduct a study to determine the feasibility of extending the highly successful Tribal Self-Governance program to other agencies within the Department of Health and Human Services (HHS). It has been more than two decades since the Department first determined that expanding Self-Governance to a number of programs within HHS is feasible. Despite these findings, HHS determined legislation is required to establish a demonstration project. As early as 2004, the Senate considered legislation to authorize a demonstration project, but the legislation was not enacted.

Tribes have been administering many of these programs for decades under grant mechanisms and have developed a high level of expertise in these programmatic areas. Enacting legislation establishing a demonstration project to implement Title VI of the ISDEAA will promote and advance Tribal sovereignty and Self-Sufficiency, result in cost savings and more efficient and effective use of Federal resources.

2. Permanently Exempt Tribal Healthcare Programs from Sequestration, Budgetary Cuts and Rescissions—Treaty and trust obligations by their very nature require the exemption of Tribal health programs from sequestration, budgetary caps, cuts, and rescissions. For decades, funding reductions/permanent rescissions of Tribal programs and services has become commonplace in order to pay for tax cuts, wars, natural disasters, and technology upgrades. These budgetary rescissions are permanent, unsupportable reductions to Tribal health programs. Factoring in the inflationary rate, Tribes are not even maintaining level funding. Tribal health obligations are mandatory not discretionary and should not be used as a means to balance the Federal budget. To do so, would not only be a flagrant disregard of these legal obligations imparted on Congress, but it would also further erode the health outcomes of AI/AN, including, substantially increasing the potential for loss of life.

3. Invest in Tribal Healthcare with Base Dollars and Recurring Funding as Opposed to Grants to Eliminate Health Disparities and Build Health Equity—Ensuring Tribes have the tools and resources to effectively govern their communities and exercise their inherent right to Self-Government will help promote health equity and eliminate health disparities in Indian Country. There has been a growing trend among agencies to fund Tribal programs and services with grant dollars rather than providing base and recurring funding. Grant funding undermines Self-Governance because it is competitive short-term funding which creates uncertainty in planning, imposes extensive regulation and reporting requirements and restricts the use of indirect costs. Tribes also experience difficulty meeting the grant requirements, match requirements, or are under-resourced to apply and compete for these grants. Eligibility does not equate to access and grant funding is inconsistent with the Federal trust obligation. Some key funding mechanisms that foster Indian Self-Governance include the provision of steady, reliable Tribal base and recurring healthcare funding, direct funding as opposed to funding that is passed through State -governments and the authority to administer funds through Self-Governance compacts.

4. Ensure Funding for Medicaid Outreach and Education—Medicaid reimbursement for healthcare services rendered to AI/AN through the Indian Health Service or Tribal Healthcare Facilities provide supplemental resources for Indian healthcare programs and accounts for a substantial portion of third-party revenues that Tribes rely on to maintain their healthcare programs and services. Additional resources should be targeted for education and outreach to ensure all Medicaid eligible AI/AN are enrolled.

B. TRIBAL PRIORITIES ADMINISTRATION FOR NATIVE AMERICANS ADMINISTRATION OF CHILDREN AND FAMILIES AND ADMINISTRATION FOR COMMUNITY LIVING

1. Child Welfare Programs Title IV B (subpart 1)—Tribal Allocation $350 Million & Promoting Safe and Stable Families Social Security Act Title IV B (subpart 2) $120 Million Tribal Allocation $3.6 Million—Title IV B provides funding to Tribes to support community-based child welfare services. Tribal tradition and culture are an integral component of our child welfare programs because it has been proven that culturally tailored programs and services increase community participation and lead to better outcomes for American Indian and Alaska Native (AI/AN) children and families. Increased funding coupled with maximum flexibility to use these funds

to provide ancillary child welfare services, including, parenting classes, conducting home visits, and addressing issues, such as, alcohol and substance abuse is essential so that AI/AN children can remain with their families and in their Tribal communities.

2. Promoting Safe and Stable Families $650 million for mandatory programs and $120 million for discretionary programs—Addressing trauma, promoting stronger families, and reducing the rates of foster care placements are all important components of Promoting Safe and Stable Tribal Families. Increased funding is needed to accomplish the goals of this program. We recommend that the programmatic increases include $650 million for mandatory programs and $120 million for discretionary programs.

3. Older Americans Act Title VI, Part A, B Native American Nutrition and Supportive Services—$55.5 million Title VI, $43 Million Nutrition and Support Services—Title VI of the Older Americans Act is the primary funding source for the provision of nutrition, healthcare, and other holistic community-based cultural programs and supportive services for our Tribal elders. However, funding for elder programs is woefully inadequate to meet existing and growing needs. The Indian Healthcare Improvement Act (IHCIA) authorized the Secretary of HHS to fund these services but, to date, no funding has been appropriated for these services. Elders hold a place of high esteem in our Tribal communites and providing services to our elders is deeply rooted in our beliefs because they play a vital role in ensuring the survival of our traditons, culture, language and spirituality.

The Jamestown S'Klallam Tribe continues to support the requests and recommendations of our Regional and National Organizations to include the Affiliated Tribes of Northwest Indians, the Northwest Portland Area Indian Health Board, the National Indian Health Board, and the National Congress of American Indians. Thank you.

[This statement was submitted by Hon. W. Ron Allen, Tribal Chairman/CEO, Jamestown S'Klallam Tribe.]

PREPARED STATEMENT OF JOHNSON & JOHNSON'S

On behalf of Johnson & Johnson's 152,700 global employees, I am pleased to provide written testimony to the Senate Appropriations subcommittee on Labor, Health and Human Services, Education, and Related Agencies in support of increased funding for the National Institutes of Health (NIH or the Agency) Fiscal Year (FY) 2024 budget.

Robust funding for NIH is necessary to ensure the Agency can fuel innovation in medical research as well as to improve the trajectory of healthcare in the United States and around the world. Johnson & Johnson also believes NIH funding encourages the pursuit of innovative solutions essential to addressing the increasingly complex health threats confronting the United States and the world.

As a physician and scientist, I have dedicated much of my life to translating basic scientific research into medical advances. In my role at Johnson & Johnson as Executive Vice President, Chief External Innovation and Medical Safety Officer, Interim Head of Janssen R&D, and as a board member of the American Association for Cancer Research, I am deeply aware of the value of our Nation's investment in research.

In the United States, medical research focused on the root cause of disease is often publicly funded by NIH through research grants utilized by more than 2,500 institutions across the country. The foundational research conducted by NIH-funded investigators plays an important complementary role to private sector research and development efforts. Specifically, healthcare companies build upon these scientific efforts as well as make substantial investments in research and development (R&D) to transform such research into the breakthrough healthcare products of tomorrow.

At Johnson & Johnson, we are committed to create life-enhancing innovations and to producing value through partnerships in order to profoundly change the trajectory of health for humanity. To that end, in 2022, Johnson & Johnson invested nearly $14.6 billion in research and development across our pharmaceutical, consumer health, and medical technology companies.[1] Our teams of scientists work tirelessly to accelerate the translation of scientific discoveries into meaningful solutions for patients and consumers. Much of our work, and that of scientists across the industry, is facilitated by our understanding of underlying disease biology—precisely the type of research funded by the NIH.

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[1] New products introduced within the past 5 years accounted for approximately 25% of 2022 sales.

In addition, Johnson & Johnson recognizes the crucial importance of early-stage companies, and the critical role NIH plays in supporting small businesses through Small Business Innovation Research (SBIR) and Small Business Technology Transfer (STTR) funding. Through Johnson & Johnson Innovation (JJI) Innovation Centers, entrepreneurs and startups can discuss the innovative ideas they are working on, seek to collaborate with Johnson & Johnson scientists, and access our global expertise and resources to accelerate their work. Through our JJDC venture investment group, they may obtain venture capital funding to support their innovations. Additionally, at our JJI JLABS incubator sites, including the newly established JLABS @ Washington, D.C. site in collaboration with Children's National and Biomedical Advanced Research and Development Authority (BARDA)—which opened in 2021—we support the life sciences ecosystem by helping entrepreneurs and scientists realize their dreams of creating healthcare solutions that improve lives. Their often disruptive, cutting-edge research may lead to novel platforms, products or technologies with the potential to advance the scientific community in ways hard to imagine only several years ago. In order for such research to become a reality, public-private partnerships are critical for incubating and supporting the future of life science development.

The work of the NIH is tied not only to innovation and the vitality of the life sciences, but also to the health of our National economy and to the health of our country. In FY 2022, NIH research funding directly and indirectly supported over 568,585 jobs and spurred nearly $96.84 billion in new economic activity. Moreover, diseases such as Alzheimer's disease, diabetes, cancer, and heart disease as well as current and future pandemics, threaten the lives of millions of our citizens and have the ability to overwhelm our healthcare system in a matter of years. Such scenarios pose enormous costs of care to patients if we do not find ways to prevent, intercept, treat, and cure them. We must also continue to address public health crises and areas of unmet medical needs, such as emerging infectious diseases and antimicrobial resistance. The pace of medical research must keep up with these challenges, and it is NIH that must reinforce that research.

Investments in medical research over the last several decades by the Federal Government and private life sciences companies, combined with the work of industry and NIH-funded investigators across the country, have produced fundamental scientific advances in increasingly sophisticated areas of scientific inquiry. As NIH is working on projects in areas such as precision medicine, gene therapy, and vaccines to prevent infectious diseases, there has never been a more critical and promising time to work in medical research, nor a more pertinent time to fund NIH.

Johnson & Johnson believes a fully and consistently funded NIH is critical to driving innovation in medical research. This funding also is a commitment to our communities by advancing science to match medical need, to our current and future generations of scientists by stimulating the life sciences ecosystem, and to the prosperity of our Nation as a worldwide leader in medical research. Sustainable, robust investment is vital—not only for strengthening this research, but for realizing its benefits for improving people's lives and reducing the burden of associated costs of disease in the United States and around the world.

[This statement was submitted by William N. Hait, M.D., Ph.D., Executive Vice President, Chief External Innovation and Medical Safety Officer.]

PREPARED STATEMENT OF JONATHAN A. PLUCKER, PH.D.

Chairman Baldwin, Ranking Member Capito, and members of the subcommittee, 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.

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.

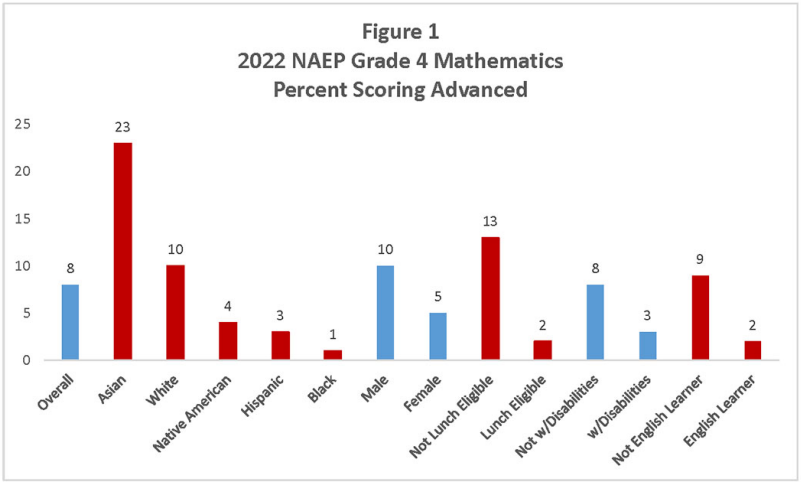
LOWER RATES OF ACADEMIC EXCELLENCE IN THE U.S.

Academic excellence has a strong relationship to economic and cultural growth. Many aspects of talent development—from recruitment to training to retention—are major concerns of for-profit businesses, cultural institutions, and non-profit organizations. Simply put, the American economy and culture have tremendous need for

talent. Strong advanced learning programs provide opportunities for students to develop their talents and achieve at the highest levels.

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 recently 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, state policymakers and advocates have worked together to create or improve laws to support advanced learning in several States, including Arkansas, Alabama, Washington, and Wisconsin. 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 for your attention to the Javits Program and the talent development of American children.

RELEVANT RESEARCH

American students are not sufficiently challenged:

Makel, M. A., Matthews, M. S., Peters, S. J., Rambo-Hernandez, K., & Plucker, J.A. (2016). How can so many students be invisible? Large percentages of American students perform above grade level. Baltimore, MD: Institute for Education Policy, School of Education, Johns Hopkins University. Available at https://

edpolicy.education.jhu.edu/how-can-so-many-students-be-invisible-large-percentages-of-american-students-perform-above-grade-level/.

Finn Jr, C. E., & Wright, B. L. (2015). Failing Our Brightest Kids: The Global Challenge of Educating High-Ability Students. Harvard Education Press.

Excellence gaps are large and growing…

Plucker, J. A., & Peters, S. J. (2016). Excellence gaps in education: Expanding opportunities for talented youth. Harvard Education Press.

Plucker, J. A., Glynn, J., Healey, G., & Dettmer, A. (2018). Equal talents, unequal opportunities: A report card on state support for academically talented low-income students. 2nd ed. Jack Kent Cooke Foundation.

…But we know how to increase academic excellence and close excellence gaps:

Card, D., & Giuliano, L. (2016). Universal screening increases the representation of low-income and minority students in gifted education. Proceedings of the National Academy of Sciences, 113(48), 13678–13683. https://www.pnas.org/doi/abs/10.1073/pnas.1605043113/.

Peters, S. J., Rambo-Hernandez, K., Makel, M. C., Matthews, M., & Plucker, J. A. (2019). The effect of local norms on racial and ethnic representation in gifted education. AERA Open, 5(2), 1–18. https://journals.sagepub.com/doi/full/10.1177/2332858419848446.

Card, D., & Giuliano, L. (2016). Can tracking raise the test scores of high-ability minority students?. American Economic Review, 106(10), 2783–2816. https://www.aeaweb.org/articles?id=10.1257/aer.20150484.

Plucker, J. A., & Callahan, C. M. (2020). The evidence base for advanced learning programs. Phi Delta Kappan, 102(4), 14–21. https://journals.sagepub.com/doi/pdf/10.1177/0031721720978056.

Meyer, M., Shen, A., & Plucker, J. A. (in press). Reducing excellence gaps: A systematic review of research on equity in advanced education. Review of Educational Research.

[This statement was submitted by Jonathan A. Plucker, Ph.D., Professor of Education, Johns Hopkins University.]

PREPARED STATEMENT OF JUMPSTART FOR YOUNG CHILDREN

Chair Tammy Baldwin (D–WI) and Ranking Member Shelley Moore Capito (R–WV), thank you for the opportunity to provide testimony on Jumpstart's Fiscal Year (FY) 2024 appropriations and policy priorities. Jumpstart is a national early education organization working to ensure every child is prepared to succeed in kindergarten. To achieve that goal, we focus on advancing equitable learning outcomes for young children in underserved communities by recruiting and supporting caring adults to deliver high-quality programming to preschool students. Much of our work relies on the community service set-aside through the Federal Work Study program. As such, we respectfully request that you provide $1.43 billion, an increase of $200 million, for the Federal Work Study program in your FY 2024 appropriations bill. We also urge support for increases to the Child Care and Development Block Grant, AmeriCorps State and National programs, and the Head Start program along with the funding to increase the AmeriCorps living allowance.

Almost thirty years ago, Jumpstart began when four college students asked each other a simple but deeply meaningful question: "What if we could offer children from underserved communities individualized attention before they enter kindergarten, giving them the critical academic and social skills—the 'jumpstart'—they need to succeed?" The idea took hold and today Jumpstart has trained more than 62,500 college students, community volunteers, and alumni who are credentialed early childhood teachers, preparing over 157,900 children for kindergarten success. Jumpstart's program is replicated across the country in 14 States and the District of Columbia. We leverage partnerships with higher education institutions, community organizations, Head Start programs, community-based preschools, and school districts to create sustainable solutions in order to close the kindergarten readiness and early educator workforce gaps.

Young children, no matter where they grow up or who their parents are, deserve access to a high-quality education. High-quality education for young children requires dedicated staff who are adequately prepared, well-compensated, and inspired to serve their students. Unfortunately, right now the early education and child care community are facing a grim labor shortage. In October of 2022, the Bureau of Labor Statistics reported that there are currently "100,000 fewer child care workers

than there were before the coronavirus pandemic." People leave professions for a variety of reasons, but in the early education and child care sector, several themes are consistent amongst practitioners who leave the field-underpaid, underappreciated, and underserved.

In the face of these challenges, Jumpstart is trying to close these workforce gaps by recruiting college students to participate in our program and serve young children. Students who participate in Jumpstart receive several opportunities, including loan forgiveness and forbearance through AmeriCorps, professional training on how to serve young children, ongoing mentorship and alumni support, and an unparalleled opportunity to give back to their local community. We find that by the end of our program, Jumpstart corps members are more likely to graduate from college, identify academic goals, develop transferable skills, such as professional organization and communication, and pursue an interest in working in the early educator field. A 2019 study of Jumpstart alumni found that 78 percent of those who participated in the Jumpstart program developed skills that helped them in their academic courses. In addition, 67 percent of respondents said that it helped them identify their educational goals.[1] In an effort to serve our most underserved communities, Jumpstart is providing direct support to children and robust professional opportunities for college students to learn more about early education.

To provide these services and sustain our programming, Jumpstart relies on the community-service set-aside through the Federal Work Study program. This year, Jumpstart will leverage more than $7.2 million in FWS to support the participation of 3,000 college students in our program at more than 70 institutions of higher education. The community service set-aside allows students to use FWS funds and gain experience directly serving the local community through a number of roles, including as a reading tutor, support staff for health centers, assistant at a public school, support staff at local nonprofits, or as a Jumpstart corps member. The partnership of FWS and non-profit sectors, such as child care, can help to address workforce needs in both the short- and long-term. Our request for increased FWS funds would provide colleges and universities with expanded capacity to provide more opportunities for students to serve their local community. As a result, barriers to entry that prevent people from entering those fields, especially early education and care, would be significantly reduced.

In addition to our FWS-related request, we also urge the Committee to increase funding for programs that have a large impact on children and families. We ask that you provide a $1 billion increase for the Child Care and Development Block Grant (CCDBG); a $93 million increase for AmeriCorps State and National programs; and a $1.1 billion increase for the Head Start program. We also urge the Committee to invest $1.5 billion to increase the living allowance of AmeriCorps members.

With these investments, we believe that Congress will have taken a first step in ensuring that young children, at a time when their development is critical, receive adequate care and education. Additionally, these investments will ensure that young people who are interested in service work or the early education sector have an opportunity to engage in this work without being shackled by financial debt or lack of opportunity. By investing in early education, more families will be free to contribute to the workforce while their children receive adequate care. At a time when policymakers are discussing ways to address workforce gaps, providing families with adequate early education is a solution that will pay dividends for years to come.

We appreciate this opportunity to share our request with the Committee and share more about how Jumpstart is working to ensure young children receive a high-quality education and workforce gaps in the early educator workforce are solved. If you have any additional questions or concerns, please contact Naila Bolus at Naila.Bolus@jstart.org.

PREPARED STATEMENT OF KIPP PUBLIC SCHOOLS

Chairwoman Baldwin, Ranking Member Capito, and Members of the subcommittee:

Thank you for allowing KIPP Public Schools (KIPP) to submit testimony on our Fiscal Year 2024 education appropriations priorities.

KIPP is the Nation's largest Charter Management Organization (CMO), a nonprofit network of 280 public charter schools and 15,000 educators serving over 175,000 students and alumni.

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[1] https://www.jstart.org/wp-content/uploads/2021/03/2019-Alumni-Survey-Exec-Summary__FINAL.pdf.

Together with families and communities, we create joyful, academically excellent schools that prepare students with the skills and confidence to pursue the paths they choose—college, career, and beyond—so they can lead fulfilling lives and build a more just world.

OUR FEAR YEAR 2024 EDUCATION APPROPRIATIONS PRIORITIES

The Charter Schools Program

As you begin working on the Fiscal Year 2024 Labor, Health and Human Services, and Education Appropriations bill, we respectfully request that you fund the Department of Education's (ED) Charter Schools Program (CSP) at $500 million, a $60 million increase from Fiscal Year 2023.

KIPP believes in building a strong public education ecosystem that includes high-quality public charter school options. With 95 percent of our students identifying as Black or Latinx, and 88 percent eligible for Federal free or reduced-price meals, we serve some of the Nation's most vulnerable and underserved students with a well-established track record of success.[1,2,3] In fact, in 2019, Mathematica released a study showing the impact of attending KIPP middle school could erase the racial achievement gap in 4-year college enrollment rates nationwide.[4] We have accomplished this success, in no small part, through the support of Federal funding via the Charter Schools Program.

The CSP, especially the Replication and Expansion grants, are pivotal to our ability to continue providing a high-quality education for thousands of students from historically underserved communities. According to a recent report by the Government Accountability Office (GAO), charter schools that opened with CSP funding were 1.5 times less likely to close 5 years after receiving funding, a pattern that held up across the entire 12 years of data studied.[5] This pattern held up even when the data was controlled for charter schools' grade level, locale, student body racial and ethnic composition, or percentage of students receiving free or reduced-price lunch.[6] In other words, CSP funding is essential for the entire public charter school sector's ability to continue providing high-quality educational options to families.

We also request this funding increase because CSP dollars are integral to allowing us, and the broader public charter sector, to meet the increasing level of demand from parents and students across the country. Another recent report from the GAO showed that CSP-recipient public charter schools had 1.3 to 1.6 times higher enrollment growths compared to non-CSP-recipient schools.[7] In the KIPP Public Schools network alone, we have nearly 30,000 students on waiting lists to attend our schools. To meet the increasing demand for high-quality charter schools across the Nation, schools like ours need the ongoing support of the CSP.

We also urge the subcommittee to include language that provides ED with greater flexibility to reallocate funds within the CSP sub-programs in response to changing demand. Additionally, we recommend the inclusion of guardrails to ensure that State Entity, Developer, and Charter Management Organization (CMO) grants, the largest and most impactful programs, continue to receive a fair annual allocation.

In addition, we want to acknowledge that the CSP's two sub-programs that aim to help charter schools access high-quality facilities, the Credit Enhancement and State Facilities Incentive grants, have received insufficient funding, and have overly restrictive requirements, making it difficult for most charter schools to benefit from them. We encourage this subcommittee to continue investigating ways to improve support within the current CSP sub-program offerings.

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[1] "KIPP: Preparing Youth for College Success." Mathematica, https://www.mathematica.org/projects/kipp-preparing-youth-for-college.

[2] "Mathematica Research on KIPP Public Schools" Mathematica. https://www.kipp.org/results/independent-reports/#mathematica-2019-report.

[3] "Charter Schools Show Steeper Upward Trend in Student Achievement than District Schools" Education Next. https://www.educationnext.org/wp-content/uploads/2022/01/ednext__XXI__1__shakeel__peterson.pdf.

[4] "Mathematica Research on KIPP Public Schools" Mathematica. https://www.kipp.org/results/independent-reports/#mathematica-2019-report.

[5] "Charter Schools That Received Federal Funding to Open or Expand Were Generally Less Likely to Close Than Other Similar Charter Schools." Government Accountability Office. https://www.gao.gov/assets/gao-23-105616.pdf.

[6] Id.

[7] "New Charter Schools Receiving Grants to Open Grew Faster Than Peers." Government Accountability Office. https://www.gao.gov/products/gao-23-106268?utm__campaign=usgao__email&utm__content=topic __education&utm__medium=email&utm__source=govdelivery.

Title I, Title III, and IDEA

These programs form the foundation of Federal funding for most public schools in the country, including high-quality public charter schools. We strongly encourage the subcommittee to increase funding to these programs to the greatest degree possible to help ensure the financial health and well-being of our public schools, educators, and students.

At KIPP, the children we serve are the heart and soul of everything we do. From the moment they walk through our doors, we make a promise to put their needs and academic success at the center of our work, and to provide a high-quality education that empowers them to create the future they want for themselves and their communities.

We thank the Chairwoman, Ranking Member, and Members of the subcommittee for considering our recommendations, and for your continued commitment to the promise of public education and the success of all students. We look forward to continuing to work with this subcommittee to ensure the success of all of our Nation's children.

PREPARED STATEMENT OF SUSAN G. KOMEN

Susan G. Komen (Komen) is the world's leading nonprofit breast cancer organization representing the millions of Americans who have been diagnosed and are living with breast cancer. Komen has an unmatched, comprehensive 360-degree approach to fighting this disease across all fronts—we advocate for patients, drive research breakthroughs, improve access to high-quality care, offer direct patient support and empower people with trustworthy information. Komen is committed to supporting those affected by breast cancer today, while tirelessly searching for tomorrow's cures. We advocate on behalf of the estimated 300,590 people in the United States who will be diagnosed with breast cancer and the almost 44,000 who will die from the disease in 2023 alone. Komen is requesting that Congress fund the Centers for Disease Control and Prevention's (CDC) National Breast and Cervical Cancer Early Detection Program (NBCCEDP) at the amount of at least $230 million in Fiscal Year 2024 (FY24).

Screening tests are used to find breast cancer before it causes any warning signs or symptoms. Regular screening enables us to detect potential cancers at earlier stages and refer patients to further care, often yielding better outcomes for patients and resulting in decreased financial pressure on our healthcare system. Without access to early detection programs, many individuals are forced to delay or forgo screenings, which can lead to disease progression and later-stage breast cancer diagnoses.

The NBCCEDP was established with the passage of the Breast and Cervical Cancer Mortality Prevention Act in 1990. The program plays a critical role in helping low-income, uninsured and underinsured women who do not qualify for Medicaid receive timely breast and cervical cancer screening, diagnostic and treatment services that are free or low-cost. The covered services include clinical breast examinations, mammograms, pelvic examinations, Pap tests, human papillomavirus (HPV) tests, diagnostic tests if screening results are abnormal, and referrals to treatment. Additionally, the NBCCEDP provides patient navigation services to help individuals overcome barriers, such as lack of provider recommendation or geographic isolation, and get timely access to quality care.

For over 30 years, the NBCCEDP has provided lifesaving breast cancer screening and diagnostic services to eligible women in all 50 States, the District of Columbia, two U.S. territories, five U.S.-Affiliated Pacific Islands and 13 American Indian and Alaska Native Tribes or Tribal organizations. The NBCCEDP has served more than 6.1 million women since it launched in 1991, detecting nearly 76,000 invasive breast cancers, over 24,000 premalignant breast lesions, more than 5,000 cervical cancers and over 235,000 premalignant cervical lesions. More statistics on the number of women served by the program in each State are available here.

The program, a partnership between the CDC and State health departments, also provides public education, outreach and care coordination to increase breast cancer screening rates and reach underserved, vulnerable populations. Each state program operates within the National framework of legislation, policy and oversight, but varies in funding, infrastructure, populations served and geographical barriers. Programs can prioritize the population they serve based on their cancer burden, environment, available resources and goals. Unfortunately, these are often influenced and limited by State funding and state legislative constraints.

The COVID–19 pandemic highlighted the broad systemic trends that exist with almost every public health crisis: consequences are more commonly and more se-

verely experienced in low-income, underserved and marginalized communities. Black women in the United States have a breast cancer mortality rate about 40 percent higher than white women. Similarly, Hispanic/Latina and American Indian/Alaska Native women are 30 percent more likely to be diagnosed with advanced stage breast cancer compared with white women.

NBCCEDP funding supports interventions which help address inequities in breast cancer screening and diagnosis since the program places special emphasis on women who are geographically or culturally isolated or who identify as racial or ethnic minorities. The program focuses on factors at the interpersonal, organizational, community and policy levels that influence screening. This approach is particularly useful as grantees can serve a wide variety of communities from remote, rural communities to urban population centers and are able to navigate differing needs. The NBCCEDP invests in evidence-based interventions, for health care systems and communities, which reflect cultural competencies needed to reach populations that often distrust the medical system. Use of multicomponent interventions of this type are found to be more effective at connecting historically marginalized communities to services. However, the CDC and State health departments need more support.

Authorized at $275 million, the program is currently funded at approximately $200 million (after excluding funds allocated to the WISEWOMAN program). Unfortunately, at current funding levels the NBCCEDP serves on average only 15 percent of the estimated number of eligible women for breast cancer screening services and less than seven percent of eligible women for cervical cancer screening.

An increase in funding in FY24 is especially crucial as the Nation continues to recover from the COVID–19 pandemic and is starting to experience the effects of Medicaid unwinding. At the beginning of the pandemic, screenings declined by over 80 percent and National Cancer Institute (NCI) studies have estimated that pandemic-related disruptions or delays in care and screening are expected to result in an excess of 2,500 breast cancer deaths by 2030. Research suggests that those postponed breast screenings appeared to disproportionately affect women of color: Non-Hispanic white women had 17 percent fewer breast cancer diagnoses, while the year-over-year decline was 53 percent for Asian women, 43 percent for Hispanic women, and 27 percent for Black women. More recent studies have shown that the decline in screening rates persisted and that rates had not returned to normal even as late as February 2022. Exacerbating the problem, in April of this year States began disenrolling individuals from Medicaid coverage for the first time since the start of the COVID–19 public health emergency. The Department of Health and Human Services has estimated that as many as 15 million individuals could lose Medicaid coverage and many of those individuals would depend on access to the services provided by the NBCCEDP should they become uninsured or underinsured as a result. The NBCCEDP has a long road ahead of not only reaching new populations that may have become eligible due to these factors, but also retaining those who were already eligible but may not have returned yet for regular screening.

The availability of the NBCCEDP impacts every taxpayer and people in every congressional district, as the uninsured will eventually seek care at our States' hospitals with late-stage disease, putting an even greater strain on the patients, the health system and state budgets. Ensuring adequate NBCCEDP funding is key to ensuring that low-income, uninsured and underinsured women across the country continue to have access to vital screening services, health education and patient navigation services, as well as enabling proper monitoring of State and local breast cancer patterns and trends.

Early detection is a sound investment and the NBCCEDP has an over 30-year track record of proving this. An increased investment in the NBCCEDP will allow the CDC and its State and local partners to broaden their reach and pursue important goals such as implementing innovative strategies and new methods to find eligible women currently not using the program, including those with no source of care and lower incomes, education and health literacy levels, ultimately helping to create a more equitable health care system. Funding NBCCEDP at $230 million would allow the program to serve an additional 64,000 women a year, potentially detecting more than 610 breast cancers and 1,140 cervical cancers and precancerous lesions.

The NBCCEDP has bipartisan support with 17 Senators signing on to a letter in support of increasing program funding to $230 million and nearly 60 members of the House of Representatives signing on to a letter in support of full funding for the program in FY24. Increasing funding for NBCCEDP to at least $230 million in the FY24 Labor, HHS, Education Appropriations Bill will result in more women being screened, more cancers being diagnosed at earlier stages and ultimately better outcomes for women and lower costs for our health care system.

PREPARED STATEMENT OF THE LEARNING AND EDUCATION ACADEMIC RESEARCH NETWORK

On behalf of the LEARN Coalition, we urge support for increased funding for several key education research programs that the Senate Labor, Health and Human Services, Education and Related Agencies (LHHS) subcommittee will debate as part of the Fiscal Year (FY) 2024 appropriations process.

LEARN, a coalition of 41 leading research colleges of education across the country, supports critical investments in research aimed at advancing the scientific understanding of learning and development. We advocate for greater funding for these priorities across all Federal agencies, including the Institute of Education Sciences (IES), the National Institute of Child Health and Human Development (NICHD), and the National Institute of Mental Health (NIMH).

Specifically, LEARN is requesting no less than $900 million for IES overall with $291.9 million dedicated to the Research, Development and Dissemination (RD&D) line item and $71.6 million for the National Center for Special Education Research (NCSER). Within the National Institutes of Health (NIH), LEARN requests that $1.87 billion go towards NICHD and $2.54 billion go towards NIMH. While advocating for these increased resources for FY2024, we are deeply appreciative of the funding that IES and its programs and NICHD and NIMH received as a part of the FY2023 appropriations process.

Overall Spending Allocation for the LHHS Subcommittee

In addition to urging the subcommittee to make key education research investments in FY 2024, LEARN wants to stress the importance of the LHHS subcommittee receiving a sufficient allocation (or "302(b)") that allows the subcommittee to robustly fund the programs and agencies within its jurisdiction. Should Congress seek to return to annual discretionary spending caps it is critical that such caps separately account for defense and non-defense discretionary spending. Whether through such caps or the more traditional subcommittee allocations, we urge that the LHHS subcommittee have the budget authority necessary to be able to make investments across its jurisdiction that improve the education, health and working conditions in our Nation.

Institute of Education Sciences

As the primary Federal agency charged with supporting research for education practice and policy, IES is essential to developing a comprehensive, reliable, evidence base and ensuring that teaching and learning practices are grounded in this evidence base. While 12–15 percent of NCER and NCSER's grant awards have been funded over the last several years, the number of grant competitions offered by IES are currently severely limited due to insufficient funding and chronic understaffing within the agency. In 2021 and 2022, NCSER was unable to fund all the grant applications rated outstanding or excellent due to a lack of sufficient funds. In addition, IES announced last spring that the Institute would not be issuing three of their grant competitions, including the main Education Research Grants competition due to a lack of funding. If grant competitions are not held that means that research cannot be conducted to further our knowledge base to improve and strengthen our country's education system—principals, teachers and most importantly students lose out.

Education research provides the bedrock of knowledge used by educators to help preK–12 students and those seeking a postsecondary education succeed. Increases provided to IES in FY 2024 are critical to support the continued examination of what works and what does not work to further our education system's curricula, instructional techniques and assessments. This additional funding will bolster IES' work in relation to education research overall as well as provide support as the Nation continues to help students make up for lost learning time due to COVID–19. Given the importance of developing reliable evidence during this critical time, LEARN is requesting $900 million for IES overall and $291.9 million for the RD&D line item within IES.

Equally important to funding for RD&D is an increase in appropriations for research in special education to $71.6 million. IES funds special education research through NCSER which is the only Federal agency specifically designated to develop and provide evaluations for programs for students with disabilities. NCSER's budget, despite increases in the past few years, is still under its overall level of spending in FY2011. Research funded by NCSER provides special educators and administrators evidence-based resources that improve academic outcomes for children with or at risk of disabilities. Special education students were one of several populations of students that were dramatically impacted by the change in schooling due to

COVID–19. Additional funding for NCSER is necessary to support data and evidence-based resources that will ensure a strong recovery for these students.

While LEARN is a consistent advocate for funding for IES, other prominent experts have also expressed concern over the relatively small amount of funding being provided to IES compared to other Federal research agencies. In a 2022 National Academy of Sciences, Engineering and Medicine (NASEM) report titled "The Future of Education Research at IES," a diverse panel of 17 experts in the field stated that Congress should re-examine the IES budget as it is currently severely underfunded despite the continuously expanding work of IES. After hours of research and discussion, the panel recognized that IES funding "does not appear to be on par with that of other scientific funding agencies," such as NIH or the National Science Foundation. LEARN urges the subcommittee to carefully evaluate this call for additional appropriations from this trusted body.

NICHD and NIMH

There are also critical education research programs within NIH that need additional support if we are to expand evidence-based knowledge in education. Specifically, we believe two NIH programs—NICHD and NIMH—require strong Federal funding in FY2024. Both programs provide critical funding to investigate the science behind learning and development, particularly for vulnerable student groups. For NICHD, LEARN supports an increase in funding to $1.87 billion. This increase will ensure that researchers can build on the knowledge already gained, evaluate what works best in treating developmental disorders and develop new research-based strategies to improve students' learning and development. Additionally, this level of funding will support NICHD's efforts to understand the long-term effects of COVID–19 on key at-risk populations, including the cognitive development of children and adolescents.

LEARN also supports an increase in funding for NIMH to $2.54 billion. This increase will help further understanding of the behavioral, biological and environmental mechanisms necessary for developing interventions to reduce the burden of mental and behavioral disorders and optimize learning and development. At a time when the mental health impact to children and adolescents remains dire following the COVID–19 pandemic, this research is needed more now than ever.

The LEARN Coalition believes that collectively these key investments in education research will drive improvements in schools, teacher and student performance in the coming years, strengthen the Nation's education infrastructure and ensure a strong, educated workforce in the long run. Thank you for considering these requests.

PREPARED STATEMENT OF LILLIE LEE

I grew up in a single-parent household as the oldest of five children. The circumstances at home required me to become a parental figure to my siblings and care for them at a young age. My mother worked hard to provide for us and, for 50 years, has been a materials handler. I witnessed my mother carry the responsibilities of two people by herself. My parents had separated, so my siblings and I had limited extended family support.

As a teacher now, I can't imagine how many parent-teacher conferences my mom attended in one night and Individualized Education Plan (IEP) meetings she had to participate in. My mom was the only reliable adult I had trusted and known, but she could not support me academically.

I always recall one stressful night when I was in fourth grade. I sat at my kitchen table, clenching my pencil tightly, frustrated with four specific division and multiplication problems from the homework assignment. My mom stopped her kitchen tasks and attempted to help and guide me to solve them. Unfortunately, I later discovered our answers were all wrong. My teacher circled each in red ink. I knew then that I needed to look beyond my immediate family for help in my pursuit of education.

I would not have attended my university if TRIO did not exist and if a neighbor had not pushed me into the TRIO office. I was an indecisive soon-to-be high school graduate nearing the end of college application season. My mom could not accompany me on most college campus tours, so my neighbor went with me to tour Marian. She advocated for me to attend a 4-year college. TRIO Student Support Services (SSS) was not a planned pit stop, as it took much work to find the office. However, my neighbor, who was as nosy as she was, pushed the campus tour guide and me into the office to learn more.

TRIO saw my potential and helped guide me through higher education. TRIO taught me invaluable academic, financial, and professional skills.

With TRIO, I was able to have many "firsts." I had my first intimidating experience learning about finances and how to apply for grants and scholarships. Because of the TRIO staff's support, I was the first in my family to receive the Pell Grant and the Educational Opportunity Association's Phyllis Gray Scholarship. I was the first in my family to select courses, handle a college schedule of classes, navigate software to locate assignments and attend a professor's office hours. I created my first resume and cover letters and learned skills to prepare for interviews.

With TRIO, I gained first-hand experience in becoming a leader through campus leadership opportunities. I wanted to help others and had ideas for the TRIO Peer Leader program. As a Peer Leader, I learned more about my leadership style. A TRIO advocate encouraged me to participate in the Model United Nations, and I had my first experience attending a collegiate Model United Nations conference in New York. TRIO SSS staff were my biggest cheerleaders.

I will soon finish my second year as an Emotional Behavior Disorder (EBD) Special Education Teacher and plan to continue my journey in Special Education as an Autism teacher. I will soon complete my first year as a Culturally Linguistic Responsive (CLR) lead champion providing insight into the mindset, culture, bias, responsiveness, and linguistic strategies in the world of education, and I plan to further my studies in education.

TRIO is more than just a program. It is also the passion of advocates who are student-centered and have built my first experience of a community. They had witnessed me have my "first-hand experiences" as a first-generation student. They had seen me cry, laugh, struggle, and soar. I have grown so much: financially and academically, and with skills to set up for success in a great career.

Through the TRIO program, I developed to know the advocates that allowed me space to speak to others about what students needed. Through TRIO, I learned what advocacy is, to become an advocate for others who endured the same struggles and obstacles as I, and to listen to the voices and narratives of first-generation students. I am honored to have had them witness my growth during the 4 years of my collegiate career and beyond.

PREPARED STATEMENT OF THE LYMPHATIC EDUCATION & RESEARCH NETWORK

KEY RECOMMENDATIONS

(1) Continue to support the National Commission on Lymphatic Disease Research at the NIH to identify emerging opportunities, challenges, gaps, structural changes, and recommendations on lymphatic disease research.

(2) Provide the National Institutes of Health (NIH) with $50 billion for FY 2024 and advance lymphatic disease research by expanding resources and encouraging better coordination among relevant institutes and centers.

(3) Provide the Centers for Disease Control and Prevention (CDC) with $11 billion for FY 2024 and enable $6 million for the Chronic Disease Education and Awareness Program.

Chairwoman Baldwin and Ranking Member Capito, thank you for the opportunity to submit the priorities of the lymphatic diseases community you as you consider FY 2024 appropriations for the National Institutes of Health (NIH) and the Centers for Disease Control and Prevention (CDC).

ABOUT LE&RN

The Lymphatic Education & Research Network (LE&RN) is an internationally recognized non-profit organization founded in 1998 to fight lymphatic diseases through education, research, and advocacy. These include lymphedema, lipedema, lymphatic anomalies, and the continuum of lymphatic diseases. With chapters throughout the world, LE&RN seeks to accelerate the prevention, treatment and cure of these diseases while bringing patients and medical professionals together to address the unmet needs surrounding lymphatic diseases, which include lymphedema and lipedema.

ABOUT LYMPHEDEMA AND LYMPHATIC DISEASES

The lymphatic system is a circulatory system that is critical to immune function and good health. When it is compromised and lymph flow is restricted, the physical impact to patients can be devastating, life altering, and can lead to shortened lifespan. Lymphedema (LE) is one such lymphatic disease. LE is a chronic, debilitating, and incurable swelling that can be a result of cancer treatment, inherited or genetic causes, and damage to the lymphatic system from surgery or an accident, or from parasites as in lymphatic filariasis. Stanford University estimates that up to 10 million Americans have lymphedema. This represents more Americans than those living with AIDS, Multiple Sclerosis, Parkinson's disease, Muscular Dystrophy and ALS—combined. The World Health Organization puts the global number of people with this disease at 250 million. There is no cure. There is no approved drug therapy. And there are currently only three drug studies worldwide seeking a treatment. Psychosocially bruised by a disease that leaves us deformed, we do our best to hide our lymphedema. We are currently isolated and alone.

Lymphedema is an equal opportunity disease, affecting women, men and children alike. Many are born with congenital or hereditary lymphedema. Others, like our veterans, get the disease because of physical trauma, bacterial infection, or as result of exposure to burn pits. Lymphedema is an ignored disease. A study concluded that physicians are currently getting an average of only 15–30 minutes of study on the lymphatic system in their entire medical training. This leaves them ill-prepared to diagnose the disease. Misdiagnosis leads to improper treatment. Those who are diagnosed find it difficult to find certified lymphedema therapists. Few medical centers exist that are prepared to address lymphatic diseases. Surgeons are experimenting with treatment that could alter the course of the disease. However, the necessary basic research is not being done to inform their procedures. And currently, Medicare and Medicaid do not cover some of the basic treatment needs of these patients—such as compression garments, which must be worn daily by patients.

FISCAL YEAR 2024 APPROPRIATIONS RECOMMENDATIONS

We have been hopeful with recent advancements, but more needs to be done. We ask that within 20 years, we will make lymphedema and other lymphatic diseases truly treatable. To reach this goal will require a commitment to important medical research. LE&RN joins the broader medical research community in thanking Congress for continuing to provide the National Institutes of Health with proportional and sustainable funding increases over the past several fiscal years, and we ask you all to continue to prioritize these activities by providing at least a $50 billion for NIH in FY 2024.

We continue to urge the subcommittee to work to expand and advance the lymphatic disease portfolio at the NIH. In late 2015, the NIH hosted a Lymphatic Symposium, where experts in the field identified a scientific roadmap that could build the research portfolio up to a level of at least $70 million annually over subsequent years by funding meritorious grants on critical topics. To further support and enhance emerging lymphedema and lymphatic disease research activities, we ask the subcommittee to continue encouraging further collaboration among relevant institutes and centers conducting research in this area. We are grateful to the subcommittee for continuing to support the establishment of a National Commission on Lymphatic Disease Research, which can thoroughly examine the portfolio and make recommendations on how best to advance this emerging scientific area under NIH's current structure. We ask that you continue to impress on NIH the critical need for this Commission and how they can work with relevant stakeholders such as ourselves. Currently, the National Institutes of Health spends approximately $25 million annually on lymphatic research, and only $5 million of this is dedicated to clinical lymphedema research. Experts state with confidence that there is no other disease affecting more Americans that receives so little attention. It must also be noted that study of the lymphatic system is poised to bring miracles for a host of diseases that are part of the lymphatic continuum: obesity, heart disease, diabetes, Rheumatoid arthritis, cancer metastasis, AIDS, Crohn's disease, lipedema, and a host of other diseases. Recent research discovered lymphatics surrounding the brain, which now has us studying its impact on Alzheimer's disease and multiple sclerosis. We appreciate the subcommittee's continued support for the establishment of a National Commission on Lymphatic Diseases and ask that NIH be held accountable for the lack of progress on its establishment. We appreciate some steps that NIH is taking to address the subcommittee's and our concerns about the National Commission, but we still are not at the point where the Commission is set to begin key work. While we remain hopeful that our continued work with NIH will continue to pay off, strong support from Congress remains essential for our success.

LE&RN also joins the public health community in asking Congress to provide the Centers for Disease Control and Prevention (CDC) with $11 billion through FY 2024 and to increase funding to increase awareness, education, and surveillance of lymphatic diseases. We encourage the subcommittee to support $6 million for the Chronic Disease Education and Awareness Program in FY 2024 which will allow CDC to work with stakeholder organizations to expand important initiatives on chronic diseases such as lymphedema and lymphatic diseases. Formal study of the lymphatic system and of lymphatic diseases is virtually nonexistent in the current curricula of U.S. medical schools, and misinformation routinely leads to misdiagnosis and under-treatment. This delay and misdirection of treatment results in irreparable physical and psychosocial harm to patients suffering from these already debilitating diseases. CDC can help to address this lack of public and provider awareness.

Thank you for the opportunity to testify before you today. LE&RN looks forward to working with you all to advance medical research and public health activities that will improve patient outcomes for the members of our community suffering from these debilitating diseases.

[This statement was submitted by William Repicci, President and CEO, Lymphatic Education & Research Network.]

PREPARED STATEMENT OF MARCH OF DIMES

PROGRAM	FISCAL YEAR 2024 REQUEST
National Institutes of Health (total)	$50,924,000,000
National Institute of Child Health and Development	$1,877,000,000
National Institute of Environmental Health Sciences	$980,700,000
National Children's Study Alternative (ECHO)	$180,000,000
Centers for Disease Control and Prevention (total)	$11,581,000,000
National Center for Birth Defects and Developmental Disabilities	$223,000,000
Emerging Threats to Moms and Babies	$100,000,000
Section 317 Immunization Program	$11,300,000,000
Newborn Screening Quality Assurance Program	$29,000,000
Polio Eradication	$276,000,000
Division of Reproductive Health	$90,081,000
Safe Motherhood Initiative	$164,000,000
Preterm Birth	$2,100,000
Perinatal Quality Collaboratives	Funded under Safe Motherhood
Maternal Mortality Review Committees	Funded under Safe Motherhood
Office on Smoking and Health	$310,000,000
National Center for Health Statistics	$215,000,000
Health Resources and Services Administration (total)	$10,500,000,000
Title V Maternal and Child Health Block Grant	$1,000,000,000
Heritable Disorders	$29,883,000
Healthy Start	$200,000,000
Grants for Maternal Depression Screening and Treatment	$24,000,000
Maternal Mental Health Hotline	$10,000,000
Title X Family Planning Program	$512,000,000
Office of the Secretary Health - Teen Pregnancy Prevention	$150,000,000
Agency for Healthcare Research and Quality (total)	$500,000,000

March of Dimes, the Nation's leading non-profit organization fighting for the health for all moms and babies, appreciates this opportunity to submit testimony for the record on fiscal year (FY) 2024 appropriations for the Department of Health and Human Services (HHS). March of Dimes leads the fight for the health of all mothers and infants through our research, community services, education, and advocacy.

Our organization strongly supports President Biden's ongoing and demonstrated commitment to maternal health in his HHS budget proposal for FY 2024, which includes strong increases for critical programs supporting families, and we recommend the following funding levels for programs and initiatives that are essential investments in maternal and child health.

EUNICE KENNEDY SHRIVER NATIONAL INSTITUTE OF CHILD HEALTH AND HUMAN DEVELOPMENT (NICHD)

March of Dimes recommends that Congress provide $1.877 billion for NICHD's groundbreaking biomedical research activities in FY 2024, which represents a $128 million increase over FY 2023. Increased funding will allow NICHD to sustain vital research on preterm birth, maternal mortality, maternal substance use, prenatal substance exposure and related issues through extramural grants, Maternal-Fetal Medicine Units, the Neonatal Research Network and the intramural research program.

Additionally, now that the Task Force on Research Specific to Pregnant and Lactating Women (PRGLAC) has laid the foundation for addressing research on safe and effective therapies for pregnant and lactating women in clinical trials by releasing recommendations in September 2018, as mandated by Congress in the 21st Century Cures Act (Public Law 114–255), and provided an additional implementation plan increased funding will allow for NICHD to more closely look at ways to include and integrate pregnant and lactating women in clinical trials. NICHD funding also supports research to address gaps in our understanding of the best way to treat mothers with opioid use disorder and the long-term impact of opioid exposure in utero. We support the inclusion of this dedicated funding to address the Nation's preterm birth crisis.

SURVEILLANCE FOR EMERGING THREATS TO MOTHERS AND BABIES INITIATIVE

March of Dimes recommends funding the Surveillance for Emerging Threats to Mothers and Babies Initiative Program (known as SET–NET) within the National Center for Birth Defects and Developmental Disabilities at Centers for Disease Control and Prevention (CDC) at $100 million, which is a $77 million increase over FY 2023. SET–NET was created during the Zika outbreak, which allowed CDC to create, a unique nationwide mother-baby linked surveillance network to monitor the virus' impact in real-time to inform clinical guidance, educate health care providers and the community, and connect families to care. Unfortunately, States were unable to sustain systems due to the program being chronically underfunded, and we were left without a national system to mobilize when COVID–19 struck.

Consequently, we have an incomplete picture on how to best care for mothers and babies with confirmed or suspected virus infection as the CDC currently only supports 29 State, local, and territorial health departments.

The increased funding will allow for CDC to address these knowledge gaps and expand the initiative to provide real-time clinical and survey data from all 50 States, territories and jurisdictions on the impact of COVID–19 and new public health threats.

SAFE MOTHERHOOD INITIATIVE

March of Dimes requests $164 million for the Safe Motherhood Initiative in FY 2024, an increase of $56 million over FY 2023. The increase in funding will assist in dedicating more resources towards Perinatal Quality Collaboratives (PQCs) and Maternal Mortality Review Committees (MMRCs).

PQCs are state or multistate networks working to improve the quality of obstetric care and improve outcomes. Currently, CDC funds over 25 State-based PQCs that are implementing recommendations across health facility networks. However, many PQCs lack adequate resources to meet demands and reach their maximum potential. Therefore, additional funding will help scale this initiative up nationwide.

Under the Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM) Program, CDC provides funding, technical assistance, and guidance to MMRCs. However, more standardized data collection is needed to help examine all the factors contributing to severe maternal mortality, preventable deaths, and poor birth outcomes. Additional funding will help reach all 50 States, DC, and Puerto Rico and Tribes with enhanced technical assistance to maximize MMRCs.

SECTION 317 IMMUNIZATION PROGRAM

For FY 2024, March of Dimes requests $1.13 billion for the Section 317 Immunization Program, which would be an increase of $448 million over FY 2023. This pro-

gram provides grants to States to support immunization efforts for underserved populations, including for adults who have no other means to pay for vaccinations. In the coming years, the U.S. can anticipate further outbreaks of new strains of COVID–19 and flu, as well as possibly measles. Therefore, a decline in vaccination coverage could compromise herd immunity and intensify outbreaks. It is critical to ensure that both adults and children have access to routine immunizations.

Increased funding for this program will fill gaps in coverage and provide long-term support, especially as the COVID–19 Public Health Emergency ends in May 2023.

NEWBORN SCREENING

Both the Newborn Screening Quality Assurance Program at CDC and the Heritable Disorders program at Health Resources and Services Administration's (HRSA) have significantly improved the quality of newborn screening programs throughout the country. NSQAP works hand-in-hand with state laboratories by performing quality testing for more than 500 laboratories to ensure the accuracy of newborn screening tests. The Heritable Disorders program assists States to improve and expand their newborn screening programs and supports the work of the Advisory Committee on Heritable Disorders in Newborns and Children (ACHDNC), which provides recommendations to the HHS Secretary for conditions to be included in the Recommended Uniform Screening Panel (RUSP).

To continue sustaining, improving, and enhancing these programs, March of Dimes urges funding of $29 million for NSQAP and $29.883 million for the Heritable Disorders program for FY 24. This would be an increase of $7 million for NSQAP and $9 million for Heritable Disorders.

GRANTS FOR MATERNAL DEPRESSION SCREENING AND TREATMENT

One in five women are affected by anxiety, depression, and other maternal mental health (MMH) conditions during pregnancy or the year following pregnancy. These illnesses are the most common complication of pregnancy and childbirth, impacting 800,000 women in the United States each year.

At the current funding level, only seven States have received grants to provide real-time psychiatric consultation, care coordination, and training for front-line providers to better screen, assess, refer and treat pregnant and postpartum women for depression and other behavioral health conditions. March of Dimes requests $24 million (increase of $14 million) in FY 2024 to add five programs and provide technical assistance to non-grantee States. This funding level matches the amount authorized through FY 28 in the Into the Light for Maternal Mental Health and Substance Use Disorders Act, which became law in 2022.[1]

MATERNAL MENTAL HEALTH HOTLINE

March of Dimes requests $10 million in FY 2024 to the new maternal mental health hotline at HRSA. This would be a $3 million increase over FY 2023 and matches the amount authorized through FY 28 in the Into the Light for Maternal Mental Health and Substance Use Disorders Act, which became law in 2022.[2] This funding will allow qualified counselors to staff a hotline 24 hours a day and conduct outreach efforts on maternal mental health issues. COVID–19 has exacerbated maternal mental health conditions at three to four times the rate prior to the pandemic and leaving these conditions untreated can have long-term effects. We urge you to please support this request to allow for the hotline to provide text messaging services, culturally-appropriate support, and continue public awareness efforts.

CONCLUSION

March of Dimes looks forward to working with you and all Members of Congress to secure the resources needed to improve our Nation's health. Federal public health programs are essential to preventing preterm birth, ending preventable maternal deaths, and addressing the maternal mental health issues that impacts mothers, infants, and families.

[1] https://www.congress.gov/117/bills/hr2617/BILLS-117hr2617enr.pdf.
[2] https://www.congress.gov/117/bills/hr2617/BILLS-117hr2617enr.pdf.

PREPARED STATEMENT OF MARYLAND PHILANTHROPY NETWORK

We strongly urge the subcommittee to support Senator Reed and Senator Whitehouse's FY24 program requests for $4 million to enable the Bureau of Labor Statistics to include nonprofit organizations as a distinct category of employer in its Quarterly Census of Employment and Wages and related reports.

The challenge:

The nonprofit sector represents more than 10% of the Nation's private workforce. Currently, they are required to either purchase relevant nonprofit employment and wage data or wait 5 years for the BLS data release. The lack of timely and accurate data threatens the health and wellbeing of tens of millions of people who rely on nonprofits for services. The absence of this information means policymakers must guess at the potential impact of legislative and regulatory proposals, or risk overlooking nonprofits entirely. The mission of the BLS includes a duty to "measure labor market activity, working conditions, price changes, and productivity in the U.S. economy to support public and private decision making." While BLS staff have made important efforts, a great disparity in available data prevails. The work required to release nonprofit and employment wage data will cost approximately $4 million annually, but it was not included in the recently released BLS FY24 budget.

The solution:

Nonprofit Employment and Wage Data

The program request submitted by Senator Reed and Senator Whitehouse provides an additional $4 million to the Bureau of Labor Statistics' Office of Employment and Unemployment Statistics for the purpose of incorporating nonprofit data into the Quarterly Census of Employment and Wages.

The Bureau of Labor Statistics (BLS), through its Quarterly Census of Employment and Wages (QCEW) program, publishes quarterly information that covers more than 95% of U.S. jobs. These reports provide granular data for a wide array of industries and jobs, which public officials and industry leaders use to make economic, financial and policy decisions. However, while BLS publishes this data for a wide range of sectors, it has not provided quarterly data for the nonprofit sector. Nonprofit sector data has instead been released only every 5 years, which means that public officials and nonprofit employers are forced to make decisions about the provision of essential services, organizational strategy, and workforce projections, without timely or accurate data. Nonprofit organizations employ approximately 10% of the private workforce in the United States. The lack of timely, comprehensive workforce and wage data for the nonprofit sector severely hampers economic development and the provision of essential services on the local, State and national level. Therefore, an additional $4 million shall be allocated to the Bureau of Labor Statistics' Office of Employment and Unemployment Statistics, and that Office shall work with other relevant Federal agencies as needed to incorporate nonprofit data into the Quarterly Census of Employment and Wages, as well as other relevant data products and reports produced by BLS.

Maryland Philanthropy Network (MPN) is making this request in collaboration with other philanthropy-serving organizations across the country and in support of a national effort led by Independent Sector, National Council of Nonprofits, and The Aspen Institute to include the nonprofit sector more intentionally in Federal decision-making. Maryland Nonprofits, the member organization for the community of nonprofits in our state is an additional partner in support of this ask.

MPN represents more than 110 private, family, corporate, and community foundations in our state. These foundations steward $9 billion in charitable assets of which approximately $1.5 Billion is directed to benefit citizens of Maryland. The QCEW data is critical to these funds being deployed intentionally and effectively. We look forward to however we may be able to partner with your office to see this through.

In partnership,

Kevin McHugh
Interim President and CEO

We are joined on this letter by our statewide partner:

Heather Iliff
President & CEO
Maryland Nonprofits

[This statement was submitted by Kevin McHugh, Interim President and CEO, Maryland Philanthropy Network.]

PREPARED STATEMENT OF MEALS ON WHEELS AMERICA

Dear Chair Baldwin, Ranking Member Moore Capito, and Members of the subcommittee:

Thank you for the opportunity to submit testimony concerning Fiscal Year 2024 (FY24) appropriations for the Older Americans Act (OAA) Nutrition Program, administered by the Department of Health and Human Services' (HHS) Administration for Community Living (ACL). To ensure the health and safety of older Americans and the sustainability of the Nationwide network of community-based senior nutrition providers who serve them, we are calling for a minimum of $1,284,385,000 for the OAA Nutrition Program to be included in the final FY24 Labor, Health and Human Services, Education, and Related Agencies (Labor-HHS-Ed) Appropriations bill.

The OAA Nutrition Program consists of Congregate Nutrition Services (Title III C–1), Home-Delivered Nutrition Services (Title III C–2) and the Nutrition Services Incentive Program (NSIP, Title III). Within the total funding requested, we urge the greatest proportional increase be allocated to Home-Delivered Nutrition Services. While there is an important and steady return to congregate dining following the COVID–19 pandemic, there remains a greater demand for Home-Delivered Nutrition Services for a variety of reasons, including shifting demographics and effective program innovations such as grab-and-go meals that meet the needs of older adults at greatest risk of hunger and isolation. The specific line-item requests are:

—Congregate Nutrition Services (Title III–C–1)—$616,513,000

—Home-Delivered Nutrition Services (Title III–C–2)—$507,803,000

—Nutrition Services Incentive Program (NSIP) (Title III)—$160,069,000

Overseen by ACL's Administration on Aging and implemented at the local level through thousands of community-based providers for over 50 years, the OAA Nutrition Program is designed to reduce hunger, food insecurity and malnutrition, and promote socialization and the overall health and well-being of older adults. Local programs successfully achieve these goals through delivery of nutritious meals, social connection and safety checks to individuals 60 and older. The OAA Nutrition Program has a long history of bicameral, bipartisan support and is one of the best examples of a public-private partnership, leveraging multiple funding sources and volunteers to collectively deliver more than 247 million meals to 2.8 million seniors annually.[1] As our Nation must address the healthcare and service needs of our aging population, the significance and effectiveness of the OAA Nutrition Program as a solution is irrefutable. For example, we can serve a senior participant in a Meals on Wheels program for an entire year for roughly the same cost as a day in the hospital or 10 days in a nursing home.[2]

Increased funding for the program is essential to ensure that senior nutrition programs can meet the pressing need for direct services in their communities. Any cuts to the program would be disastrous, causing eligible older adults who rely on these services as a lifeline-and do not have alternative sources of food-to lose access to their means of daily nutrition. That directly risks the health and well-being of seniors across the county. Hunger among older adults is an urgent issue. In 2021, 10 million (13%) older adults 60+ were threatened by or experienced hunger. In 2021, 7.6 million (9.8%) seniors experienced low or very low food security. Nationwide, the fraction of seniors experiencing very low food security increased nearly 90% between 2001 and 2021.[3] It has also been estimated that almost half of all older adults may be at risk of becoming, or are already, malnourished.[4] Today, millions of older adults are forced to make difficult choices about the foods they eat due to financial strain and/or may forgo eating altogether to be able to afford paying for other necessities, such as utilities, rent and/or medication. For most receiving Meals on Wheels, the meals often make up half or more of their total daily food intake.

Older adults who are food insecure and lack consistent access to nutritious meals experience worse health outcomes and are at increased risk of heart disease, depression, diabetes and declines in cognitive function and mobility compared to those who

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[1] Administration for Community Living (ACL), 2022, Older Americans Act Title III Programs: 2020 Program Results, report available at https://acl.gov/news-and-events/announcements/acl-releases-older-americans-act-program-highlights.

[2] Meals on Wheels America, 2023, National Snapshot What We Deliver Fact Sheet, available at https://www.mealsonwheelsamerica.org/learn-more/facts-resources.

[3] Ziliak and Gundersen, 2023, The State of Senior Hunger in America in 2021: An Annual Report, report prepared for Feeding America, available at https://www.feedingamerica.org/research/state-senior-hunger.

[4] Kaiser et al., 2010, "Frequency of malnutrition in older adults: a multinational perspective using the mini nutritional assessment", Journal of the American Geriatrics Society 58(9):1734–8, abstract available at https://pubmed.ncbi.nlm.nih.gov/20863332/.

are food secure.[5] Most older Americans possess at least one factor that puts them at greater risk of food insecurity, malnutrition, social isolation and/or loneliness, which can have grave and costly impacts on their health and our health system. The individuals who rely on senior nutrition services are generally facing even greater risk for threats to their health and independence, including having multiple chronic conditions, taking three or more medications daily and experiencing functional impairment. The management of chronic conditions alone includes screenings, check-ups, monitoring and coordination of treatment and patient education with a provider. This translates to increased Federal spending on programs like Medicare, which expended nearly half (48%) of its revenue on physician services and other Part B benefits in 2021.[6]

Further, older adults commonly experience a variety of life circumstances that put them at elevated risk of social isolation and loneliness, such as retirement from work, living alone and/or losing a spouse or loved one. Nationally, 24% of older adults are socially isolated and 43% feel lonely. Social isolation and loneliness also have serious health impacts and are associated with higher risk of cardiovascular disease, diabetes, cognitive decline and premature death.[7] Additionally, lack of social connection is related to significant economic costs, accounting for an estimated $6.7 billion in excess Medicare spending annually.[8] For Meals on Wheels recipients, who are more than twice as likely to live alone than other older adults, the visit from the volunteer or staff member delivering their meal may be the only person they see that day or even that week.

OAA services simultaneously address the issues of senior hunger, isolation and malnutrition. Services are statutorily targeted toward seniors with the greatest social and economic need, including those who are low-income; are a racial or ethnic minority; live in a rural community; have limited English proficiency; and/or are at risk of institutional care. The impact these services have on seniors' lives is powerful, and older adults who receive them have better health, as a result. Of home-delivered participants, 92% report the meals help them live independently and 77% percent say the meals help improve their health. Most seniors receiving OAA nutrition services consistently report that participating in the program helps them feel more secure, prevents repeated falls or lessens the fear of falling and allows them to stay in their own home.[9] Meaningful social connection is an inherent component of the Meal on Wheels service model, addressing the negative effects of social isolation, and having regular visits from a staff member or volunteer puts 'eyes and ears' in the home, providing environmental safety checks and established approaches for addressing identified hazards, fall risks and home repair needs. As articulated in the Surgeon General's recent Advisory on loneliness and isolation, social connection has positive impacts on longevity and better health, and Meals on Wheels programs are an essential part of providing this support to older Americans.[7]

Senior nutrition programs also help avoid preventable emergency room visits, hospital admissions and readmissions, extended stays in rehab and premature institutionalization—ultimately reducing overall healthcare costs. A rigorously designed study from 2015 found that older adults receiving home-delivered meals experienced statistically significant improvements in health compared to their counterparts who did not receive services. Between baseline and follow up, the group of older adults who received home-delivered meals and safety checks were more likely to have improved physical and mental health, including reduced feelings of anxiety and loneliness, and fewer hospital admissions and falls—a major contributor to preventable hospitalizations and healthcare spending among older adults.[10]

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[5] Ziliak and Gunderson, 2021, The Health Consequences of Senior Hunger in the United States: Evidence from the 1999–2016 NHANES, report prepared for Feeding America, available at www.feedingamerica.org/research/senior-hunger-research/senior.

[6] Cubanski and Neuman, 2023, What to Know about Medicare Spending and Financing, available at https://www.kff.org/medicare/issue-brief/what-to-know-about-medicare-spending-and-financing/#:~:text=Spending%20on%20Part%20B%20services,(48%25%20in%202021).

[7] National Library of Medicine, 2020, Social Isolation and Loneliness in Older Adults: Opportunities for the Health Care System, available at https://www.ncbi.nlm.nih.gov/books/NBK557972.

[8] Office of the U.S. Surgeon General, 2023, Our Epidemic of Loneliness and Isolation: The U.S. Surgeon General's Advisory on the Healing Effects of Social Connection and Community, available at https://www.hhs.gov/surgeongeneral/priorities/connection/index.html.

[9] Administration for Community Living (ACL), 2022, National Survey of OAA Participants, available on ACL's AGID National OAA Participants Survey Frequency Tables, available at https://agid.acl.gov/.

[10] Meals on Wheels America, 2015, More Than a Meal Pilot Research Study, report prepared by Thomas & Dosa, available at https://www.mealsonwheelsamerica.org/learn-more/research/more-than-a-meal/pilot-research-study.

Congregate and home-delivered meal programs are highly trusted and sought out for the nutrition and social connections they offer. Despite the emergency resources from Congress and incredible efforts from the OAA network to quickly scale services in response to the COVID–19 pandemic, the rising need has not abated and challenges in addressing persistent demand remain. Surveys of Meals on Wheels America membership found that 97% of programs report there are older individuals in their communities who need meals who they are not currently serving and about 63% of programs reported that the major limitation to serving meals to all the seniors in their community who needed them was funding to pay for the meals.[11,12]

Many programs are taking drastic steps to sustain themselves due to funding challenges, such as cutting back or discontinuing services altogether. Further, nearly all senior nutrition programs are facing at least one significant barrier to providing home-delivered meals to seniors in need, such as rising food costs, fluctuating gas prices, labor and volunteer shortages and continuing supply chain issues.[12] The gap between those struggling with hunger and those receiving nutritious meals through the OAA will continue to widen across the country if funding continues to fall short of need.

We understand the difficult decisions you face with respect to annual appropriations bills and other budgetary challenges. However, the risks and benefits of healthy aging cannot be underestimated. The OAA Nutrition Program should not just be held harmless in appropriations negotiations but should receive greater investments. The services provided can be the difference between life and death and offer the chance to not only help millions of older adults and their families but to also provide substantial economic relief to our healthcare system. As the subcommittee develops its FY24 Labor-HHS-Ed appropriations bill, we urge you to include $1.284 billion for the OAA Nutrition Program, so that local community-based senior nutrition programs can ensure the health, safety and social connectedness of older adults in your States and across the country. Thank you for your leadership, past support and consideration amid this appropriations cycle. We look forward to working together to ensure that no older adult in America is left behind, hungry and isolated.

[This statement was submitted by Ellie Hollander, President and CEO, Meals on Wheels America.]

PREPARED STATEMENT OF MENTOR

On behalf of MENTOR, our network of Affiliates, and youth mentoring programs across the country, I thank Chair Baldwin and Ranking Member Moore Capito for the opportunity to provide testimony in support of critical Federal investments for America's young people. I write this on behalf of the thousands of mentoring programs and millions of volunteer adult mentors that serve our communities each day, as well as the millions of young people in the United States still waiting to find the supportive relationships they need to thrive—including an average of 63 per program on wait lists. Specifically, we advocate for Federal programs that promote mentoring and positive youth development in the Departments of Education, Labor, and Health and Human Services, including the Full-Service Community Schools program, the 21st Century Community Learning Centers program, Student Success and Academic Enrichment Grants, Supporting Effective Instruction State Grants, Title I WIOA Youth Programs, and Project AWARE.

MENTOR is the unifying national champion for expanding quality youth mentoring relationships and connecting volunteers to mentoring opportunities. At a time when 1 in 3 young people are growing up without a mentor—a data point that has grown in recent years among our country's youngest generation—MENTOR seeks to close this "mentoring gap" and ensure that all young people have support they need to succeed, everywhere they are. We seek to leverage resources and provide the tools and expertise that programs require to provide high-quality mentoring for young people who need it most, build greater awareness of the value of mentors, and positively inform public policy in order to bring opportunity to young people in need.

Quality mentoring through structured programs or through relationships that form naturally with teachers, coaches, faith leaders, and other caring adults can

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[11] Meals on Wheels America, 2021, 2021 Member Perspectives and Practices Survey, conducted by Trailblazer Research, available at https://www.mealsonwheelsamerica.org/learn-more/research/member-perspectives-practices-survey.

[12] Meals on Wheels America, 2022, Fall 2022 Member Pulse Survey, available at www.mealsonwheelsamerica.org/learn-more/research/covid-19-research-portfolio.

have a profound positive impact on educational success, healthy development, and overall wellbeing. It is an innovative, evidence-based practice that is one of few prevention and intervention tactics with the potential to support young people of all demographics and backgrounds in all aspects of their lives. We believe that this critical time in our Nation's history requires an approach that considers the inextricable linkage between a young person's academic achievement, mental, social, and physical health. In order for us to meet this moment, Federal investment into evidence-based programs that support positive youth development is required.

THE BENEFITS OF QUALITY YOUTH MENTORING

Research confirms that quality evidence-based mentoring has positive effects on young people in a variety of personal, academic, and professional situations:

—Reducing Risky Behaviors: Mentors serve as positive examples to help youth make healthy decisions and avoid high-risk behaviors. Young people who meet regularly with their mentors are less likely than their peers to use illegal drugs and alcohol. Mentoring can also be integrated into multi-component violence prevention and intervention efforts, reduce aggressive behaviors such as fighting and bullying and provide comprehensive support to youth at risk for committing violence or victimization.

—Workforce Development: Mentoring helps develop the talent pipeline for our economy. Mentors prepare young people for the workforce through career exposure, skill-building, and goal-setting. Mentoring can also lead to higher retention rates and wage increases, and is particularly impactful for disadvantaged youth, such as those with disabilities, youth of color, and youth identifying as female, who are often underrepresented in industries such as science, technology, engineering, and math (STEM).

—Educational Achievement: Many students find meaningful relationships during the school day. In fact, analyses of one prominent national data set from Applied Developmental Science suggest that teachers and other school personnel, such as counselors, coaches, or front office and cafeteria staff, are among the most cited sources of mentors. Further, students who are chronically absent are more likely to drop out of school and have behavioral issues. Mentoring can increase school engagement and improve scholastic efficacy and school-related misconduct.

—Social Emotional Development and Mental Health: Mentoring provides young people with a sense of belonging and promote positive social attitudes. In fact, research has shown that the strongest benefit from mentoring is a reduction in depressive symptoms. It can also help reduce mental health stigma and increase treatment entry and adherence. Ultimately, mentoring provides pro-social activities, increased positive relationships, life skills training, and access to networks—helping lead young people to productive futures.

Mentoring programs can effectively and safely provide these benefits when they are fully trained on the most up-to-date mentoring evidence and training. In 2015, through funds from the Youth Mentoring Program, The National Mentoring Resource Center (NMRC) was created to improve the quality and effectiveness of mentoring. MENTOR and its Affiliates provide mentoring tools, program and training materials, and no-cost, evidence-based technical assistance to mentoring programs, school districts, workplaces, and faith-based institutions across the Nation through the NMRC. This important resource has bolstered the ability of mentoring programs to serve young people from vulnerable populations, including young people at-risk of entering the juvenile justice system, youth in foster care, and victims of commercial sex trafficking.

CLOSING THE MENTORING GAP

Unfortunately, mentoring organizations across the Nation still face barriers in providing high-quality mentoring services. Inflationary costs and workforce shortages have prevented a full recovery from the COVID–19 pandemic. Many lack the training that could bolster their programs to better support young people. These issues combined have provided many obstacles for mentoring programs; but with the support of both private and public funds, mentoring organizations can increase capacity to serve every young person in their community.

As you consider the FY24 Labor-HHS-Ed appropriations bill, please consider increasing resources to the following Federal programs, which allow for the mentoring movement to grow in schools, workplaces, and communities across the country:

—The Full-Service Community Schools Program provides school district grantees with comprehensive academic, social, and health services for students, students' family members, and community members in school settings by integrating ex-

isting school and community programs and implementing coordinated strategies that can support and positively impact communities experiencing the effects of concentrated poverty. Grantees of this program may provide services including mentoring and other youth development programs. We call on Congress to fund this program at $500 million in FY24.

—The Nita M. Lowey 21st Century Community Learning Centers Program provides States with funding to support before- and after-school and summer learning programs for students attending high-poverty, low-performing schools. Mentoring services are an allowed activity for this funding. We call on Congress to fund this program at $2.1 billion in FY24.

—Student Success and Academic Enrichment Grants (Title IV–A of ESSA) are a flexible program for States and districts to spend on various projects, including those that support "safe and healthy students," where funding can be used to support mentoring. We call on Congress to fund this program at $1.48 billion.

—Supporting Effective Instruction State Grants (Title II–A of ESSA) is a formula grant that is distributed to improve the quality and effectiveness of teachers, principals, and other school leaders through preparation, training, recruitment, retention, and professional development. Funding from this program can be used by nonprofit organizations to provide technical assistance to school districts to train on, among other topics, having a "mentoring mindset." We call on Congress to fund this program at $3 billion for FY24.

—WIOA Title I Youth Programs funding can be used to serve eligible youth who face barriers to education, training, and employment, including youth mentoring and workplace mentoring. We call for maximum funding for this program in FY24.

—Project AWARE provides funding to develop infrastructure for school-based mental health programs and services with the purpose of increasing awareness of mental health issues among school-aged youth, provide training for school professionals to help them identify and respond to mental health issues, and connect school-aged youth with necessary services. We call for robust funding for this program for FY24.

Thank you again for this opportunity to provide testimony on this critical Federal resource supporting young people. Feel free to reach out with any follow-up questions.

[This statement was submitted by Abbie Evans, Vice President of Government Relations and Strategic Partnerships, MENTOR.]

PREPARED STATEMENT OF METAVIVOR

FISCAL YEAR 2024 APPROPRIATIONS RECOMMENDATIONS

—Please provide the National Institutes of Health (NIH) with an increase of at least a $3.5 billion for FY 2024 to bring total agency funding up to a minimum of $50.9 billion annually.

—Please continue to support additional investment for the cancer "moonshot" as outlined by the 21st Century Cures Act and otherwise ensure the National Cancer Institute (NCI) has adequate additional resources, consistent with the recent budget request.

—Please continue to emphasize the importance of Federal research activities focused on controlling and eliminating cancer that has already disseminated (Metastatic Cancer) through committee recommendations and timely oversight of ongoing activities.

—Please support full funding at NIH and CDC for emerging efforts to modernize the Surveillance, Epidemiology, and End Results Research Program (SEER) Registry to better capture the experience of metastatic cancer patients.

Chairwoman Baldwin, Ranking Member Capito, and distinguished members of the subcommittee, thank you once again for considering the views of METAvivor and the stage IV metastatic cancer community as you work on FY 2024 appropriations for medical research and public health. The community is deeply grateful for the sustained investment in NIH, and emerging calls for a robust and comprehensive effort to enhance cancer research. Please maintain this commitment for FY 2024 by supporting innovative medical research, including the "moonshot", ARPA–H, and related activities.

ABOUT METAVIVOR

My name is Jamil Rivers. I had a typical family before my diagnosis of "de novo" metastatic breast cancer. I was 39 years old, married, with three children and a full-time job. We were very active and always doing something. I have a big, tight-knit family and we love to travel. I had just changed jobs and we moved into a new house. I never missed a beat—and then my husband was diagnosed with stage-one colon cancer. I became his caregiver. It was in 2017, and everyone got sick in the wintertime like we always do. We had colds and were coughing, but my cold didn't go away. I also had this pain and this pinch, like I had pulled a muscle on my right side. When I went to the doctor about my cold and cough, they had prescribed me antibiotics. I also asked for an ultrasound because appendicitis runs in my family. The results showed that I had lesions in my liver. I had no other symptoms and no other pain, but further testing showed I had stage IV "de novo" metastatic breast cancer. It was the most shocking news ever.

The breast cancer had spread to my liver, my spleen, lymph nodes, lungs, bones, my abdomen and my chest wall. I was devastated. I'm blessed with this beautiful family and my kids are really young. At the time they were only 5, 6 and 16 years old. Why would God bless me with this beautiful family and then strip me from them? I couldn't wrap my brain around the fact that my husband and I could both have a serious health issue. It just wasn't a possibility.

"Who is going to take care of our kids?" That was the first thing I thought about in the midst of my devastation. But after that, I realized I had to survive for them; I have to be here for them. I wanted my kids to know that I did everything I could possibly do in my power to be here for them. I had to process my diagnosis so I could focus on my health. You never think this could happen to you but it did. It happened to me.

I'm the type of person who, when a challenge is brought to me, I figure out how to execute it and get it done. I basically had to figure out. I empowered myself and armed myself with as much knowledge, information, resources and support as possible. My mission was survival.

I'm my kids' mom and no one else can be. I'm the breadwinner in my family and everyone is also on my benefits. It was imperative that I keep my job and do well at my job so I could continue to take care of them. I started chemotherapy right away because, on paper, I was literally dying. The kids had to see me lose all of my hair and be really tired. That's when I started researching what else I could do in terms of integrative therapy to help me manage the side effects of the chemo in order to still work, be active and take care of my kids the same way I always had.

Now, my husband is in recovery and after 1 year of chemotherapy, my tumors have shrunk to the point where they're a microscopic size so you can't see them on a scan... also known as "no evidence of disease". I'm still working, taking care of the kids and involved in their school activities. I want to soak in every waking second with my family.

I'm not giving up anytime soon.

Through my advocacy, I have tried to help bring more attention to metastatic breast cancer, the need for more research funding and investment towards metastatic breast cancer. I now serve as Board President of METAvivor and work alongside others to push this important work forward. I hope the lives of the more than 600,000 people with stage IV metastatic cancer is considered when making decisions about the future of cancer research and especially funding the stage IV metastatic cancer research. METAvivor has worked hard to fund research. Since 2009, we have funded over $18 million but we need more...stage IV metastatic cancer needs more research.

THE FACTS ABOUT METASTATIC STAGE IV CANCER

Roughly 600,000 Americans die annually from cancer. Ninety percent of these deaths are caused by a metastasis. If we wish to lower the death rate, we must tackle metastasis. For more than 20 years, the primary focus has been on preventing cancer altogether and if that fails, catching it early. But aside from convincing people to stop smoking, forbidding smoke in common areas and removing colon polyps prior to malignancy, little progress has been made. For most cancers, it is believed there are multiple causes, few if any of which are known, making prevention a formidable goal. Improved equipment has allowed some cancers to be diagnosed as early as stage 0; however, stage 0 patients are also metastasizing. And although we are slowly adding drugs to the treatment repertoire, a treatment's effectiveness often runs out in 2–3 months. Thus, we empty our toolbox of drugs far too quickly and we, metastatic patients, die. Saving lives is an achievable goal but tragically is not being realized because the focus continues to be prevent and early de-

tect. Those goals have been maximized. Backs have been turned to the metastatic community long enough. It is high time to include metastasis as a major focus area.

ABOUT SEER MODERNIZATION FUNDING

As the saying goes, what gets measured, gets done. Currently, cancer registries do not capture data on metastatic recurrence or metastatic progression. There are many opportunities though to properly incorporate critical metastatic cancer information into cancer registries moving forward, including squeezing more out of current registry data, linking registries to data resources that can inform about recurrence or progression, and build the infrastructure necessary to systematically incorporate recurrence information into registries. For example, NCI is working to enhance reporting through pathology, radiology, and hospitals while several research teams are exploring algorithms that use administrative data to identify recurrence events. Currently these efforts are concentrated in areas in which information infrastructure exists to support them and are not yet nationally scalable. A key emerging conclusion is that there would be a tremendous value in "A Big Count" of breast cancer metastases on an ongoing basis. This would be achievable if States would develop scalable processes and invest the time and resources to do the counting and gather the data. This could incorporate the utilization of innovative tools developed by NCI or could be complementary to those efforts. Congress asked NIH and CDC to provide an overview of the resources necessary to modernize SEER and include information on metastatic cancer, and we urge Congress to continue working to provide appropriate resources to swiftly advance modernization activities. This includes both necessary funding as well as committee recommendations regarding utilization for SEER modernization activities.

Laura Bowers, Texas.—I was first diagnosed with metastatic breast cancer (MBC) in 2018, about 4 years after my initial diagnosis of stage II breast cancer. At first, the metastases were only in my bones, and for a couple of years they responded well to a treatment regimen with minimal side effects. But in April 2021, I was diagnosed with brain metastases. The doctor said they were everywhere in my brain, >15 tumors spread throughout my head. Because of the large number of tumors, I wasn't a candidate for surgical removal or targeted brain radiation. Instead, my doctor recommended whole brain radiation, which is basically what it sounds like, irradiation of the entire brain. Immediately after three weeks of radiation treatment, I started on a cocktail of three chemotherapy drugs. That combination made me feel so miserable that I was actually happy when that chemo regimen stopped working and I had to switch to different drugs. Over the past 2 years, I have changed chemo regimens four more times. Each change has been due to the development of drug resistance over time, resulting in the progression of the brain tumors. Many metastatic breast cancer patients are living with this same reality. Eventually, many patients either run out of options, or they just can't fight anymore. That's why we need to continue to fund promising metastatic breast cancer research. There has been great progress made in recent years, and more metastatic patients are surviving long-term than ever before. With continued commitment, I truly believe we can achieve a cure for this terrible disease.

Lauren Izzo, Texas.—On February 9, 2022, my life changed completely when I was diagnosed with Stage IV Metastatic Breast Cancer de novo (from the beginning). Prior to being diagnosed with MBC, I was a healthy, active 44-year-old stay at home mom. I exercised, never smoked, ate mostly healthy meals that I cooked myself, and had never been sick—I've had the occasional cold or stomach bug, but no health conditions, illnesses, never an abnormal health test result, and the only time I had ever been in the hospital was when I had my son. I found a lump in my left breast, went to my PCP, had a mammogram and ultrasound which led to a biopsy, and then a breast cancer diagnosis—all within in a matter of weeks. According to my doctors, I was probably Stage II. The tumor was not large, and only one lymph node was positive for cancer. Because I was young, to get a baseline, and also to ease my mind about some back pain I had been experiencing for the last few months, my oncologist sent me for a PET scan. She expected it to be clear. Only about six percent of new diagnoses are Stage IV at diagnosis. As it turns out, the results were not good. The PET scan showed that I had numerous cancerous lesions in my bones—my spine, my iliac (pelvic/hip) bones, and my ribs. Two of those lesions in my spine, at L2 and S2, were large enough to be the cause of my pain and were at risk of fracturing. I was stunned. Stage IV, or metastatic, breast cancer (MBC) is incurable. Treatable, but incurable. The statistics are not good. The 5-year survival rate is somewhere around 30 percent. MBC is the only breast cancer that will kill you. I will either die of MBC or with MBC. Interestingly, although I have a disease that is ultimately terminal, I will (for now) look perfectly healthy. The

goal of treatment for early-stage breast cancer (stages I–III) is to cure it, so they throw everything at it: the big guns, surgery, the chemo that makes you feel and look like death. Because stage IV breast cancer is not curable, the goal of treatment is to get your disease stable, to keep it from progressing, to minimize the side effects of treatment, and to maximize quality of life. That means I won't have surgery or chemo for now; I will keep my breasts and my hair. Because my cancer is estrogen receptor positive, I had surgery to remove my ovaries, putting me into surgically induced menopause. I take a pill that lowers estrogen and blocks the action of estrogen in my body. I also take a pill called a CDK 4/6 inhibitor that attempts to stop the cancer cells from dividing and growing. I will take these pills daily until they stop working, and then I will move on to another treatment, and this will continue until I run out of treatment options. I hope that this will be many years, that I will be an outlier who lives for decades with MBC, but the statistics are not good. The average survival time for someone with MBC is approximately 3 years. I'm a 45-year-old mom to a 10-year-old. Statistically, I will probably not make it to my 50's. My son will probably lose me when he is still a child. My new normal is a strange place to be. I live in three-month intervals, waiting for the results of each scan to see if my cancer remains stable, making sure that my treatments continue to work. I feel mostly well, I'm not having any terrible side effects, and my pain is manageable without narcotics. But at the same time, I feel like I'm just waiting for the next bad thing to happen. Because it will, sooner or later, get bad again. I am sad and angry and afraid. I am also outraged. It is infuriating that although MBC is the only breast cancer that will actually kill you (you cannot die from early-stage breast cancer), only 2–5 percent of funds raised for breast cancer research is focused on patients with metastatic disease. It is infuriating that 115 people will die of MBC each day in the United States. The primary focus for most breast cancer fundraising efforts is on prevention (which does nothing for people who are already diagnosed) and early detection (which does nothing for people diagnosed with MBC). All deaths from breast cancer are from MBC, and all people with MBC will die from it. I will die from this. 2–5 percent of the funding. We deserve better than this. We are your wives, mothers, sisters, and daughters. We are dying for a cure.

[This statement was submitted by Jamil Rivers, Board Chair, METAvivor.]

PREPARED STATEMENT OF THE MICHELSON CENTER FOR PUBLIC POLICY

The Michelson Center for Public Policy (MCPP) thanks the subcommittee for its long-standing support of biomedical research and education. Through our network of foundations, we are invested in opportunities that expand educational access, build equity for postsecondary students, and advance biomedical research. Using these opportunities, we hope to empower underserved and vulnerable communities through our advocacy and strategic partnerships. With that said we urge the subcommittee to support efforts that improve education for all and invest in science and innovation. For biomedical research, MCPP urges the subcommittee to provide NIH with $100 billion in base funding in FY 2024. For education, MCPP urges the subcommittee to provide the Department of Education Fund for the Improvement of Postsecondary Education (FIPSE) with the full $725 million proposed by the president's FY 2024 budget request, and within the $725 million, provide funding increases to the Student Basic Needs and Open Textbook Pilot Grant programs.

The Michelson Center for Public Policy (MCPP) is a 501(c)(4) social welfare organization that propels legislative change through meaningful collaboration with elected officials, government agencies, and civic leaders to achieve positive outcomes in medical research, education, equity, and animal welfare. MCPP is an affiliated but separate organization from the Michelson Philanthropies network of foundations (Michelson 20MM Foundation, Michelson Found Animals Foundation, and Michelson Medical Research Foundation) and complements the Michelson Philanthropies' thought leadership and expertise with bold and effective advocacy. MCPP's founder and co-chair is physician, inventor, and philanthropist Gary Michelson, M.D. He is committed to using his platform to advocate for robust investment in biomedical research, improve educational access for all, support the next generation of innovators, and accelerate the timeline to treatments and cures.

The NIH is the world's largest funder of medical research and the basic, clinical, and translational research that it funds is the very fuel that feeds the American engine of discovery and drives innovation in pharmaceuticals and biotechnology. Now is the time to bolster our ability to respond to the emerging public health threats of tomorrow by continuing to invest heavily in biomedical research with transformative potential. Through the Michelson Medical Research Foundation, Dr. Michelson makes grants to support high-quality, cutting-edge medical research be-

cause a single breakthrough could benefit the lives and health of hundreds of millions. But philanthropy cannot do it alone. Truly transformative medical advances are seeded by robust investment in the NIH and these investments have exponential returns for the economy, jobs, tax revenues and—most importantly—humankind.

MCPP is thankful for the strong bipartisan support that the subcommittee has shown by providing the NIH consistent funding increases during this time of constrained budgets but, we must do more. The Biden Administration has proposed to fund the NIH at $51.1 billion in FY 2024, which includes $2.5 billion for the Advanced Research Projects Agency for Health (ARPA–H). This is not nearly enough to keep up with biomedical research inflation and the costs of scientific innovation. We must dramatically increase NIH's program level funding, so a lack of funding does not cause patients to go untreated and diseases remain a threat to public health.

A crucial component of ensuring that the NIH is equipped to meet the health challenges of the future is supporting the next generation of scientists. Early career researchers in the biomedical sciences face many struggles as they move toward independence. Lack of independent funding opportunities and tenure-track faculty positions place many early career researchers in a cycle of training positions that may hinder growth, innovation, and scientific independence. In addition, the NIH funding ecosystem is harmfully "hypercompetitive." In FY 2022, only one out of every five applicants were ultimately awarded NIH funding,[1] and the resulting grant was almost always less than the amount requested to effectively perform the research. This system especially disadvantages early career investigators, squandering the potential of scientists with groundbreaking and innovative ideas.[2] Furthermore, among early career researchers, women, parents, and those from underrepresented backgrounds in STEM bear a disproportionate amount of this burden. MCPP urges the subcommittee to build NIH's ability to devote more of its annual budget to programs that support early career researchers and invest in promising young investigators conducting highly innovative research.

MCPP would also like to thank the subcommittee for the sustained discretionary funding increases given to the U.S. Department of Education in recent years. Vigorous support for our Nation's K–12 and higher education programs are vital to strengthening the U.S. economy and furthering our National competitiveness. Furthermore, it is absolutely essential that Federal investments are made to increase the access to and affordability of postsecondary education for all American students. Decreasing the cost of higher education is one of the most impactful ways to increase equity and ensure all who would like to pursue a postsecondary degree or credential are able to.

MCPP is enthusiastic about the investments made in FY 2023 to support student basic needs and provide access to support services for students. MCPP urges Congress to provide the $725 million in funding proposed by the president's budget request for FIPSE in FY 2024. Within the $725 million for FIPSE, MCPP requests Congress provide funding increases for the Student Basic Needs program and the Open Textbook Pilot program to allow ED to make new grant awards under each. Both of these programs are essential to increasing accessibility to higher education for low-income, minority, and first generation students. Ensuring students' basic needs are met is vital to supporting their academic achievement and overall well-being. Research published by the Community College Journal of Research and Practice indicates that students who are food insecure are more likely to have lower grade point averages than their peers who are food secure.[3] Food insecurity is a persistent problem among the postsecondary student population. In California alone, 2 of 5 students within the California State University and University of California systems and half of students within the California Community Colleges have reported being food insecure.[4] The Federal Government should continue its investment in the Student Basic Needs Grant program to continue to provide crucial support to some of the most vulnerable students in our postsecondary system.

MCPP supports providing access to open education resources as a mechanism to bring down the cost of postsecondary education. Open educational resources (OER) reside in the public domain or have been released under an intellectual property license that allows use of them for free. Research conducted by the U.S. Public Interest Research Group Education Fund (U.S. PIRG) found that 65% of students in 2020

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[1] https://report.nih.gov/nihdatabook/report/136.
[2] https://nexus.od.nih.gov/all/2018/05/04/the-issue-that-keeps-us-awake-at-night/.
[3] https://www.tandfonline.com/doi/abs/10.1080/10668926.2013.850758.
[4] https://20mm.org/student-basic-needs/.

reported not purchasing a textbook because of its cost.[5] Increasing funding for the Open Textbook Pilot within FIPSE is essential to scaling the utilization of OER across the United States and bringing down the cost of participation in postsecondary education in the United States.

As emphasized in this testimony, MCPP is supportive of Federal policies that increase access to and completion of postsecondary education programs. In addition to increasing appropriations for the Student Basic Needs and Open Textbook Pilot programs highlighted above, MCPP supports the $165 million in funding proposed by the president's budget request for the Postsecondary Student Success Grant program.

MCPP thanks the subcommittee for its important work dedicated to education and biomedical research, and we appreciate this opportunity to urge the subcommittee to continue the success of NIH by providing $100 billion in FY 2024 and to continue supporting the needs of postsecondary students through the provision of $725 million to FIPSE and including funding increases for the Student Basic Needs, Open Textbook Pilot, and Postsecondary Student Success grant programs.

PREPARED STATEMENT OF THE MOORE CENTER FOR THE PREVENTION OF CHILD SEXUAL ABUSE

The Moore Center for the Prevention of Child Sexual Abuse at the Johns Hopkins Bloomberg School of Public Health (Moore Center) welcomes the opportunity to submit this statement for the record about the importance of Federal investment in child sexual abuse prevention research. The Moore Center was founded in 2012 on the premise that child sexual abuse is a preventable, not inevitable public health problem. Our mission is to create, through rigorous science, a public health approach to preventing child sexual abuse. Together with many stakeholders in the child welfare community, the Moore Center requests that Congress appropriate $10 million for child sexual abuse prevention research at the Centers of Disease Control and Prevention's National Center for Injury and Violence Prevention, Division of Violence Prevention, in FY 2024.

Child sexual abuse and the damage it causes to children, adults, families, and communities too often makes headlines. Astoundingly, approximately 13 percent of all children will become victims of the crime. Child sexual abuse is associated with serious mental and physical health problems that shorten the lifespan and reduce its quality. Effects include increased risk for post-traumatic stress system disorder, substance use disorders (including opioid abuse), HIV, heart disease, and suicide. Given this, it is no surprise that our 2018 study found that the economic burden of child sexual abuse was $9.3 billion in 2015, and costs each victim more than $280,000 in earning and other losses over their lifetime.[1]

The Federal Government rightly funds treatment and other services for crime victims, including victims of child sexual abuse, and funds criminal justice efforts to detect, prosecute and hold accountable those who commit child sexual abuse. Indeed, the Federal Government annually spends approximately $529,000,000 solely to incarcerate people with sex crimes against children in Federal facilities. Yet 95 percent of all sex crimes are committed by people with no prior sex crime convictions. As important as victim and criminal justice efforts are, they do little if anything to prevent harm from occurring in the first place.

The scant focus on preventing child sexual abuse stands in stark contrast to robust Federal efforts that address all other forms of child victimization as preventable public health problems and not solely criminal justice programs. For decades, we have supported the development, validation, and dissemination of programs such as home visitation that effectively prevent child physical abuse and neglect, as well as school-based programs that effectively prevent peer-on-peer bullying, teen dating violence, and suicide. The lack of similar strategies to prevent child sexual abuse is primarily due to the failure to fund similar research in this space.

In the absence of validated prevention efforts, organizations and individuals that work with children have had to develop and implement idiosyncratic and untested prevention efforts. Youth serving organizations, schools, religious groups, sports clubs, after-school programs, child care settings, hospitals, and other youth-focused organization have to create and recreate their untested prevention strategies. Indeed, most States mandate that child sexual abuse curricula be implemented in K–12 schools, yet few such programs have been tested for their effectiveness. There

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[5] https://20mm.org/oer/.

[1] Letourneau, Elizabeth J., et al. "The Economic Burden of Child Sexual Abuse in the United States." Child Abuse & Neglect, vol. 79, 2018, pp. 413–422., doi:10.1016/j.chiabu.2018.02.020.

is no way to tell if any given prevention effort might be effective, ineffective, or even harmful to children in the absence of evaluation.

The FY 2019 appropriations bill directed the CDC to release a report on the current state of child sexual abuse prevention research. The report, released in December 2019, outlines significant gaps in existing research efforts, which include the need to: improve surveillance systems and data collection; increase the understanding of risk and protective factors; and, strengthen, develop and disseminate evidence-based prevention policies, programs and practices.

In FY 2020, $1 million was allocated to the CDC's Division of Violence Prevention, which funded two grants to study adult child sexual abuse perpetration prevention. The Moore Center was a recipient of one of these grants, which is being used to conduct research to validate our Help Wanted intervention, an online prevention program designed to provide individuals with sexual interest in younger children with the support and resources to maintain their commitment to non-offending. Virginia Commonwealth University was the recipient of the other grant, which will be used to evaluate Praesidium's Armatus(r) Learn to Protect program, a program focused on the prevention of school employee-perpetrated child sexual abuse, misconduct, and exploitation of students.

In FY 2021 child sexual abuse prevention research received a $500,000 increase. In response, the CDC published a funding opportunity announcement for proposals to evaluate approaches on primary prevention of child sexual abuse perpetrated by youth or adults. Child sexual abuse prevention research received funding increases the following 2 years as well, with $2 million in FY 2022 and $3 million in FY 2023.

The Moore Center is very appreciative for the funding increases and recognizes the difficulty in giving programs funding increases; however, it is critical that additional funding is allocated in FY 2024 to address the aforementioned research gaps identified by the CDC. We believe that a $10 million appropriation would allow for meaningful advances to be made in the successful prevention of child sexual abuse.

We want all American children to grow up free from abuse; Federal investment in child sexual abuse prevention research is needed to make this wish a reality. The foundation and philanthropic community currently supporting prevention research and evaluation cannot continue to fund it alone. We urge you to include $10 million for research on the primary prevention of child sexual abuse at the CDC as funding priority for FY 2024.

We look forward to working with the committee on efforts to protect our children from child sexual abuse and hope that you will consider the Moore Center a resource in the future. Thank you in advance for your time and consideration.

[This statement was submitted by Elizabeth J. Letourneau, Ph.D., Director, Moore Center for the Prevention of Child Sexual Abuse.]

PREPARED STATEMENT OF MR. JOSEPH GIVENS

I grew up about five miles down a gravel road in a farm community known as Snake Island, Arkansas. My family of five lived in a two-bedroom mobile home. Neither of my parents has a high school diploma, and both grew up in poverty as they were children of farmhands. My father worked at a rice mill and took every second of overtime allowed, and my mother worked side jobs and managed our house. For them, it was a tough life of balancing time with their family and seeking resources to support that family. They dreamed that my brother, sister, and I would not have such a difficult life, and they knew that the best way for my family to get out of poverty was an education.

In my sophomore year of high school, my classmates and teachers began to talk about college pathways. I remember going home to my parents and asking what we needed to do to get me and my brother on track for college. I remember the worried look on their faces as they shared the disappointing news that college was costly, and since we were barely getting by financially, there was no way they could set up a college savings account. Our best hope was for me and my brother to work at a rice mill during the day and take classes at the community college at night.

During my family's worries about our future, the Upward Bound program came to my high school and offered hope that we could go to college. My brother and I were excited to tell my parents about this excellent program that would help us make good grades, learn how to be college students, and find a way to achieve our dream. The opportunity seemed too good to be true. My mother called the president's office at the college to make sure this wasn't some scam. I look back at my family's life at that crossroads and will forever be thankful we found the opportunity that helped my whole family move out of poverty.

My brother and I entered college at Arkansas State University with full-ride academic merit scholarships, a feat made possible by Upward Bound. I remember that I had to earn a 32 on my ACT to get that academic scholarship, and from the moment I entered Upward Bound, our math teacher was working to get us to reach that goal. I took several practice tests, each inching closer to the plan, until finally, I made it, and the reality of affording a college education became real.

College was incredibly challenging for me and my brother. In the fall semester of our sophomore year of school, he was diagnosed with Ewing Sarcoma, a very aggressive cancer. He decided this illness would not get between him and his dream of college, so he took classes while receiving chemotherapy. We scheduled afternoon classes so I could take Josh to treatments in the early morning. For him, the side effects of cancer and the treatments were harsh, and for me, becoming a caretaker at 19 was overwhelming. Without Student Support Services, we would have had to drop out of school. They helped provide tutors to help us maintain academic strength when we were so very distracted. They offered personal counseling and referred us to mental health resources to deal with the stresses of dealing with his terminal diagnosis. Because of this support, we finished our bachelor's degree in less than 5 years, despite these overwhelming difficulties.

The life-changing impact of these programs reaches beyond the students. As an undergraduate, I took a class in entrepreneurship and used that knowledge to help my parents write a business plan, secure a loan, and launch a small business. With that business's additional income, they could buy land and build a house. My sister joined Upward Bound after my brother and me and inspired by the nurses caring for my brother, she committed herself to working in the medical field. She is now head nurse managing several dialysis clinics in Arkansas. Because my siblings had a viable path to college, my cousins had a realistic path to follow us there. We shared the information from Upward Bound with my extended family, and now, nine of my 11 cousins have graduate degrees. A few are teachers, one is an investment banker, and another is a software engineer. Upward Bound changed the trajectory of my whole family.

The excellent work of my TRIO coordinators and directors and the transformational potential of this program moved me, so I decided to commit to my professional life to ensure that others could realize their dream of having a college degree. I look at the small, rural Arkansas community I grew up in, and I know we need this program more now than ever. As the small, family farm way of life is coming to a close and economic possibilities in these areas become more challenging, we need to ensure that there is a viable future for children living in remote areas of the country. Moreover, programs like TRIO embrace the backgrounds of the students they support, encourage students to remain in their communities, and leverage their education to transform them. As a McNair Postbaccalaureate program director, I work to connect low-income and first-generation college students to opportunities to work alongside distinguished faculty members and contribute to research. These students are preparing to create jobs and technology that doesn't yet exist. Alumni from my program have gone on to develop the self-driving technology at Ford, to guide Gulf Coast preservation initiatives for the Army Corp of Engineers, and even to pioneer the development of laboratory-grown blood transfusions.

I decided to pursue a career in educational opportunity after my brother passed away. I could have an impact in cultivating the next generation of scholars who will find cures for diseases like cancer. This May, I will attend the graduation ceremony of a former student earning an M.D./Ph.D. from the University of Arkansas. After graduation, she will begin her career as a medical scientist in the very same research center that treated my brother during the years of his cancer fight. TRIO has been at the center of transformational experiences in my life. It is the best example of the American Dream that if you believe in something and work hard enough to achieve it, you can make it a possibility.

[This statement was submitted by Mr. Joseph Givens, Council for Opportunity in Education.]

PREPARED STATEMENT OF NAF

NAF is a national non-profit organization that transforms the high school experience to prepare students for college, career, and future success. Our educational design is replicable, sustainable, and cost-effective, and because it integrates within public schools, supports lasting systemic reform and equity nationwide. NAF believes Congress should invest in programs that provide quality career and technical education for high school students, including support for paid work-based learning. We urge Congress to support increased funding to the Department of Education for

the Perkins Basic State Grant and the Career and Technical Education National Programs. We urge Congress to support increased funding for the Workforce Innovation and Opportunity Act (WIOA) Title I State Formula Grants at the Department of Labor. Finally, we urge Congress to restate the need for work-based learning coordinators for high school students and provide the necessary funding.

DEPARTMENT OF EDUCATION

NAF respectfully requests $200 million in FY2024 for the Career-Connected High Schools initiative within the CTE National Programs. This funding supports competitive grants to consortia of local educational agencies, institutions of higher education, nonprofits and employers to help integrate and align the last 2 years of high school and the first 2 years of postsecondary education and would include paid work-based learning experiences, as well as funds for technical assistance, evaluation, and other ongoing activities. These partnerships would create new structures and supports to help high school students-with a focus on underserved students-develop and navigate clear pathways to postsecondary education and career preparation, accrue college credit, pursue in-demand, high-value credentials, and gain direct experience and skills in the workplace that lead to high-quality jobs. An additional competitive priority would focus on paid work-based learning and funds could be used to support stipends for program participants, particularly important for students from low-income backgrounds.

NAF respectfully requests a $400 million increase in FY2024 to the Perkins Basic State Grant as it is the principal source of dedicated Federal funding for career and technical education and is currently funded at least $320 million below its inflation-adjusted level from 20 years ago. Perkins funding provides critical programs and supports to students in every district such as career counseling, dual enrollment, work-based learning, and industry-recognized credentials.

DEPARTMENT OF LABOR

NAF respectfully requests robust funding for the Workforce Innovation and Opportunity Act (WIOA) Title I State Formula Grants, including funding for Youth Programs. The budget for Title I programs falls nearly one billion dollars short of the funding in 2001 before adjusting for inflation. We remind Congress of its request to the Department to encourage local secondary education authorities to be included on local workforce development boards and furthermore to increase the availability and support for in-school youth.

NAF urges the subcommittee to reiterate its support for and include the following report language:

> Research shows that participation in work-based learning during high school has a positive impact on students, including completing high school, and helps them secure higher-quality jobs, boosting equity and economic opportunity. The Committee recommends $5,000,000 in Fiscal Year 2024 for the first year of a 5-year demonstration program to provide full-time, work-based learning coordinators in underserved communities with an already proven track record for secondary career and technical education. Work-based learning coordinators conduct outreach, engagement, recruitment and coordination of work-based learning activities, including, but not limited to, paid internships or pre-apprenticeships for high school students, with local community employers, especially with in-demand industries of information technology, health sciences, and engineering. The work-based learning coordinators may be employed by the local education agency, local workforce development board or local workforce development agency, a group of employers, or a consortium of eligible entities. In making grant awards, the Committee directs the Secretary to require a plan for evaluations in each individual grant proposal, including types of work-based learning opportunities completed, demographics of participating students, and students' post-secondary career plan, as well as to conduct a national assessment of all grantee proposals once complete.

Public secondary education institutions play a critical role in preparing youth for future success through initiatives like career and technical education programs, access to local colleges, and work-based learning opportunities with employers. As a principal public institution that teens attend before becoming adults, the secondary education system plays an invaluable role in empowering the next generation for success in the workforce. Work-based learning programs ensure a connection between schools and the working world, whether it's preparing students to enter existing jobs, encouraging entrepreneurial endeavors, or serving as a foundation for career opportunities after post-secondary education.

Work-based learning has proven impacts on earnings, job quality and stability and is a critical lever in addressing systemic racial and economic inequities. Students in NAF academies are more likely to graduate on-time than their peers who are not involved with career academies. NAF has an overall positive effect on all students but is particularly impactful for those at-risk of not graduating-with full, 4-year program participation in a high-quality career academy, these students were 10 percentage points more likely to graduate on-time than their non-NAF counterparts. Black and Hispanic students attending NAF academies also are shown to have higher high school graduation rates.[1] Students who graduated from a career academy amassed 11% more total earnings each year over the 8 years following high school than those who did not attend a career academy. Youth who drop out of high school can expect to earn $10,000 less annually compared to high school graduates.[1,2] During the 2022–23 school year, more than 112,000 students attended 604 NAF academies across 35 States and territories. NAF academies reported 99% of the seniors graduated with 88% of graduates planning to go to college.

Work-based learning helps students build relationships, sharpen essential skills, and expand their networks beyond their immediate communities. Relationships with adults nurtured through work-based learning opportunities are also shown to be long-lasting and beneficial to students up to a decade later. Eighty percent of jobs are filled through personal and professional connections.[3] Young people deserve an education that builds workforce essential skills, helps them create social capital, and connects them to opportunity.

While funding to schools for career and technical education is provided through the Perkins Career and Technical Education Act, this funding cannot be used to pay students for their work. However, paid internships are vital to closing the equity gap. Moreover, opportunities to intern in the nonprofit and government sectors can foster interest in public service careers among underserved students. This potential for increased awareness of civic affairs would represent an important step toward a more engaged and inclusive democracy.

CONCLUSION

Work-based learning is advantageous for employers and communities. It is a proven way to grow the talent pipeline and help prepare students for the workforce.[4] By partnering with high schools to provide work-based learning opportunities to students, employers play an active role in developing a talent pipeline aligned with their workforce needs. Employers also gain the opportunity to observe prospective employees in action before making the investment to hire them.[5] The nation must invest in work-based learning, so workers have the skills they need to succeed, and employers have the diverse talent they need to thrive. NAF appreciates the opportunity to share its expertise and appreciates you for considering this vital request.

[This statement was submitted by Lisa Dughi, CEO, NAF.]

PREPARED STATEMENT OF THE NATIONAL ADULT PROTECTIVE SERVICES ASSOCIATION

The National Adult Protective Services Association (NAPSA) thanks the Committee for the opportunity to submit the following testimony regarding Fiscal Year (FY) 2024 Federal appropriations. On behalf of NAPSA, I thank you for your support of Adult Protective Services (APS) programs and vulnerable adults who are victims of abuse, neglect, self-neglect, and exploitation. APS programs serve both older adults and younger adults with disabilities, populations that are frequently forgotten in service provision. As the National professional association representing APS programs, staff, allies, and the clients they serve we see the importance of these funds and the need to continue to invest as the population ages and cases increase

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[1] ICF. (2017). Transforming the American High School Experience: NAF's Cohort's Graduation Rates from 2011–2015, 2017.

[2] Kemple, J. J., & Willner, C. J. (2008). Career Academies Long-Term Impacts on Labor Market Outcomes,. mdrc.

[3] Fisher, J. F. (2020, February 14). How to get a job often comes down to one elite personal asset, and many people still don't realize it. Retrieved from CNBC: https://www.cnbc.com/2019/12/27/how-to-get-a-job-often-comes-down-to-one-elite-personal-asset.html.

[4] Ross, M., Moore, K. A., Murphy, K., Bateman, N., DeMand, A., & Sacks, V. (2018, October). Pathways to high-quality jobs for young adults. Retrieved from Brookings: https://www.brookings.edu/research/pathways-to-high-quality-jobs-for-young-adults/.

[5] Benefits of Work-Based Learning. (n.d.). Retrieved from JFF: https://www.jff.org/what-we-do/impact-stories/center-for-apprenticeship-and-work-based-learning/benefits-work-based learning/#:~:text=Jobseekers%20also%20see%20work%2Dbased,of%20%20a%20skilled%20regional%20workforce.

in complexity. We submit this FY 2024 testimony in support of funding in the Department of Health and Human Services (HHS) that plays a unique role in this area. Within the Administration for Community Living, NAPSA's request includes $100 million for Adult Protective Services (APS) formula grants to directly support programs. Within the Administration for Community Living NAPSA's request includes $20 million for the National APS Training Center, National Adult Maltreatment Reporting System, and innovation grants. Within the Administration for Children and Families, NAPSA requests a minimum of $1.7 billion for the Social Services Block Grant Program which provides critical funding to over 30 APS programs. Additionally, language is needed to ensure funding goes directly to the agency overseeing the APS program. In some States this entails funding to go to an agency serving older adults and a separate agency serving adults with disabilities. Support should also be provided for Tribal APS program development.

APS programs support and protect the most vulnerable in their communities, including older adults and people with severe disabilities. Abuse has significant financial, physical, and psychological impacts to the individual, community, and the Nation. The Department of Justice estimates that 1 in 10 older adults will experience abuse annually and that people with disabilities are 2.5 times more likely to be victims of violence. The direct medical costs of injuries and care related to elder abuse exceed $5 billion a year and further costs to the individual and community result from lifelong injuries, moving into long-term care, and having to enroll in Medicaid. Additionally, victims have higher mortality rates than their peers. While these illustrate the costs that can be easily calculated, emotional and psychological costs are even higher.

On the services side, APS is often under resourced due to decreased budgets and rising caseloads. Administrators also note that cases are becoming more complex. Opioid and substance abuse cases can bring new safety challenges and lack of available services, particularly in rural areas. Rising financial exploitation cases test the skills of programs who often do not have the resources to hire a forensic accountant necessary to unravel such cases. The COVID–19 pandemic only further highlighted the necessity of APS. In many cases APS was the only agency in the field and the first to go back to in-person visits. Caseworkers are stretched thin and in need of more support and training in light of these complexities.

We were pleased to see the first ever funding to APS programs as part of the COVID–19 emergency packages. This funding allowed programs to build critical infrastructure including provision of personal protective equipment across the country, building wrap around services in Washington, providing continuing victim support in Maine, creating Tribal partnerships in Wisconsin, and creating a liaison for clients who are homeless in West Virginia. However, due to the time limited and emergency nature of the funding States were largely not able to address basic infrastructure gaps such as supporting and growing the workforce.

We applaud the inclusion of $15 million in funding for APS programs through the FY 2023 bill and look forward to the possibilities for APS. But it is our understanding that after administrative costs only $13 million will go out to States. This is a significant cut from what went out during the COVID–19 pandemic. The average decline from 1 year of emergency funding would be nearly $2 million. Washington would likely see a $2.3 million cut, Maine a $838 thousand cut, a $1.9 million cut in Wisconsin, and an $838 thousand cut in Texas. These cuts are a direct threat to vulnerable Americans and result in disappearance of services and staff. Proposed cuts passed by the House of Representatives could completely eliminate funding. Sufficient, ongoing funding is needed to sustain and expand these programs.

Staffing is the most crucial issue for APS across the Nation. APS is a labor-intensive service relying upon investigators, intake workers, case managers, experts in financial abuse, capacity assessment, support personnel, and others. It is difficult if not impossible to have an effective program without trained, competent and seasoned workers. APS is hard work and requires truly capable personnel. Adequate staffing is the most important need for APS and consistent funding is needed to support these positions. Our request of $100 million to APS programs is a down payment for sustainability and support to vulnerable Americans.

Justice for older adults and people with disabilities should be more than a tagline, it should be a reality. Abuse, neglect, self-neglect, and exploitation exist across the Nation and within each of our communities. Its prevention and remediation are core to our humanity. We look forward to the committee's support.

[This statement was submitted by Jennifer Spoeri, Executive Director, National Adult Protective Services Association.]

PREPARED STATEMENT OF THE NATIONAL ALLIANCE FOR PUBLIC CHARTER SCHOOLS

Chairwoman Baldwin, Ranking Member Capito, and Members of the subcommittee, I am pleased to present the views of the National Alliance for Public Charter Schools (the National Alliance) on the fiscal year (FY) 2024 appropriation for the Charter Schools Program (CSP) and other programs administered by the U.S. Department of Education (ED or the Department). The National Alliance is the leading national nonprofit committed to advancing the public charter school movement. Significant enrollment growth during the pandemic underscores how charter schools offer choices to communities that need them most, and additional resources are critical to meet future need. The CSP has been level-funded since FY 2019 and, due to this stagnation, in 2021 the Department lacked funds to make new grants to enable schools to open or expand. As the subcommittee considers the budget for FY 2024, we ask that you increase the CSP appropriation to at least $500 million to help meet this need.

The National Alliance also strongly supports additional resources for programs that support all public schools, including Title I, Title III, and the State grants program under the Individuals with Disabilities Education Act. We endorse the Administration's request for increased funding for these programs, which will help public schools, including charter schools, address the continuing impacts of the pandemic and reach the outcomes we want for all students.

CHARTER SCHOOL ENROLLMENT, OPERATION, AND ACCOMPLISHMENTS

Across the Nation more than 7,800 public charter schools serve a diverse student body of 3.7 million students—7.5 percent of America's public school students. Charter schools were the only sector of public education to grow during the pandemic; during the first two full school years of the pandemic, approximately 240,000 additional students enrolled in charter schools, representing nearly 7 percent growth. Nearly 60 percent of charter school students are eligible for free and reduced-price lunch and more than two thirds are students of color—both higher percentages than in district schools. Around the country, charter schools serve families whose needs were not being met by district schools and charter school enrollment has grown, in large part, because of what charter schools offer to families in historically underserved communities.

And charter schools are delivering results. A 2021 National Bureau of Economic Research (NBER) meta-analysis of three decades of research found that charter schools in urban areas boost student test scores, particularly for low-income students and students of color; that attending some charter schools increases college enrollment and voting; and that there is a small but beneficial competitive influence on neighboring schools' student achievement.[1]

A 2020 study from the Program on Education Policy and Governance at Harvard University similarly found greater academic gains between 2005 and 2017 for students in charter schools than for students in district schools. Black and low-income students showed the greatest gains. This was the first nationwide study to compare student achievement trends over time between sectors rather than effectiveness at a single point in time.

THE IMPORTANCE OF THE BIPARTISAN FEDERAL CHARTER SCHOOLS PROGRAM (CSP)

Created in 1994 during the Clinton Administration, the CSP has long received bipartisan support. The program was originally authorized to provide start-up funding for new charter schools, but has evolved to address additional objectives, including meeting the needs of charter schools for adequate facilities and supporting the expansion and replication of high-quality charter schools operated or managed by charter management organizations.

Since its inception in 1994, Congress has made significant investments in the growth of charter schools through the CSP. The total appropriation for the CSP amounts to less than 2 percent of the appropriations for Title I over that same time period, or about 5 percent of the funds made available for education under the American Rescue Plan in a single year (2021). This modest investment helped charter schools grow from only a handful to the 7,800 schools operating today. Such growth would be impossible without this investment. Charter schools also often lack access to appropriate facilities or facilities funding, and Federal funding for the two CSP facilities programs, while insufficient, helps address this significant need.

[1] Cohodes, Sarah, and Katharine Parham. May 2021. Charter Schools' Effectiveness, Mechanisms, and Competitive Influence. Cambridge, MA: National Bureau of Economic Research. https://www.nber.org/papers/w28477.

FISCAL YEAR 2024 REQUEST

For FY 2024, we request $500 million for the CSP and recommend giving the Department of Education flexibility to allocate funds across CSP programs in response to current needs, as provided for in the Administration's budget request. $500 million would provide sufficient funding to support the opening of new schools and expansion of high-quality schools and would help charter schools access appropriate facilities. Increased funding for the CSP will help provide high-quality educational options to more families, particularly those in communities that were hit hard by the pandemic and where the learning needs are greatest.

We also request appropriations language that will enable CSP State Entity grantees to provide more support to new schools and to foster the development of high-quality charter schools. Increasing the technical assistance set-aside from 7 percent to 10 percent, and the administrative set aside to 5 percent, will ensure that State entities can provide subgrantees that are under-resourced, such as small non-profits, with the resources they need to administer their grants, and enable States to support subgrantees without additional fundraising.

The proposed appropriations language would also provide resources for State Entity grantees to provide a small amount of funding to support potential charter school developers through the pre-planning stage. Under the current rules for the CSP, there is no clear authority for subgrants to individuals that have not yet submitted a charter application that would help them incubate new schools. Unless an individual has access to other means of support, it can be difficult for prospective charter school leaders—especially those who are educators—to devote the time and resources necessary to develop a high-quality charter application.

Lastly, the State Facility Incentive Grants (SFIG) program was created to incentivize State leaders to create programs that provide per-pupil funding assistance for facility costs. In practice, few States have been able to benefit because the matching requirements are difficult for State legislatures to meet within the required time frame. Moreover, some States provide schools with facilities assistance that is not allocated on a per-pupil basis. While those programs are just as beneficial to charter schools as per-pupil facilities aid programs, they are not eligible for support under SFIG. In order to increase the usefulness of this program, we therefore request that the changes that would be made through the Equitable Access to School Facilities Act (recently introduced by Senators Bennet and Cassidy) be included in this year's bill. The Equitable Access to School Facilities Act would expand the types of State facility aid programs the SFIG program can support. Specifically, it would allow the Secretary of Education to make competitive grants to States to improve access to facilities and facilities funding, promote charter schools' access to public buildings, and improve access to facilities in low-income and rural communities. SFIG was not amended during the last reauthorization of the Elementary and Secondary Education Act (ESEA) and the updates proposed by the Equitable Access to School Facilities Act will make needed changes to increase the impact of the program.

Thank you for the opportunity to testify on the FY 2024 budget for the CSP and other critical Department of Education programs. If the National Alliance can be of any assistance to the subcommittee as you proceed with your work, please do not hesitate to contact me or a member of my staff.

ADDITIONAL RESEARCH FINDINGS

CSP funds support the opening of successful charter schools:

—A 2022 U.S. Government Accountability Office (GAO) report found that within the first 5 years of operation, schools that did not receive CSP funding were 1.6 times (or 40 percent) more likely to have closed than those that received CSP funding.

Research shows that high-quality charter schools can deliver life-changing results, especially for students from low-income backgrounds and students of color:

—A 2020 study from the Program on Education Policy and Governance at Harvard University found greater academic gains for students in charter schools, with the difference amounting to almost an additional half year of learning for students in charter schools over the course of the study, with Black and low-income students making the most significant gains.

Public demand for charter schools is strong:

—A 2022 poll conducted by the Harris poll found that three in four parents support expanding the number of slots in existing public charter schools in their

area. Three in four would consider sending their child to a public charter school if one were available.

—The poll also found that 84% of American parents agree that, although they may not choose a charter school for their child, charter schools should be available to families who would.

[This statement was submitted by Nina Rees, President and CEO, National Alliance for Public Charter Schools.]

PREPARED STATEMENT OF THE NATIONAL ALLIANCE ON MENTAL ILLNESS

Chair Baldwin, Ranking Member Capito and Members of the subcommittee: On behalf of the National Alliance on Mental Illness (NAMI), we wish to express our gratitude for Congress's historic and bipartisan investments in mental health services in recent years. NAMI is dedicated to building better lives for the millions of people affected by mental illness. NAMI is a voice for youth, veterans and service members, individuals experiencing homelessness and justice system involvement, family caregivers, and anyone impacted by mental health conditions. What connects us is the shared hope of new and innovative treatments, improved access to mental health care, and support through recovery. As you consider spending levels for Fiscal Year (FY) 2024, I appreciate the opportunity to discuss major areas of need within mental health care that this subcommittee has the opportunity to address.

The focus on mental health by leaders in both parties is transforming mental health services across the country at a time when this is more urgent than ever. Nearly 1 in 3 teen girls contemplated suicide in 2021.[1] Nearly 60 percent of teen girls had persistent feelings of hopelessness.[2] An astounding 160 million Americans live in mental health provider shortage areas,[3] and mental health is the Nation's top health care concern.[4] As the organization that represents individuals affected by mental illness and their loved ones, we look forward to working with you in the year ahead to ensure that investments in mental health remain at the top of our Nation's priority list.

While these numbers are stark, we know that the unprecedented leadership by Congress on this issue is making a difference—accelerating access to mental health services in every community. As an example, with the bipartisan passage and recent nationwide launch of the 988 Suicide & Crisis Lifeline, Congress has invested in a future where any person in crisis can get the help they need. In just the first 6 months, the Lifeline saw a more than 36 percent increase in calls, texts and chats over the same period the previous year, translating to more than 2.4 million people getting connected to crisis care at the moment they need it most.[5] The bold goal that 988 should become as commonplace to Americans to get help in a mental health crisis as 911 is for any person in a physical health crisis will only be achieved by continued Congressional leadership in sustaining these critical investments over time. As more people become aware of 988, more will reach out for help. In FY 2024, an estimated 9 million individuals will reach out to the trained crisis counselors of 988 for lifesaving help.

NAMI urges the subcommittee to invest in the 988 Suicide & Crisis Lifeline and a crisis continuum of care. The 988 number represents a once-in-a-generation opportunity to fundamentally reimagine how we support people experiencing a mental health crisis, particularly as we ensure that 988 serves as an entry point to a continuum of crisis services. A fully developed crisis response system must be responsive to anyone, anywhere, at any time, through 24/7 local call centers, mobile crisis teams staffed by mental health professionals, and crisis stabilization options that connect people to follow-up care.

We urge Congress to use its power of the purse, as well as its broad oversight and legislative authorities, to ensure all communities can appropriately respond to people in mental health and suicidal crisis by robustly funding the Lifeline to meet

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[1] Centers for Disease Control and Prevention. 13 Feb 2023. "U.S. Teen Girls Experiencing Increased Sadness and Violence." https://www.cdc.gov/media/releases/2023/p0213-yrbs.html.

[2] Ibid.

[3] Health Resources and Services Administration. 21 March 2023. "Health Workforce Shortage Areas." https://data.hrsa.gov/topics/health-workforce/shortage-areas.

[4] Ipsos. 26 Sept 2022. "Mental health replaces COVID as the top health concern among Americans." https://www.ipsos.com/en-us/news-polls/mental-health-top-healthcare-concern-us-global-survey.

[5] Substance Abuse and Mental Health Services Administration. 988 Lifeline Performance Metrics. https://www.samhsa.gov/find-help/988/performance-metrics (July 2022–February 2023 data).

growing demand and incentivizing the rapid expansion of associated crisis response services. Within these priorities, we request:

—9–8–8 Suicide & Crisis Lifeline, Health and Human Services; Substance Abuse and Mental Health Services Administration (SAMHSA)
  —*Funding Request for FY 2024:* $836 million for operations of 988 at local call centers and national back up centers to ensure capacity to meet the anticipated increase in demand to 9 million contacts and to support broad public awareness efforts.
—Mental Health Crisis Response Partnership Pilot Program, Health and Human Services; Substance Abuse and Mental Health Services Administration (SAMHSA)
  —*Funding Request for FY 2024:* $100 million to expand the availability of mental health crisis services via mobile crisis response for individuals who need more support than can be provided via 988 calls, texts or chats.

NAMI also urges the subcommittee to continue efforts to address the youth mental health crisis affecting so many of our children. Our children are struggling and calling out for help. Congress must answer the call. A significant challenge is the severe shortage of youth-serving mental health providers. The Pediatric Mental Health Care Access (PMHCA) program promotes behavioral health integration into pediatric primary care by funding state or regional networks of pediatric mental health teams. These teams provide teleconsultation, training, technical assistance, and care coordination for pediatric primary care providers to diagnose, treat, and refer children with behavioral health conditions and substance use disorders. This is an important opportunity to address children's mental health needs in a place they often visit for their well-child visits: pediatricians' offices. These consultations provide pediatricians with the confidence and knowledge to directly diagnose and treat many of the more common mental health conditions they see in children, alleviating the chronic workforce shortages in the mental health community. NAMI urges the subcommittee to prioritize the following:

—Pediatric Mental Health Care Access Program, Health and Human Services; Health Resources and Services Administration (HRSA)
  —*Funding Request for FY 2024:* $14 million to expand capacity of the PMHCA program to reach more pediatricians providing frontline care to children.

The mental health needs across the country are as diverse as the people who make up our communities. We urge this subcommittee to support access to a range of mental health services by increasing overall funding for the Community Mental Health Services Block Grant (MHBG). Since 1992, the MHBG has helped expand the Nation's mental health infrastructure by providing funding for community-based mental health services to all States and territories. There is no more urgent a time than now to invest in this critical safety net to help States meet the unprecedented demand for mental health services. The MHBG will give our States the flexibility to respond to our mental health crisis in the best way that addresses the needs in their community. Specifically, NAMI requests the following investment:

—Community Mental Health Services Block Grant, Health and Human Services; Substance Abuse and Mental Health Services Administration (SAMHSA)
  —*Funding Request for FY 2024:* $1.653 billion to address the growing demand for mental health services and doubling the set-aside for crisis services to 10%.

Finally, we must also look to the future and invest in research for improved understanding and treatment of mental illness to alleviate this mental health crisis. The National Institute of Mental Health's (NIMH) mission is to transform the understanding and treatment of mental illnesses through basic and clinical research, paving the way for prevention, recovery, and cure. Without adequate funding for research at NIMH, we are sacrificing the cures of tomorrow. Therefore, NAMI urges this subcommittee to increase funding for NIMH to improve precision medicine in the mental health space and spur the development of more effective treatment options for serious mental illness and continue to perform its life-altering and life-saving research.

—National Institute of Mental Health (NIMH), Health and Human Services; National Institute of Health, National Institute of Mental Health (NIMH)
  —*Funding Request for FY 2024:* $2.54 billion for continued research related to youth mental health, the mental health impacts of COVID–19 and to accelerate research on precision psychiatry and enhance precision mental health care.

As you set our Nation's budget priorities for FY 2024, we urge you to continue to make mental health care one of those key national priorities. Members of the Ap-

propriations Committee on both sides of the aisle have made unprecedented investments in mental health, substance use, and suicide prevention over the last several years. We look forward to continuing our partnership working with Congress to fight our country's ongoing mental health crisis. Thank you for your continued leadership in transforming mental health care in America.

[This statement was submitted by Hannah Wesolowski, Chief Advocacy Officer, National Alliance on Mental Illness.]

PREPARED STATEMENT OF THE NATIONAL ALOPECIA AREATA FOUNDATION

THE FOUNDATION'S FISCAL YEAR 2022 L–HHS APPROPRIATIONS RECOMMENDATIONS

—At least $50 billion for the National Institutes of Health (NIH).
  —Proportional funding increases for National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS), National Institute of Allergy and Infectious Diseases (NIAID) and the National Center for Advancing Translational Science (NCATS)
—Please provide $11 billion for the Centers for Disease Control and Prevention (CDC).
  —Please provide $6 million for the Chronic Disease Education and Awareness Program.

Chairwoman Baldwin, Ranking Member Capito, and distinguished members of the subcommittee, thank you for your time and your consideration of the priorities of the alopecia areata community as you work to craft the FY2024 L–HHS Appropriations Bill.

ABOUT ALOPECIA AREATA

Alopecia areata is a prevalent autoimmune skin disease resulting in the loss of hair on the scalp and elsewhere on the body. It usually starts with one or more small, round, smooth patches on the scalp and can progress to total scalp hair loss (alopecia totalis) or complete body hair loss (alopecia universalis).

About 2% of people across the world will experience alopecia areata at some point in their lifetime. Nearly 6.7 million people in the U.S. and 160 million worldwide have alopecia areata or have had or will have it. About 700,000 people in the U.S. currently have some form of alopecia areata. The disease disproportionately strikes children and onset often occurs at an early age. This common skin disease is highly unpredictable and cyclical. Hair can grow back in or fall out again at any time, and the disease course is different for each person. In recent years, scientific advancements have been made, but there remains no cure or indicated treatment options.

The true impact of alopecia areata is more easily understood anecdotally than empirically. Affected individuals often experience significant psychological and social challenges in addition to the biological impact of the disease. Depression, anxiety, and suicidal ideation are health issues that can accompany alopecia areata. The knowledge that medical interventions are extremely limited and of minor effectiveness in this area further exacerbates the emotional stresses patients typically experience.

ABOUT THE FOUNDATION

NAAF, headquartered in San Rafael, California, supports research to find a cure or acceptable treatment for alopecia areata, supports those with the disease, and educates the public about alopecia areata. NAAF is governed by a volunteer Board of Directors and a prestigious Scientific Advisory Council. Founded in 1981, NAAF is widely regarded as the largest, most influential, and most representative foundation associated with alopecia areata. NAAF is connected to patients through local support groups and also holds an important, well-attended annual conference that reaches many children and families.

NAAF initiated the Alopecia Areata Treatment Development Program (TDP) dedicated to advancing research and identifying innovative treatment options. TDP builds on advances in immunological and genetic research and is making use of the Alopecia Areata Clinical Trials Registry which was established in 2000 with funding support from the National Institute of Arthritis and Musculoskeletal and Skin Diseases; NAAF took over financial and administrative responsibility for the Registry in 2012. NAAF is engaging scientists in active review of both basic and applied

science in a variety of ways, including the November 2012 Alopecia Areata Research Summit featuring presentations from the Food and Drug Administration (FDA) and NIAMS.

NAAF is also supporting legislation to provide coverage for cranial prosthetics under Medicare. This bill will grant increased access to cranial prosthetics and therapies for patients with alopecia areata and other forms of medical hair loss. Many patients living with medical hair loss suffer from a variety of diseases, including cancer. With no known cause or cure, alopecia areata is an autoimmune skin disease affecting approximately 6.9 million Americans, many of whom are children.

NATIONAL INSTITUTES OF HEALTH

NIH hosts a modest alopecia areata research portfolio, and the Foundation works closely with NIH to advance critical activities. NIH projects, in coordination with the Foundation, have the potential to identify biomarkers and develop therapeutic targets. In fact, researchers at Columbia University Medical Center (CUMC) have identified the immune cells responsible for destroying hair follicles in people with alopecia areata and have tested an FDA-approved drug that eliminated these immune cells and restored hair growth in a small number of patients. This huge breakthrough has led to NIAMS providing a research grant to the researchers at Columbia to continue this work. In this regard, please provide NIH with meaningful funding increases to facilitate growth in the alopecia areata research portfolio.

PATIENT PERSPECTIVE

"There is a chance you could lose all your hair." That was the last thing anyone ever wants to hear. I will never forget standing in the shower in November 2015 with my hands full of hair and in complete disbelief. Was this really happening to me? I felt as though my identity was being ripped away from me as every strand of hair fell out of my head. My hair was my identity. Who would I be without it? How was I going to live like this for the rest of my life?

I lost all of my hair on my entire body including eyebrows and eyelashes within four weeks and I was diagnosed with the autoimmune disease called alopecia areata. For the next year, I did everything in my power to grow my hair back from every topical cream to medicines that compromised my immune system to weekly steroid injections into my scalp. This was the worst pain I had ever experienced in my life but I would do anything to grow my hair back.

Nothing was working. I had to stop as my mind, body, and soul couldn't take it anymore.

I don't know what was worse, the treatments or the stares I would receive out in public as everyone thought I was going through treatment for cancer. I wanted to blend in with society so badly, but wigs were so expensive. I refused to look at myself in the mirror because I hated the reflection. I wore a hat everywhere I went even to bed until the lights were turned off to take it off and I wouldn't take any pictures, especially during the holidays because I was ashamed of my appearance. I wanted my life back so I could be a good mom to my daughters and just enjoy life. Alopecia areata is not just cosmetic, it takes an emotional toll as it caused severe anxiety and depression that I continue to deal with years later. I was very fortunate to have the unconditional support of my parents who helped me to purchase wigs so I could feel somewhat normal again; however, there are too many people with alopecia areata who do not have the luxury of support that I was blessed with. Your support would impact people's lives immensely."

Thank you for the opportunity to testify before you today. NAAF looks forward to working with you all to advance medical research and public health activities that will improve patient outcomes for the members of our community suffering from alopecia.

[This statement was submitted by Gary Sherwood, Communications Director, National Alopecia Areata Foundation.]

PREPARED STATEMENT OF THE NATIONAL AREA HEALTH EDUCATION CENTERS ORGANIZATION

Chairwoman Baldwin, Ranking Member Capito, and distinguished members of the subcommittee, thank you for the opportunity to submit testimony on behalf of the National AHEC Organization (NAO). I serve as the chief executive officer of NAO with over 15 years of experience as an AHEC Center Director from Kentucky. The NAO is the professional organization that represents Area Health Education Centers (AHECs) across the country. We support advances in the AHEC network

to improve health by leading the Nation in recruiting, training, and retaining members of a diverse health workforce in rural and underserved communities. As a member of the Health Professions and Nursing Education Coalition (HPNEC), NAO is pleased to recommend $1.51 billion for the health professions training programs under Title VII and VIII of the Public Health Service Act that are administered by the Health Resources and Services Administration (HRSA). Of this amount, the NAO recommends $67.00 million in fiscal year (FY) 2024 for the Area Health Education Center program.

The national AHEC network consists of more than 300 AHEC program offices and centers, serving over 85% of the counties in the United States. With 50 years of operation, AHECs meet the current and emerging needs of the communities they serve through robust community-academic partnerships, with a focus on exposure, education, and training of the current and future health care workforce.

HIGHLIGHTED AHEC PROGRAMMATIC ACTIVITIES

—*AHEC Scholars Program:* This 2-year program initiative recruits, trains, and supports interdisciplinary groups of health professions students committed to increase health care quality through community-based service and health care transformation. Every AHEC Scholars program includes 40 hours of didactic and 40 hours of community-based or clinical activities each year. Through these experiences, Scholars develop new skills and knowledge designed to expand their understanding of the social determinants of health and health equity (or lack of), for populations living in rural and underserved communities. This curriculum is a critical tool to prepare a diverse, equitable, compassionate, qualified health care workforce.

—*Continuing Education:* The NAO and member AHECs provide accredited continuing education programs and professional support for healthcare professionals who seek licensure and certification credits with an emphasis on rural health and health care in underserved areas.

—*Health Professions Pipeline:* AHECs expose students in grades 9–12 to health careers through job shadowing, health career presentations, and summer programming. Undergraduates participate in AHEC networking/enrichment programs to enhance their knowledge, experience, and forward the pathway to health professions school admission.

—*Clinical Rotations:* Clinical training rotations are available throughout most of the AHEC network to enhance clinical expertise for medical students, residents, pharmacy, PA, APRN and other health professions students in rural and underserved communities.

The AHEC program is reauthorized through FY 2025. The AHEC authorization language recommends a funding level of $250,000 annually for each AHEC Center. A FY 2024 funding level of $67 million would facilitate that recommendation.

JUSTIFICATION FOR NAO'S FUNDING RECOMMENDATION:

Funding the AHEC program at $67 million provides critical opportunities to support AHECs as they:

—Foster strategic community-based partnerships within the communities they serve to address the health workforce needs related to the emerging health issues such as COVID–19 pandemic;

—Strengthen linkages between academic health science centers and community health service delivery systems to provide additional training opportunities for students, faculty, and practitioners;

—Increase the return on Federal investment by leveraging State and local resources to meet the required 1:1 funding match in support of health workforce development;

—Expedite the transformation of the health care system by training the current and future workforce for a value-based, patient-centered, team-based practice environment for innovative models of care.

The AHEC network is a part of a critical pipeline that fuels the recruitment, training, distribution, and retention of a national health workforce. At a time where the AAMC projects our Nation will have a shortage of nearly 120,000 physicians by 2030, AHEC stands as a central access point in meeting this demanding shortage area. Primary care practitioners are the front-line in prevention of disease and providing cost savings in the United States healthcare system. In recognizing this, the AHEC program engages in pre-pipeline, pipeline, and post-pipeline activities that guide individuals through health careers pathways and beyond, with a special emphasis on primary care providers. In 2022, AHECs introduced more than 248,000 students, ranging from high school to collegiate status, to careers in the health pro-

fessions and health workforce. AHECs facilitated 25,385 student clinical rotations, many of which were in rural and underserved areas. Additionally, AHECs were responsible for training 377,184 professionals through continuing education, and more than 8,000 students were enrolled in the AHEC Scholars program. These facts make AHECs integral in the recruitment, interdisciplinary training, and retention of the healthcare workforce.

AHECs have a continual focus on improving the health care system by working with 120 medical schools, 600 nursing and allied health schools, healthcare settings like CHCs, behavioral health practices, and community-based organizations across the Nation. Through these longstanding partnerships, the AHECs employ traditional and innovative approaches to develop and train a diverse health care workforce prepared to deliver culturally appropriate, high-quality, team-based care for rural and underserved communities. AHECs are embedded in the communities they serve, positioning them to respond rapidly to emergent training needs of health professionals, health professions students, and inter-professional teams on issues associated with natural disasters, disease outbreaks, and substance use disorders.

Chairwoman Baldwin and Ranking Member Capito, thank you and the committee for the opportunity to present the views of the National AHEC Organization. Allow me to re-emphasize the funding request of $67.00 million for the Area Health Education Centers program. As you begin the FY 2024 process, we look forward to working with the subcommittee to continue prioritizing health workforce initiatives that improve training opportunities, the quality of our healthcare workforce, and alleviate patient care, research in health disparities, and health professionals going into the health workforce.

[This statement was submitted by Dwain Harris, Chief Executive Officer, National Area Health Education Centers Organization.]

PREPARED STATEMENT OF THE NATIONAL ASSOCIATION FOR PUBLIC HEALTH STATISTICS AND INFORMATION SYSTEMS

Chair Baldwin, Ranking Member Capito and Members of the subcommittee, thank you for the opportunity to submit testimony in support of at least $340 million in Fiscal Year 2024 funding for the Data Modernization Initiative (DMI) at the Centers for Disease Control and Prevention (CDC) and $215 million for the National Center for Health Statistics (NCHS).

My name is Shawna Webster, and I am the Executive Director of NAPHSIS, the National nonprofit organization representing the state vital records and public health statistics offices in 57 States and jurisdictions across the United States. Formed nearly 90 years ago, NAPHSIS represents more than 350 public health professionals from the 50 States, five territories, New York City, and the District of Columbia.

On behalf of our members, who manage vital statistics and serve as the stewards of individual identity in their States, territories, and localities, NAPHSIS and our partners educate policymakers about the importance of vital records and infrastructure modernization in order to secure continued Federal investment in these priorities. NAPHSIS also provides technical assistance and training, educational programs, and access to resources that assist in vital records and health statistics management. Our nation's vital records offices promote public health, fostering birth and death statistics that reveal critical public health trends, and protect individual identity through their oversight of official birth and death records.

Federal funding is critical for the operation of each of the 57 vital records jurisdictions. NCHS, which funds a small portion of state vital records programs, plays a critical role in our public health data infrastructure and should be both independently funded at a higher level and also better incorporated into the DMI. For the past two decades, NCHS' reimbursement for annual birth and death data has been stagnant at only $21 million per year nationally for 57 vital records jurisdictions. This decades-old pricing structure is based on population, regardless of the fact that all jurisdictions need the same basic systems and services to provide this essential public health data set. This is not nearly enough to adequately support the National vital statistics cooperative program that exists between the jurisdictions and NCHS. For this reason and many others, vital records offices are universally financially challenged, and the majority are "fee funded," which means they rely on sales of birth and death certificates, which can cost as little as $18—not state appropriations—to get by.

Yet, vital records serve critical public health, civil registration, and administrative functions. These data are used to monitor disease prevalence and our Nation's overall health status, develop programs to improve public health, and evaluate the effec-

tiveness of those interventions. Because of Congress' longstanding leadership in supporting the modernization of the National Vital Statistics System-moving from paper-based to electronic filing of birth and death statistics—NCHS has funded States and territories to speed the release of birth and death statistics, including infant mortality and prescription drug overdose deaths. In fact, the percentage of mortality records reported within 10 days has increased from less than 10 percent in 2010 to 65 percent in 2022. However, some States lag behind and several, including West Virginia, have only recently implemented their first electronic death reporting system.

It is critical for the Nation to have strong public health surveillance systems in place. Led by the CDC, vital records offices, State and local health departments, and public health laboratories across the country need a nationwide, interoperable public health surveillance infrastructure to detect emerging health threats and facilitate the immediate and ongoing response. We do not have this today. Instead, legacy systems, some decades old, and systemic barriers, like lack of interoperability, delay our public health response at all levels. This has been particularly problematic in the area of vital records—including death reporting. For example, today, the mechanisms to report deaths—whether by a State medical examiner, coroner, hospital, physician, or other provider—are not interconnected with a patient's medical record or electronic health record (EHR) and require reporters to enter data twice into two different systems or worse, still rely on fax machines.

For our vital records agencies, system upgrades are needed for both statistical, and more importantly during a public health threat, surveillance purposes. We need to increase support to vital records and NCHS to aid in real-time transmission of birth and death data, giving epidemiologists and other public health staff at the State and local level access to actionable data. Additionally, advancing interoperability is critical to ensure that physicians and other providers can seamlessly report deaths through their existing EHR systems to eliminate delays and mitigate errors.

NAPHSIS is a founding member of the Data: Elemental to Health Campaign. Years before COVID–19 we called on Congress to provide the first ever dedicated funding for public health data systems and to build a 21st century public health data superhighway. Along with our partners in the campaign, NAPHSIS has called for a robust Federal investment through the DMI at the CDC to upgrade and subsequently maintain our Nation's public health surveillance systems.

Congress has recognized the urgent need for these upgrades and invested more than $1 billion in CDC's DMI. These resources have provided an important foundation for the creation of a 21st century public health data infrastructure that will speed the seamless exchange of data for all diseases and conditions, help to predict and prevent public health threats before they occur, and to allow rapid response when they do occur. However, significant work remains to be done as State and local jurisdictions have not received sufficient funding to begin their system and workforce upgrades in earnest. Additional sustained funding is needed to ensure we are building and maintaining an enterprise-wide data infrastructure. Data: Elemental to Health estimates data modernization will cost at least $7.84 billion over 5 years at the state, territorial, local, and Tribal levels. We need robust, sustained, annual funding for DMI to provide resources for public health systems and infrastructure to keep pace with evolving technology.

The Electronic Vital Records System is one of five key pillars that form a modernized public health surveillance system. It is a national system of 57 vital records jurisdictions that provide secure electronic collection of birth and death data from hospitals, funeral homes, physicians, and medical examiners. It allows for timely and accurate reporting of birth outcomes and causes of death, which serve to monitor and respond to public health crises as they arise in communities, including tracking infectious disease outbreaks and reducing preventable deaths and infant and maternal mortality rates.

Two years ago, CDC allocated funding directly to vital records for the first time ever, providing $1.35 million per jurisdiction through CDC's Epidemiology and Laboratory Capacity (ELC) program to support electronic vital records modernization.

This was an important investment and the first time ELC funding has gone directly to support vital records upgrades. However, unexpected restrictions on this funding have limited NAPHSIS' and jurisdictions' ability to support the State and Territorial Exchange of Vital Events (STEVE) system, which allows jurisdictions to share vital event data with one another and with partners at CDC. As future funding opportunities arise, NAPHSIS supports the delivery of DMI funding through NCHS to support necessary upgrades to vital statistics systems to enable more, better, and faster vital records data. The best way to support vital records is through

NCHS, but to accomplish that, NCHS must be funded at higher, more sustainable levels throughout the lifespan of DMI.

The core data systems for a national infrastructure already exist, have demonstrated value, and are used to varying degrees at the State and local levels. Modernizing our Nation's public health data infrastructure requires significant Federal investment and a commitment by Congress to see the project through in the near and long term. To truly transform our public health data systems and ensure they are prepared to respond to all future threats we need robust, sustained annual funding for the DMI and increased resources for NCHS.

NAPHSIS respectfully requests that the subcommittee provide funding of at least $340 million for the public health Data Modernization Initiative at CDC in Fiscal Year 2024 and continue to provide sustained, annual funding thereafter. NAPHSIS also supports $215 million for NCHS, which will support NCHS's continued work to support vital records directly, monitor the health of the American people, and to allow the agency to make much-needed investments in the next generation of its surveys and statistical data products. Thank you.

[This statement was submitted by Shawna Webster, Executive Director, National Association for Public Health Statistics and Information Systems.]

PREPARED STATEMENT OF THE NATIONAL ASSOCIATION OF CLEAN WATER AGENCIES

The National Association of Clean Water Agencies (NACWA) represents over 350 public wastewater and stormwater utilities nationwide providing essential services to protect public health and the environment. The utilities we represent collectively provide vital clean water services to more than 150 million Americans daily.

NACWA appreciates the opportunity to submit testimony today for the subcommittee's FY 2024 Public Witness Hearing. Thank you for your consideration and please feel free to contact NACWA to discuss these requests further.

Agency: U.S Department of Health and Human Services

Program: Low Income Household Water Assistance Program (LIHWAP) Funding

Request: $1 billion for FY 2024

The Low Income Household Water Assistance Program (LIHWAP) was created by Congress during the COVID–19 pandemic to help households maintain access to critical drinking and clean water services and provide relief for households facing economic uncertainty. This was the first time that Congress directly recognized and provided funding to address the burden that rising water and sewer bills have on lower income households. This critical step acknowledged that water is essential for public health and wellbeing, on par with other vital needs (e.g., energy and food) for which assistance for eligible households has been available for decades.

While LIHWAP was essential during the pandemic, such a program was desperately needed before COVID–19 and continues to be needed in communities across the Nation. Water and sewer bills comprise a significant and growing proportion of household income, well above what the U.S. EPA deems affordable in many low-income communities. LIHWAP directly addresses rising costs and the water affordability crisis where it is most acutely felt—by the lowest income Americans.

LIHWAP's emergency funding (a total of $1.38 billion appropriated in FY21) is available through the end of FY 2023. Already, some States have used their full allocation, and others are anticipated to see funds run out before September 30.

While LIHWAP was established as a temporary program via the COVID–19 relief legislation, NACWA strongly believes that Congress should authorize and fund a permanent Federal low-income water assistance program. In the interim, NACWA urges Congress to appropriate an additional $1 billion to the existing LIHWAP for FY 2024 to avoid a gap in Federal low income water assistance funding and help ensure continued access to clean and safe water.

Agency: U.S Department of Health and Human Services

Program: Low Income Household Energy Assistance Program (LIHEAP) Funding

Request: $5.1 billion for FY 2024

The Low Income Home Energy Assistance Program (LIHEAP) is a vital, long-standing program that helps households manage the costs of heating and cooling. In addition to direct bill assistance and emergency aid, LIHEAP can help reduce energy costs long-term by supporting weatherization and energy efficiency upgrades.

LIHEAP helps more than six million low-income families afford the cost of heating and cooling each year. Like water, energy costs are a significant and growing portion of many household budgets.

Many of the same households that struggle with the costs of water also struggle with the energy bills, and one hardship can often lead to another. For this reason, NACWA supports full funding for LIHEAP alongside funding for LIHWAP.

Agency: U.S Department of Health and Human Services

Program: Centers for Disease Control and Prevention, Emerging Infectious Diseases

Funding Request: Support the Department's FY 2024 request for the NWSS

In response to the COVID–19 pandemic, the Centers for Disease Control and Prevention (CDC) launched the National Wastewater Surveillance System (NWSS) in September 2020. CDC developed the NWSS to coordinate and build the Nation's capacity to track the presence of COVID–19 in wastewater samples collected across the country. Wastewater surveillance is the only guaranteed scientific approach to collecting infectious disease data, especially as clinical testing subsides, and at-home tests go unreported. Wastewater surveillance infrastructure is in place in hundreds of communities in the U.S. The approach has been extensively deployed to monitor the spread of infection in cities, neighborhoods, and congregate living settings such as dormitories and correctional facilities.

The future of the NWSS holds great promise not only for direct COVID–19 detection and early warning, but could prove essential to defining and mitigating future domestic biological threats. Furthermore, NWSS procedures and infrastructure could be deployed for the detection and source tracking of new emerging pathogens in the future.

NACWA encourages the Committee to continue supporting CDC's domestic threat detection programs, including NWSS, and requests robust appropriations in line with the agency's FY 2024 request.

PREPARED STATEMENT OF THE NATIONAL ASSOCIATION OF COUNTY AND CITY HEALTH OFFICIALS

The National Association of County and City Health Officials (NACCHO) is the voice of the nearly 3,000 local health departments across the Nation. Every day, local health departments work to keep their communities safe and healthy through essential services like screening and treatment for both chronic and communicable diseases; maternal and child health services; environmental health services; epidemiology and surveillance; routine immunizations; primary prevention services; regulation, inspection, or licensing; and emergency preparedness and response.

To enable local health departments to support Federal public health priorities and effectively lead in their communities, NACCHO requests the following funding:

—$100 million for the Public Health Workforce Loan Repayment Program at the Health Resources and Services Administration (HRSA);
—Report language to ensure funding from the Centers for Disease Control and Prevention (CDC) to States makes it to the local level as intended; and
—$1 billion for the CDC Public Health Infrastructure and Capacity Program

PUBLIC HEALTH WORKFORCE LOAN REPAYMENT PROGRAM

The workforce is the backbone of the Nation's governmental public health system but is facing a crisis. In the decade prior to the pandemic, State and local health departments lost 15 percent of essential staff and 80,000 more full-time equivalents—an increase of nearly 80 percent—are needed to provide a minimum package of public health services.[1] Job losses for local health departments, in particular, led to over a 20% reduction in workforce capacity leading up to the COVID–19 pandemic.[2] While all health departments need additional staff, the most acute need is in small local health departments which often serve rural communities. Without sufficient staff, health departments may not be able to carry out essential services, leaving their communities underserved, more susceptible to public health threats, and at increased risk of negative health outcomes.

Last year, Congress recognized the need to bolster the public health workforce and included in the Consolidated Appropriations Act of 2023 bipartisan legislation

[1] https://debeaumont.org/staffing-up/.
[2] https://www.naccho.org/uploads/downloadable-resources/Programs/Public-Health-Infrastructure/NACCHO__2019__Profile__final.pdf.

authorizing the Public Health Workforce Loan Repayment Program, a commonsense incentive to promote the recruitment and retention of public health professionals at local, State, and Tribal public health agencies. NACCHO respectfully urges Congress to now follow through on this commitment and fully fund the program at its authorized level, by providing $100 million to HRSA in FY 2024 to implement the Public Health Workforce Loan Repayment Program.

In my home state of New Jersey, State and local health departments struggle to hire professionals because government salaries are less competitive and new public health graduates are burdened with student loans. Prospective candidates prefer higher paying jobs in the private industry and government public health is consistently challenged with attracting employees. Student loan repayment assistance is a critical financial benefit to attract new employees and will provide my department a means to entice and hire young talent. More importantly, the 3-year commitment required by the program would be a tremendous benefit to our being able to retain staff. Public health professionals are passionate about their work and most employees who work for 3 years in governmental public health become "lifers." The repayment program will attract candidates to my department and the 3-year commitment will help us keep them.

CONGRESSIONAL DIRECTION AND OVERSIGHT TO ENSURE FEDERAL FUNDS REACH THE LOCAL LEVEL

Federal funding intended for both State and local health departments continues to have variable reach to local public health agencies. In New Jersey, the majority of financial support is from local tax dollars; local health departments receive no money from the State and a minimal amount of Federal funding via pass-through. Health department budgets are poorly supported with local dollars and must compete for funding with other local needs that are often more visible, such as paving roads and removing snow. The true value of local health departments is often unknown—when we are doing our jobs right, people don't see us—so limited tax dollars are used to make other, more visible investments. However, taken as a whole, this patchwork approach to public health funding at the community level means that one's access to basic public health services and supports can vary greatly by zip code.

With the recent influx of Federal funding in response to the COVID–19 pandemic, my health department's infrastructure increased by 20 percent. We are doing more now for the communities that we serve than ever before and are finally able to provide appropriate needed services like homebound vaccinations and substance abuse prevention services.

Unfortunately, other local health departments have not seen the same levels of access to pandemic-related funding due to great variation in how States chose if, how, when, and how much Federal resource will reach the local health department level. Either way, no matter where they are in the country, local health departments need access to sustained, predictable Federal funding to build or maintain these needed services and be prepared to handle the next public health emergency.

Congress has acknowledged this issue and included report language in the FY2022 Consolidated Appropriations Act to ensure Federal funding reaches the local level equitably and efficiently. NACCHO requests similar language be included in FY2024 appropriations for CDC-wide activities and program support that specifically encourages CDC to require States to fund local health departments when programmatically appropriate and urges CDC to publicly track and report how funds provided to State health departments are passed through to local health departments, including amount, per grant award, by local jurisdiction. This Congressional direction and oversight will provide vital transparency to the flow of Federal public health funds and help to identify best practices.

PUBLIC HEALTH INFRASTRUCTURE AND CAPACITY

Local health departments operate on limited and unpredictable budgets that do not allow for long-term investments in necessary infrastructure and cross-cutting needs. Federal public health funding has traditionally followed a boom-and-bust cycle in response to crises, and funds are often limiting (for example, tied to a specific disease state or programmatic function) making it difficult to invest in or sustain critical health department functions. Local health departments need sustainable, disease-agnostic, predictable funding to support local public health infrastructure and focus on certain skillsets that are critically necessary—like communication, outreach, data analysis, and digitalization—but that are largely lacking due to current funding constraints, hindering efforts to support Federal public health objectives.

NACCHO is grateful that Congress established the Public Health Infrastructure and Capacity program in FY2022 and continued to bolster the program in FY2023, which helped support $3.2 billion in awards from CDC to local, State, and territorial jurisdictions for public health workforce and infrastructure. Those awards were an important down payment, but a sustained investment is needed to rebuild our long under-funded governmental public health system. NACCHO respectfully urges the Committee to continue to invest in the Public Health Infrastructure and Capacity program by providing $1 billion in FY2024.

Importantly, CDC included with those awards explicit guidance that 40 percent of a State's funds should go to local health departments within 1 year, without additional administrative barriers, and expanded directly-funded local health departments from five to 48 localities. Unfortunately, the State Department of Health in New Jersey opted to keep all of the Federal workforce dollars at the state level and will hire regional employees to assist local health departments with hiring and training new employees, instead of letting local health departments use the funds themselves. Truthfully, that does not provide financial support to improve my department's infrastructure. Potential candidates may be well-trained, but if my health department does not have the money to hire them, their training and expertise cannot be harnessed. Hence, I wish to reiterate how important it is for Congress to exercise oversight over how funds are flowing to ensure they are being used as intended. Local health departments are the trench workers and the first to respond, but often the last to receive funds, which in this case could have been used for foundational needs like hiring and retaining staff, addressing staff wellness, providing training and professional development opportunities, and improving systems and capacity related to workforce development and management.

Thank you for the opportunity to provide testimony on the FY 2024 appropriations priorities for local health departments. NACCHO looks forward to working with your subcommittee to ensure local health departments are adequately supported in their mission to protect the health and safety of communities across the Nation.

[This statement was submitted by Margaret Jahn, MS, MPH, President of NACCHO and Director of the Freehold Area Health Department in Freehold, New Jersey.]

PREPARED STATEMENT OF THE NATIONAL ASSOCIATION OF ELEMENTARY SCHOOL PRINCIPALS

On behalf of the National Association of Elementary School Principals, I am pleased to submit the following testimony regarding the FY24 appropriations for Federal K–12 education programs.

We strongly urge the subcommittee to provide the largest possible increases for education, especially for those Federal programs that support socio-economically disadvantaged students, students with disabilities, and a comprehensive, well-rounded education.

—Title I Grants to Local Education Agencies—$20.5 billion
—Title II, Part A Supporting Effective Instruction State Grants—$2.4 billion
—Title IV, Part A Student Support and Academic Enrichment State Grants—$1.48 billion
—IDEA Part B State Grants—$16.28 billion

Federal K–12 education programs have suffered a decade's worth of disinvestment. Even with considerable recent funding increases, these programs currently receive less now than they did in FY11 when adjusted for inflation. Emergency COVID–19 funding helped schools address the unique and unprecedented challenges of a global pandemic, such as providing uninterrupted educational services to students, improving air quality, cleaning and sanitizing facilities, and academic recovery. This one-time funding was welcome both for the immediate pandemic-related expenses as well as the longer-term recovery needs that will continue well after the funds are exhausted. But it is neither a panacea nor a sufficient replacement for ongoing investments via the regular appropriations process.

Funding increases for the aforementioned programs in FY24 are targeted investments that will help address the post-pandemic needs of students, families, educators, and schools as well as enhancing the systemic capacity of school systems to best serve the needs of their communities.

The Title I and IDEA funding will provide additional resources for the socio-economically disadvantaged students and students with disabilities that have been disproportionately impacted over the past several years.

Effective teachers and school leaders are two of the most influential factors in student success and for a significant number of school districts the Federal dollars from the Supporting Effective Instruction State Grants (Title II) are the only sources of funding to help train existing educators. Not only are effective educators an essential strategy for the academic recovery of students, but this educator assistance bolsters job satisfaction and helps with staff retention at a time when many schools are facing personnel shortages.

The Student Support and Academic Enrichment State Grants (Title IV) provide schools with funding to support a well-rounded education and to promote safe and healthy school environments. A comprehensive education delivered in a supportive and engaging setting is more important than ever for students.

Thank you for your consideration of our views and we look forward to continuing to offer the perspective of elementary and middle school leaders throughout the legislative process.

[This statement was submitted by David Griffith, Associate Executive Director, Policy and Advocacy, National Association of Elementary School Principals.]

PREPARED STATEMENT OF THE NATIONAL ASSOCIATION OF FEDERALLY IMPACTED SCHOOLS

Dear Chairman Baldwin and Ranking Member Capito:

The National Association of Federally Impacted Schools (NAFIS) strongly urges the Senate Labor-Health and Human Services-Education Appropriations subcommittee to continue recognizing the Federal Government's obligation to federally impacted communities as you set funding priorities for the U.S. Department of Education.

We urge you to provide at least a $2 million increase for Federal Property, a $65 million increase for Basic Support, a $1.5 million increase for Construction and a $1.5 million increase for Children with Disabilities in the Department of Education's Impact Aid Program for FY 2024.

NAFIS represents the 1,100-plus Impact Aid-recipient school districts that together educate 10 million students across the Nation. Impact Aid is the oldest elementary and secondary education program and is a partnership between local communities and the Federal Government where there is significant non-taxable property, such as military installations, Indian treaty or trust land, Alaska Native Claims Settlement Act land, Federal low-rent housing facilities, national parks, and national laboratories. Congress recognized in 1950 that the Federal Government had an obligation to help meet the local responsibility of financing public education in areas impacted by a Federal presence. That same recognition holds true today.

NAFIS is grateful for the subcommittee's past support of the Impact Aid program, and we hope to see that support continue in FY 2024. Federally impacted school districts cannot afford stagnant appropriations or a loss of funding. FY 2024 will require additional funds to build on the important funding progress made in the last few years.

Section 7003 Basic Support: Although appropriations have increased in recent years, Basic Support remains significantly underfunded. The Basic Support payment formula is based on several factors, including the actual cost of education. That cost is measured by the Local Contribution Rate (LCR), which is based on per pupil expenditures (PPE) from 3 years prior.

Basic Support is currently funded at about 60% of the payment formula. Because the program is so underfunded, the Impact Aid law includes a proration factor called the Learning Opportunity Threshold (LOT), which measures the need a school district has for Impact Aid funds. The higher a school district's LOT, the more reliant it is on Impact Aid.

In 2020, for the first time in more than a decade, LOT paid out at over 100%. That means the highest need Impact Aid districts got their full payment. However, hundreds of other school districts still received far less than they would have if the program were fully funded.

For FY 2021, the LOT Payout is estimated to be 98%. Whenever the LOT Payout is below 100%, all federally impacted school districts—including those with the most need that rely most heavily on Impact Aid funds to operate—receive payments below those calculated by the formula in the Impact Aid law.Due to the impact that COVID–19 had on state revenue nationwide, the LCR for FY 2023 actually dropped to 2.26% down from 4.6% in Fiscal Year 2022. The LOT percentage payout for FY 2023 is expected to reach 100%, however due to ESSER funding and state revenue increases, we expect that the LCR in the Impact Aid formula could increase between 3.5% and −5% in FY 2024 based on projected increases in per pupil expenditures

for the 2020–2021 school year (NCES data will be available in September on which the FY 2024 LCR will be based). Without a corresponding increase in appropriations, the LOT Payout could drop substantially.

Fiscal Year	LOT Payout	LCR Rates
FY 2011	97.066%	$5,215.00
FY 2012	96.109%	$5,330.00
FY 2013	87.061%	$5,404.50
FY 2014	91.730%	$5,406.00
FY 2015	93.074%	$5,386.00
FY 2016	93.690%	$5,468.00
FY 2017	92.332%	$5,635.50
FY 2018	96.187%	$5,840.50
FY 2019	98.138%	$6,036.00
FY 2020	101.15%	$6,268.50
FY 2021*	98%	$6,495.00
FY 2022*	100 + %	$6,794.00
FY2023*	100 + %	$6,947.00

* Estimated final rates.

The increases in appropriations and LOT Payout have been critical for federally impacted school districts, especially given increased costs stemming from the COVID–19 pandemic. A $65 million increase for FY 2024 would build on these increases and help the program keep pace with the rising costs of education. With that increase, the 7003 Basic Support formula will still be approximately $850 million below fully funding its formula. We encourage Congress to make up this gap and set a glide path to fully fund the formula.

Section 7003(d) Children with Disabilities: Another important element of Impact Aid is the Children with Disabilities (CWD) section, which provides funding for military-connected or Indian lands students with an active Individualized Education Program (IEP). It has been funded at $48 million since 2008, despite rising costs of providing special education services. This currently means a school district receives approximately $1,200 per eligible student living on Federal property (or $600 for military-connected students who do not live on a military installation). As the cost of special education rises, this $48 million appropriation is stretched too thin, especially given the chronic underfunding of IDEA. Payments per CWD dropped from $1,215.65 in FY 2018 to $1,205.00 in FY20. FY 21 and FY 22 remain incomplete with the expectation that the dollar level will remain at or near $1,200. School districts are continuing to educate their students with disabilities, spending significant general funds to do so. Therefore, NAFIS seeks a $1.5 million increase for this line item.

Section 7002 Federal Property: We thank you for the $5 million increase in 7002 payments in FYs 2019 through 2023. For FY 2024, we request an additional $2 million to build on these increases. These funds will partially offset new costs as the Federal Government continues to take property off local tax rolls and as the value of taxable land on which the funding formula is based increases.

Section 7007 Construction: Finally, the Construction section of Impact Aid receives very little support, languishing at a $17 million level for the past several years. We are grateful for FY2023's increase of $1 million for this line item but even at $18 million Impact Aid Construction still falls woefully short of the $45 million it received in FY 2005. For FY2024, we request a $1.5 million increase over last year. Additionally, we recommend that FY 2024 Impact Aid Section 7007 funds be distributed under Section 7007(a) formula grants, since FY 2023 funds will be dispersed through Section 7007(b) competitive grants—as per language inserted in the annual House/Senate Appropriation Bill even years dollars as paid out under the formula provision 7007 (a) and odd years under 7007 (b) competitive grants.

School superintendents are saying...

> Impact Aid provides the necessary funding to ensure that all students in our district have access to a Free Appropriate Public Education and high levels of learning every day for every student to ensure that all students are prepared to graduate Life, College, and Career ready!—*Washington*
>
> We would not be able to operate without Impact Aid; our Impact Aid funds pay for all support staff, consultants, utilities, daily operations, professional development, curriculum, materials, and technology needs.—*Montana*

Impact Aid money has helped improve our relations with the Southern Ute Tribe. Over the last 10 years, we have developed a meaningful MOU, included a representative from the Tribe on our administrative team, added a Ute Language Class, and had regular and meaningful community meetings with Tribal leaders to get important feedback.—Colorado

Because of Impact Aid, we have truly leveled the playing field and dramatically improved the working relationship with the Seneca Nation. Instead of the conversation being framed "you are not doing enough" the conversation is now "how can we partner to do more for all children". Because we have been able to use IA funding to improve program, graduation rates, dropout rates, Advanced Placement rates our enrollment has dramatically increased in the past 5 years (+300 students). Simply put IA has made our "product" better, much better.—*New York*

Additional investments in Impact Aid are critical to help school districts close achievement gaps, update technology, expand access to early childhood and afterschool programs, integrate culturally relevant curriculum, replace failing infrastructure, offer competitive salaries to recruit and retain school leaders, and more. These investments help school districts provide supportive and nourishing learning environments for all students. Through increased funding, we ask you to continue to view the program as a critical Federal investment and a tax replacement program for federally impacted communities.

Sincerely.

[This statement was submitted by Nicole Russell, Executive Director, National Association of Federally Impacted Schools.]

PREPARED STATEMENT OF THE NATIONAL ASSOCIATION OF NUTRITION AND AGING SERVICES PROGRAMS

Chair Baldwin, Ranking Member Capito:

I write on behalf of the National Association of Nutrition and Aging Services Programs (NANASP). NANASP represents senior nutrition providers and other aging services programs across the country. Our members serve over 4 million older adults annually. We are asking for a total of $1.284 billion for the Older Americans Act (OAA) senior nutrition programs within the HHS Administration for Community Living for FY 2024. We support President Biden's FY24 budget increase of $217 million in funding to $1.284 billion for OAA Title III–C, and we would like an allocation of 616 million for congregate meals (III–C1) and 507 million for home delivered meals (III–C2).

Within that total, we urge the subcommittee to have the allocation between Titles C–1 and C–2 for FY 2024 reflect as much as possible the current realities on the ground. It needs to be remembered that prior to the COVID–19 pandemic, two-thirds of meals served under the OAA were in congregate settings. That was completely reversed due to the closing of almost all congregate sites in the early days of the pandemic, meaning virtually all meals were home delivered. We are grateful that we are seeing a steady and gradual return to congregate dining, but it will take some time. In addition, we hope the subcommittee will recognize the value of "grab and go" meals, both at the start of the pandemic but also in recent months as the pandemic has waned. Title III–C–2, home delivered nutrition, has been the primary funding source for "grab and go" meals. That needs to be reflected in the allocation.

We also make this ask in light of several realities impacting these programs across the Nation. The first reality is that local senior nutrition programs are still recovering from the COVID–19 pandemic. Programs across the country want to continue to reopen congregate meal sites, both to provide nutrition and nutrition education and also to allow the critical socialization opportunities these programs provide. This is especially important when we see the spike in older adults who are isolated and lonely.

The second reality is unrelenting inflation. Two critical components of the nutrition program are food and transportation. Today, food inflation rates continue to run higher than general inflation rates-food prices were 10.1 percent higher in January 2023 than in January 2022—and transportation costs, led by the volatility of gas prices, also run higher.[1]

The third reality relates to workforce, both paid staff and volunteers. Without any question, senior nutrition programs (and the aging network in general) are short on personnel and volunteers. In the case of volunteers, early in the pandemic, programs

[1] https://www.ers.usda.gov/data-products/food-price-outlook/summary-findings.

lost some of their most valued volunteers who themselves tended to be older and at higher risk of getting COVID–19. One positive step this subcommittee can also take to address this issue is to increase funding for the Senior Community Service Employment Program (SCSEP), Title V of the OAA. This program provides part-time community service jobs for low-income adults. This includes many who work in our nutrition programs. Therefore, higher funding for this program would also be helpful for the OAA nutrition programs.

Our ask also relates to the growing recognition of the importance of nutrition to health. Funds we invest in the OAA nutrition programs address and even prevent health conditions such as diabetes, heart disease, high blood pressure and malnutrition. Providing older adults with at least one meal a day for at least five days per week along with nutrition education to assist them in making healthy choices when they are not eating at the program site can help lower health care costs.

Our ask also recognizes that food insecurity and malnutrition in the older adult population is growing. In fact, it is estimated that 1 in 2 older adults are malnourished or at risk of malnutrition. The OAA nutrition program for 51 years has stood strong in identifying and serving those older adults who otherwise might be food insecure or malnourished, as well as those who are isolated without access to food. These problems, especially senior isolation, grew worse in some parts of our Nation because of the pandemic. We must recognize this and provide resources for those proven programs that make a genuine and positive difference.

A funding level of $1.284 billion will most certainly allow the OAA to both maintain its current service and grow to meet the needs of more older adults. This is a program that is recognized in communities across our Nation. Its staff and volunteers are trusted entities. They have performed with great effectiveness even in difficult times like the pandemic. We appreciate the bipartisan commitment this subcommittee has made to the OAA nutrition programs in the past. Please continue to provide the resources they need to allow them to positively impact the health and well-being of older adults.

[This statement was submitted by Robert Blancato, Executive Director, National Association of Nutrition and Aging Services Programs.]

PREPARED STATEMENT OF THE NATIONAL ASSOCIATION OF RSVP DIRECTORS

The National Association of RSVP Directors (NARSVPD) recommends an FY 2024 funding level of $63 million for the RSVP program, administered by the Corporation for National and Community Service (CNCS); an increase of $7.9 million. These funds will bring successful programs to scale, enable more seniors to live independently, break down social isolation, support veterans and military families, and meet other local needs. RSVP has the largest rural footprint of any national service program and is an important participant in disaster relief programs in rural communities.

RSVP deploys more than 100,000 volunteers across the country to support the efforts of hundreds of community organizations. It is not means tested and it recruits volunteers without regard to income. It provides opportunities for people 55 and over to make a difference through volunteer service and offers maximum flexibility and choice to its volunteers by matching the personal interests and skills of volunteers with opportunities to solve community problems. Usually, most serve between 10 and 40 hours a week, but there is no set schedule. RSVP's flexibility allows volunteers improve the lives of their neighbors and friends every day.

The need for RSVP has never been greater. The number of Americans ages 65 and older is projected to more than double from 46 million today to over 98 million by 2060, and the 65-and-older age group's share of the total population will rise to nearly 24 percent from 15 percent.

Further, according to the Population Reference Bureau, "The aging of the baby boom generation could fuel a 75 percent increase in the number of Americans ages 65 and older requiring nursing home care, to about 2.3 million in 2030 .... Demand for elder care will also be fueled by a steep rise in the number of Americans living with Alzheimer's disease, which could nearly triple by 2050 to 14 million, from 5 million in 2013."

According to the National Academy of Social Insurance, the growing aging population will increase the number of people needing Long Term Services and Supports (LTSS) to an estimated 15 million by 2050 but the availability of family caregivers is expected to decline. By 2030, there is projected to be a national shortage of 3.8 million unpaid family caregivers and 151,000 paid care workers. Thus, there will be a growing need for paid long-term services and supports. RSVP can help meet these challenges.

RSVP programs help seniors are particularly susceptible to loneliness, which is linked to early mortality, both by providing them with volunteer opportunities and connecting them to their communities. Research shows that the lack of social relationships is as much a risk factor for death as smoking or obesity. Researchers at Johns Hopkins found that "older people who are socially isolated face a 28 percent greater chance of developing dementia than do their counterparts who are not socially isolated." The article also reported that "the Centers for Disease Control and Prevention says social isolation affects roughly a fourth of U.S. adults 65 and older." A study of recently widowed older adults found that "higher intensity volunteering may be a particularly important pathway for alleviating loneliness among older adults."

Further, a large research study involving more than 64,000 subjects aged 60 and older suggests that volunteering slows the cognitive decline of aging. "The effect is significant. It's consistent," Dr. Sumedha Gupta said. Further, "we find that as people volunteer, their cognitive health scores improve. If they don't volunteer, their cognitive scores decline faster."

Investing in RSVP is a cost-effective way of improving the health of Older Americans.

RSVP efficiently deploys volunteers across to support the work of community organizations. According to CNCS, in FY 2021, RSVP volunteers working through local nonprofits, county governments, local United Way organizations, social service agencies, faith-based organizations, and many others provided disaster relief services across the Nation, helping victims of hurricanes, tornadoes, floods, forest fires, and industrial accidents; helped more than 2,000,000 people mitigate the impacts of COVID–19 and other public health crises; helped more than 167,000 people expand their educational and economic opportunity and mentored more than 22,000 children; provided independent living services to almost 892,000 adults, primarily frail seniors; provided respite services to nearly 2,500 caregivers; provided support to 9,358 family members of the US Armed Forces; and, recruited an additional 5,400 community volunteers.

The following examples demonstrate the breadth of RSVP activities. In fact, with sufficient imagination and planning, RSVP volunteers can be deployed to address a wide variety of community problems.

There are almost 1650 RSVP volunteers in Dane, County, Wisconsin. Some drive older adults who don't have access to car, bus, family, or friends to transport them to medical appointments. Drivers use their own vehicles and are reimbursed for mileage. In their "Vets Helping Vets" program fellow vets do the driving and provide support and fellowship. The program is expanding to provide other opportunities including volunteering at the Veteran's coffee shop, the VA Hospital, and homeless day centers, as well as at special one-day events celebrating Veterans.

In Dane County communities outside of Madison, RSVP works with local senior centers to offer home delivered meals for seniors, improving the health and quality of life of older adults, and allowing them to remain in their homes.

RSVP volunteers are found in Madison and Dane County schools tutoring and mentoring. Tutors work one-on-one or with small groups of children in kindergarten through 12th grade, assisting with reading, math, and other subjects.

RSVP's Triad program provides residents with the knowledge they need to feel safer and more secure in their communities. Triad brings together older adults, law enforcement and the community at-large to increase safety and reduce the fear of crime. Triad provides the community with vital information about personal safety and crime prevention. Triad has offered on-line sessions about dementia safety, biking and walking safety, and an introduction to local police.

As one Waunakee Home-delivered Meal Recipient "If it wasn't for RSVP, I wouldn't be able to live in my home."

In Connecticut, RSVP volunteers support veterans and military families. The first RSVP Veterans Coffeehouse in Connecticut was established by Thames Valley Council for Community Action's (TVCCA) RSVP in Killingly in 2015. Since then, six additional coffee houses have opened. The coffeehouses reach hundreds of veterans from World War II to Iraq and Afghanistan each week and provide them with companionship, confidential counseling, and access to services. Several veterans and their families gained access to benefits including housing, medical care, energy assistance, food assistance, and other supports. The coffee houses have evolved into public-private partnerships staffed by RSVP volunteers and vets and attract support from local businesses, Chambers of Commerce, churches, senior centers, and others. Fittingly, the coffeehouses have helped a number of vets receive long overdue medals honoring their service.

Volunteers at Federal Hill House in Providence Retired & Senior Volunteer Program (RSVP) volunteers work in our food pantries, obtain training to lead evidence-

based health and wellness activities, or volunteer with the Volunteer Income Tax Assistance Program (VITA). They tutor school age children, serve meals to older adults, and can provide transportation for their peers.

The 800 volunteers in the RSVP of the United Way of Central West Virginia currently serve Boone, Cabell, Doddridge, Harrison, Kanawha, Lincoln, Marion, Mercer, Monongalia, Monroe, Preston, Putnam, Summers, Taylor, Upshur, and Wayne Counties. Volunteers serve at a variety of area nonprofits, assisting local health care providers, emergency services, blood donor services, food banks, schools, and nursing homes. They help promote independent living through senior assistance, provide office support and computer skills to nonprofits, and take the lead in organizing neighborhood projects.

In the RSVP program in Athens, Alabama, Volunteer Income Tax (VITA) preparers help elderly and low-income residents in Athens-Limestone and Morgan Counties complete their income tax filings. This year, stationed at local libraries, they served almost 2900 hours in 10 weeks and filed 2,337 returns that resulted in Federal tax refunds of $2.2 million, state refunds of $266,000, Earned Income Tax Credit (EITC) refunds of almost $440,000, and Child Tax Credit (CTC) refunds of more than $340,00. Another 187 people sought assistance or advice but did not file.

Some 10,000 "baby boomers" retire every day and will do so every day for the next 20 years. RSVP is the only national program able to place large numbers of senior volunteers in high quality volunteer positions.

RSVP is cost-effective and an excellent investment. Using Independent Sector's estimate of the value of an hour of volunteer service, RSVP volunteers provide more than $1 billion worth of service to the Nation each year, a return of almost $20 for every Federal dollar invested.

The average Federal RSVP grant is about $88,000. In 2021, the cost of a semi-private room in a nursing home (national annual median rate) was $94,000. The national annual median rate for a private room is $108,400. (See Genworth Financial, Cost of Care Survey 2021). In many States, it costs more to put one senior in a nursing home for a year than it does to support an entire RSVP program.

We recognize the fiscal challenges we face. But we at NARSVPD believe that funding RSVP at $63 million is a particularly worthwhile investment that will ultimately save Federal dollars by keeping our communities healthier, more connected, and less likely to draw on other Federal resources. Supporting RSVP's transition into a more flexible and adaptable program will result in significant benefits to both the volunteers and the communities they serve.

The funds that NARSVPD seeks will train projects to better use social media as a recruitment tool, ensure that every program has a 21st century website.

We support changing outcome and performance measures to reflect new realities, expanding the number of regional offices, hiring more staff with experience in Senior Corps programs, and full funding of the Silver Scholarship program, a much-needed incentive for potential volunteers.

NARSVPD also urges that all appropriated funds be used to fund existing programs and that all funds that are returned to the Corporation through relinquishments be re-allocated to existing programs.

For additional information, contact: Betty Ruth, NARSVPD President, at bruth@al-rsvp.com or Gene Sofer at eugenesofer@gmail.com.

[This statement was submitted by Betty M. Ruth, President, National Association of RSVP Directors.]

PREPARED STATEMENT OF THE NATIONAL CENTER FOR LEARNING DISABILITIES

As you work to develop the Fiscal Year (FY) 2024 Labor, Health and Human Services and Education appropriations bill, the National Center for Learning Disabilities (NCLD) urges you to prioritize children with disabilities, their families, and schools by increasing spending levels for the programs that support them.

Learning disabilities are brain-based differences that impact reading, writing, math, organization, concentration, listening comprehension, social skills, motor skills or a combination of these. There are approximately 2.3 million students ages 5–21 identified as having specific learning disabilities (SLD) and receive specialized instruction and support through the Individuals with Disabilities Education Act (IDEA). Children with SLD make up 34% of all students served under IDEA (the largest of the 13 disability categories defined in the law) and 5% of all students in schools.[1] Additionally, an estimated 6.1 million children ages 2–17 are diagnosed

[1] IDEA Sect. 618 Static Data, 2020–2021.

with ADHD and an estimated one-third of individuals with learning disabilities also have ADHD.[2,3]

Research confirms that when provided the right services and supports, children with learning and attention issues can and do thrive in school and life. Yet, our Nation's schools are struggling to serve these students. There is a great need for continued investment from the Federal Government.

We urge you to adopt the following recommendations as you finalize the FY 2024 appropriations bill:

FUNDING FOR STUDENTS AND INDIVIDUALS WITH DISABILITIES

To support students with learning disabilities, their parents, and the educators who work with them, NCLD urges you to pass a funding bill that increases investments in programs within IDEA. Despite a longstanding promise from Congress since IDEA was enacted to fully fund IDEA, or 40% of the additional costs of educating students with disabilities, that promise has never been fulfilled and previous increases have only covered a portion of annual inflation. Specifically, we ask you to:

—Increase funding for the IDEA Part B (Grants to States) to at least $16.26 billion;
—Increase IDEA Part B Section 619 (Preschool Program) to at least $503 million;
—Increase IDEA Part C (Ages 0–2) to at least $932 million;
—Increase IDEA Part D (National Activities) to the following amounts:
  —State Personnel Development: at least $53.6 million
  —Technical Assistance and Development: at least $55.3 million
  —Personnel Preparation: at least $300 million
  —Parent Training and Information Centers: at least $49.2 million
  —Media and Technology: at least $36 million
  —Special Olympics Education Program: at least $36 million

FUNDING FOR RESEARCH AND INNOVATION

Funding and Report Language for Learning Disabilities Research Center and Innovation Hubs (NIH/NICHD)

Thanks to continued investments into scientific brain research, we know more than ever about LDs and how to support students who have them. This same research has also revealed much about how children learn, how their brain develops, and the evidence-based interventions that can help students—with and without LD—succeed.

The Eunice Kennedy Shriver National Institute for Child Health and Human Development (NICHD) within the National Institute of Health (NIH) has been the leading source of funding for LD research for decades and has yielded groundbreaking research in the science of reading and other areas. NICHD funds more than 50 research centers across the country on a variety of topics related to child health and development. However, only three of those are related to learning disabilities, despite LD being the most prevalent type of disability in students.

We urge the Committee to include the following report language supporting the use of NIH funds for LD research:

> Learning Disabilities Research Centers and Learning Disabilities Innovation Hubs.-The Committee is increasingly concerned with the decline in achievement for students with disabilities and recognizes the need for continued research and improved interventions. The Committee recognizes the importance of NICHD's funding of Learning Disabilities Research Centers and Learning Disabilities Innovation Hubs, which are the only source of Federal funding available to researchers interested in exploring child development and learning disabilities to conduct randomized control trials and explore the relationships between different variables at work. While learning disabilities do impact an individual's education and academic achievement, these disorders are brain-based, and so clinical research using the latest technology and advances in neuroscience is essential. To continue robust research into language, reading development, learning disabilities, and disorders that adversely affect the development of listening, speaking, reading, writing, and mathematics abilities, the Com-

[2] Danielson, M. L., Bitsko, R. H., Ghandour, R. M., Holbrook, J. R., Kogan, M. D., & Blumberg, S. J. (2018). Prevalence of parent-reported ADHD diagnosis and associated treatment among US children and adolescents, 2016. Journal of Clinical Child & Adolescent Psychology, 47(2), 199–212.

[3] World Health Organization. (2019). International statistical classification of diseases and related health problems (11th ed.). https://icd.who.int/.

mittee urges NICHD to continue its investment in its Learning Disabilities Research Centers and Learning Disabilities Innovation Hubs

(THIS TEXT WAS INCLUDED FROM PAGE 116 IN FY 2023 HOUSE BILL REPORT LANGUAGE)

In order to ensure sufficient funding for LD Research Centers and Innovation Hubs, we also request the following:

—Increase funding for the Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD) to $1.877 billion within the National Institute of Health

Funding for Special Education Research and Statewide Longitudinal Data Systems

Within the Institute for Education Sciences (IES), National Center for Special Education Research (NCSER) supports high quality and rigorous research on special education and related services and the full range of issues facing children with disabilities, parents of children with disabilities, school personnel, and more. Its findings help inform interventions, teaching strategies, and other critical factors in educating children with disabilities. Moreover, innovations in special education research have served as an impetus for improvements in general education. For example, Response to Intervention (RTI) was developed by psychologists as a new framework for more accurate identification of students for special education services and for supporting students who required more instruction to succeed but did not necessarily display a learning disability. Researchers experimented with identifying students and providing extra systematic instruction. Today, RTI is commonly used when making decisions in both general and special education. Yet, funding for NCSER has been significantly reduced over the past decade and we urge the Committee to restore funding to its FY 2010 funding levels ($70 million).

Additionally, data systems are an indispensable tool for making informed decisions about priorities within communities, and existing State data systems are ill-equipped. States need Federal support to evolve their data systems so that they are oriented toward access and support responsive policymaking. Currently the best mechanism for providing Federal financial support is bolstering funding through the Statewide Longitudinal Data Systems grant program within IES, whose purpose is to help States successfully design, develop, implement, and expand K12 and P–20W (early learning through the workforce) longitudinal data systems. We urge you to:

—Increase funding for the Institute of Education Sciences to at least $900 million
  —Including at least $70 million for the National Center for Special Education Research
  —And $100 million for Statewide Longitudinal Data Systems

OTHER CRITICAL EDUCATION INVESTMENTS

In order to ensure access and equity in schools, NCLD recommends no less than the following amounts for each program:

—Increase Title I in the Every Student Succeeds Act (ESSA) to $36.5 billion;
—Increase Title II Part A in ESSA (Supporting Effective Instruction State Grants) to $3 billion;
—Increase Title III in ESSA (Language Instruction for English Learners) to $2 billion;
—Increase Title IV Part A in ESSA (Student Support and Academic Enrichment Grants) to $1.48 billion;
—Increase Title IV Part B in ESSA (21st Century Community Learning Centers) to $2.09 billion;
—Increase Title IV—Part E in ESSA (Family Engagement Centers) to $25 million;
—Increase the U.S. Department of Education's Office of Civil Rights to $178 million;
—Increase Title II, Part A of the Higher Education Act (HEA) (Teacher Quality Partnerships) to $1 billion;
—Increase Title II of HEA (Augustus F. Hawkins Centers for Excellence program) to $300 million;
—Increase State Assessment Grants and Competitive Assessment Grants to $469.1 million;
—Fund Career-Connected High Schools at $200 million; and
—Fund School Based Mental Health Services Professionals and School Based Mental Health Services grants at $428 million.

[This statement was submitted by Lindsay Kubatzky, National Center for Learning Disabilities.]

PREPARED STATEMENT OF THE NATIONAL COALITION FOR SERVICE LEARNING STEERING COMMITTEE

I. INTRODUCTION

On behalf of the 52 national and 123+ regional, State, and local organizations, institutions, and commissions that are members of the National Coalition for Service-Learning, the coalition's steering committee requests that the Senate Appropriations subcommittee on Labor, Health and Human Services, Education, and Related Agencies include a $250 million annual appropriation for a Service Learning Fund in the FY24 Labor, Health and Human Services, Education and Related Agencies Appropriations bill for the Corporation for National and Community Service (CNCS). The CNCS will administer this Fund through the Learn and Serve America program as authorized by Subtitle B of the Edward M. Kennedy Serve America Act.

II. WHAT IS SERVICE LEARNING, AND WHY SUPPORT IT?

Service-learning is an approach to teaching and learning in which students engage in community service to address community needs while building their academic and civic knowledge and skills. Service-learning is for students of all ages and may be organized by K–12 schools, colleges and universities, afterschool and youth development programs, or nonprofits. It is a pedagogy that addresses individual students' civic understandings and skills, overcoming the complex challenges of our time, and advancing community development.

Service learning is distinct from current national service programs such as AmeriCorps and Peace Corps as it engages students (K–12 and college-aged students) with early and high impact civic experiences and community service. Other national service programs focus on opportunities for recent graduates, retirees, and other groups to perform direct service or capacity building activities using their previous expertise and interests, while service learning programs in schools:

—Enhance education engagement, which can reduce absenteeism, reduce disciplinary referrals, improve student performance and grades, and impact student retention through graduation;

—Reduce the achievement gap, with evidence that low-income students who serve in their communities through school outperform those who don't; and

—Introduces workforce skills and interests, helping students to develop career networks, job readiness skills, and learn about career pathways through service and community engagement skills that are today expected across the 21st century labor market.

Service learning also projects and sustains our Nation's civic health and democratic institutions by:

—Encouraging dialogue across difference, as students express greater acceptance of cultural diversity, report greater trust, acceptance, and ability to communicate with those different from themselves; and

—Advances civic education and engagement, as students demonstrate greater interest in continuing to vote and volunteer, discuss political issues with their parents and peers, and believe they can make a difference in their communities, States, country, and world.

III. JUSTIFICATION FOR FY24 APPROPRIATIONS FOR LEARN AND SERVE AMERICA

Prior to the COVID–19 pandemic, we already saw stressed educational systems, divided communities, and too many young, disengaged people. The pandemic further amplified existing inequities, isolated individuals, and put students' educational outcomes at risk. This lack of engagement has led to students struggling academically, socially, and emotionally. Notably, the United States Surgeon General's Advisory on the Healing Effects of Social Connection and Community released in May 2023 warns that Americans of all backgrounds, and particularly children and the elderly, are facing unprecedented and high levels of loneliness, depression, and other significant mental health challenges that threaten the health and wellbeing of our Nation's social fabric. Among the recommendations outlined in the advisory to overcome these important issues is increased opportunities to serve one's community given the "virtuous cycle between social connection and volunteerism or service." The impacts for low-income and minority students are even worse. The pandemic has primed us for deep-seated change in public education. We must ensure that we

embrace the connections between education, economic opportunity, and national service.

The final report of the bipartisan, Congressionally-appointed National Commission on Military, National, and Public Service was published in March 2020. After 2 years of study, the Commission recommended a dramatic increase in service-learning opportunities for K–12 and higher education students, giving young people the problem-solving and academic achievement skills they will need to be successful in school, work, and life. In the Commission's vision, every American will be exposed to service opportunities throughout their lifetime, beginning with young people experiencing robust civic education and service-learning during elementary, middle, and high school.

IV. APPROPRIATION REQUEST & IMPACT

The Commission recommended that Congress create a Service-Learning Fund and provide $250 million in annual appropriations to CNCS in Subtitle B to award competitive grants to State educational agencies, local educational agencies, institutes of higher education, State Service Commissions, and nonprofits to develop and implement service-learning programs for K–12 and postsecondary students across the country, including:

—$50 million for service-learning programs in public schools and institutions of higher education;

—$100 million for Summer of Service programs for students who will be enrolled in grades 6–12 at the end of the summer; and,

—$100 million for Semester of Service programs for students in grades 9–12.

Collectively, these programs would engage approximately 2 million students who would serve more than 41,300,000 hours, providing more than $1 billion value to their communities each year.

Perhaps more importantly, funding for service-learning programs has a lasting impact in the schools and organizations funded: teachers and educators, once trained, can continue to organize service-learning for participants, provided funding is available for program activities. This kind of funding enhances the positive culture and character of schools and their communities.

Eligible entities for these competitive grant programs are a State educational agency; a State Service Commission; a territory; an Indian tribe; an institution of higher education; or a public or private nonprofit organization (including community-based entities); a public or private elementary school or secondary school; a local educational agency; a consortium of such entities; or a consortium of 2 or more such entities and a for-profit organization.

V. REPORT LANGUAGE

We also request that accompanying report language include the following:

"Within the total for Service Learning, the Committee provides funds for Summer of Service programs, Semester of Service programs, and service-learning programs in public schools and institutions of higher education. The Committee further recommends that fifty percent of the funds are directed to economically disadvantaged communities and five percent are set aside for payments to Indian Tribes, the United States Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands, to be allotted in accordance with their respective needs. All funds are competitive. Eligible applicants include SEAs, LEAs, IHEs, non-profit organizations, and state service commissions to carry out service-learning programs for K–12 and postsecondary students. Grantees that receive funding for low-income communities are not required to match Federal funds."

VI. CNCS' CAPACITY TO MANAGE NEW LEARN AND SERVE AMERICA FUNDING

AmeriCorps's mission is to improve lives, strengthen communities, and foster civic engagement through service and volunteering. Service-learning programs achieve this mission for our youngest citizens. Appropriating $250M for Learn and Serve America would result in LSA programs being approximately 17% of CNCS's budget (using the agency's FY22 proposed budget of $1.2M). Youth ages 5–18 (K–12 school age) are approximately 20% of the U.S. population. An appropriation for CNCS to include children and youth in the agency's work to unite America through service that's close to their share of the population is critical to the long-term success of CNCS/AmeriCorps. Implementing 3 new competitive grant programs will require increased capacity and resources at the agency. We propose a 2% set-aside ($5M of the proposed $250M appropriation) for staffing and administrative expenses, training and technical assistance contracts, and program evaluation.

Agency Staffing and Operations

—There are at least two former Learn and Serve America staff still working at AmeriCorps in other roles who could be reassigned to manage these programs.
—The proposed set-aside could pay for staff at either HQ and for additional Portfolio Managers in each of the regional offices to manage the grants awarded.

Training and Technical Assistance

—The Coalition for Service Learning organizing members—The George Washington University Honey W. Nashman Center for Civic Engagement and Public Service, America's Service Commissions, National Summer Learning Association, National Youth Leadership Council, Peace Jam, and Youth Service America—have decades of experience in providing training and technical assistance to the service-learning field and would be ready to
—The Semester of Service and Summer of Service programs are based on frameworks developed by two of the Coalition for Service Learning organizers, and have existing training and professional development materials already available.

Existing Field Capacity

While there is no current Federal capacity to support service-learning programs, capacity does exist at the State and local level:

—The Coalition for Service Learning includes more than 170 member organizations—52 national organizations and 123+ State and local organizations—all of which provide capacity to their partners, chapters, affiliates, or members in nearly every State.
—Each State education agency still has a representative on each State's governor-appointed state service commission, and would play a key role in supporting grantees in their States.
  —A 2011 scan found that:
    —25 States allow academic credit to be awarded for community service or service-learning activities
    —21 States have adopted policy stating that student engagement is positively affected by participation in service-learning
    —6 States allow schools to offer a stand-alone, credit-bearing service-learning course
    —18 States tie service-learning/community service to student achievement
    —9 States include service-learning as a valuable strategy for at-risk students
—Many state service commissions include youth service or service-learning as one of their priorities and support these programs in their States.
  —11 state service commissions currently have funding to assess the landscape of youth service in their States and work to increase youth participation
  —23 state service commissions have youth-focused programming, including several through Volunteer Generation Fund Grants
—The Charles Stewart Mott Foundation, National Youth Leadership Council, and Afterschool Alliance have supported at least 12 state afterschool networks to increase the capacity for service-learning in OST programs in their States.

VII. HISTORY OF LEARN AND SERVE AMERICA

From the 1970s through the early 2010s, service-learning grew tremendously throughout the United States at all education levels, in part because of the efforts of Learn and Serve America, the Federal program that from 1992–2011 provided grants to schools, colleges, and community groups to support this educational method. Learn and Serve America, which was administered by the Corporation for National and Community Service (now dba AmeriCorps), provided an "on ramp" to a lifetime of civic engagement for up to 1.4 million students each year. In addition to awarding grants, Learn and Serve America provided free resources on service-learning to the public, teachers, faculty members, schools, youth, and youth service groups through the National Service-Learning Clearinghouse. In a typical year, Learn and Serve America funding supported nearly 600 individual schools, 450 school districts, 985 community colleges, and 240 colleges and universities annually. More than 35,000 K–12 teachers and higher education faculty benefited from direct funding for service-learning each year.

PREPARED STATEMENT OF THE NATIONAL COALITION FOR HOSPICE AND PALLIATIVE CARE

The National Coalition for Hospice and Palliative Care (Coalition) appreciates the opportunity to submit testimony to the Senate Appropriations subcommittee on Labor, Health and Human Services, and Education and Related Agencies on the appropriations for the National Institutes of Health. In FY 2024, the Coalition requests $12.5 million to implement the strategy as outlined in NIH's most recent Congressional Justification to Congress for the NIH to advance a multi-institute NIH effort to expand and intensify the strategic coordination of palliative care research efforts.

Request: The Coalition requests that the Committee provides $12,500,000 for the National Institute on Aging (NIA), as identified by NIH, as the lead agency to implement a trans-Institute, multi-disease strategy to focus, expand, and intensify national research programs in palliative care. Funding would establish a comprehensive multi-Institutes and multi-Centers initiative aimed at a wide variety of palliative care research, training, dissemination, and implementation of projects to intensify the strategic coordination of palliative care research efforts. The Coalition supports funding to establish an extramural-based palliative care consortium with multiple sites to provide technical assistance, pilot and exploratory grant funding, research dissemination, data repositories, data analytics, and career development support for interdisciplinary palliative care.

The Coalition recommends this funding be inclusive of $3,000,000 for several multi-year, early-career development grants modeled after NIA's GEMSSTAR program. This level of funding would supplement current existing funding at multiple Institutes, Centers, and Offices (ICOs) and support a coordinating center within the National Institute on Aging (NIA) to convene subject matter experts from relevant ICOs; provide career development grants for early-stage investigators; and facilitate NIH-supported core facilities that help connect scientists with needed tools and expertise.

Why do we need palliative care research? The purpose of palliative care research is to improve the evidence-base in order to relieve suffering and improve quality of life for persons and families living with serious illness. "Serious illness" is a health condition that carries a high risk of mortality AND either negatively impacts a person's daily function or quality of life, or excessively strains their caregivers."[1] Numerous studies have demonstrated that high-quality palliative care can provide significant benefits for patients, caregivers, and to the health care system itself.[2] Palliative care is "beneficial at any stage of a serious illness, is an interdisciplinary care delivery system designed to anticipate, prevent, and manage physical, psychological, social, and spiritual suffering to optimize quality of life for patients, their families and caregivers. It can be delivered in any care setting through the collaboration of many types of care providers. Through early integration into the care plan of seriously ill people, palliative care improves quality of life for both the patient and the family."[3]

Current Challenges: There are growing populations of persons living with serious illness for longer periods of time across the lifespan that would benefit from palliative care but for various reasons do not have access. Even when identified, the current evidence base is inadequate to ensure appropriate symptom management, reduce strains on family caregivers, and meaningfully improve quality of life. Research has also uncovered marked inequities in access to palliative care that need to be addressed. Black Americans suffer disproportionately in the face of serious illness and experience worse pain management, ineffective communication from providers, and an outsized burden on family caregivers.

The Coalition thanks the leadership of the Appropriations Committee in multiple prior years for including consistent report language and requests to NIH to establish a trans-Institute strategy due to the growing health care demands for increased access to quality evidenced based palliative care and the inadequate sustainable research infrastructure.

PRIOR CONGRESSIONAL APPROPRIATIONS REPORT LANGUAGE

FY' 23: Explanatory Statement to Accompany the Consolidated Appropriations Act, 2023, Palliative Care [p. S8887, Division H—Departments of Labor, Health,

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[1] (Kelley AS, Bollens-Lund E. J Palliat Med, 2018).

[2] https://aahpm.org/uploads/advocacy/The__Evidence__for__High-Quality__Palliative__Care.pdf.

[3] National Consensus Project, Clinical Practice Guidelines for Quality Palliative Care, 4th edition, 2018.

and Human Services, and Education, and Related Agencies Appropriations Act, 2023]

—Reiterates need for NIH to develop and implement a trans-Institute strategy to expand and intensify national research programs in palliative care.

—Urges NIH to ensure palliative care is integrated into all areas of research across NIH

—Requests update in FY'24 Congressional Justification

FY'19 [p. 121, Senate Report 115–289, Labor/HHS FY 2019 Appropriations]

—Strongly urges NIH to develop and implement a trans-Institute strategy to expand and intensify national research programs in palliative care to address quality of care and quality of life for the rapidly growing population of individuals in the U.S. with serious or life-threatening illnesses.

FY'11 [pp. 125–126, Senate Report 111–243, Labor/HHS FY 2011 Appropriations]

—Strongly urges the NIH to develop a trans-Institute strategy for increasing funded research in palliative care for persons living with chronic and advanced illness.

On behalf of all of those we serve, the Coalition urges Congress to continue its support for a trans-NIH strategy for palliative care/serious illness research by funding the National Institutes on Aging $12.5 million based on its recent commitment NIA to take on this leadership role.

According to NIH, "Palliative care has the potential to improve patient care, patient- clinician communication, and patient-centered outcomes while decreasing unwanted burdensome treatments and enhancing quality of life for people with serious illness, their loved ones, and their care partners. NIH recognizes the importance of palliative care, with several NIH Institutes, Centers, and Offices (ICOs) supporting a diverse set of research projects and initiatives focused on this essential area."[4]

NIA is the leading funder of palliative care research at NIH and currently funds more than a dozen clinical trials on palliative care, including those on dementia-specific palliative care and trials using telehealth to deliver palliative care. Additionally, the National Cancer Institute (NCI), National Institute of Child Health and Human Development (NICHD), National Institute of Nursing Research (NINR), National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) have specific palliative care research and clinical trials underway.

New Opportunities in Palliative Care Research: NIH/NIA Commitment

Multiple and additional ICO's have pledged to work together, under NIA's leadership, to implement this trans-Institute palliative care/serious illness research strategy including NIA, NCI, NICHD, NIDDK, NINR, National Institute of Mental Health (NIMH), National Health, Lung and Blood Institute (NHLBI), the National Institute of Minority Health and Health Disparities (NIMHD), National Institute of Neurological Disorders and Stroke (NINDS) and the Office of Women's Health.

Coalition Recommendation: In FY 2024, to summarize, the Coalition requests $12.5 million for NIH/NIA to implement a trans-Institute, multi-disease strategy to focus, expand, and intensify national research programs in palliative care. Funding would establish a comprehensive multi-Institute and multi-Center initiative aimed at a wide variety of palliative care research, training, dissemination, and implementation of projects to intensify the strategic coordination of palliative care research efforts. An extramural-based palliative care consortium should be established with multiple sites to provide technical assistance, provide pilot and exploratory grant funding, research dissemination, data repositories, data analytics, and career development support for interdisciplinary palliative care. Of this amount, at least $3,000,000 should be provided for several multi-year, early-career development grants modeled after NIA's GEMSSTAR program.

The Coalition thanks you for this opportunity to submit recommendations for the record.

The mission of the Coalition is to convene the field, advocate for equitable health care policies, improved health outcomes and establish best practices.

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[4] https://officeofbudget.od.nih.gov/pdfs/FY24/br/NIH%20FY%202024%20CJ%20Significant%20Items%20Volume%20final.pdf.

PREPARED STATEMENT OF THE NATIONAL COUNCIL FOR DIVERSITY IN THE HEALTH PROFESSIONS

Chairwoman Baldwin, Ranking Member Capito, and distinguished members of the subcommittee, thank you for the opportunity to submit this statement for the record on behalf of the National Council for Diversity in the Health Professions (NCDHP). I am Dr. Wanda Lipscomb and I serve as President of the NCDHP and Director of the Center of Excellence for Diversity in Medical Education at Michigan State University. NCDHP was established in 2006 and is composed of institutions that are either currently or formerly distinguished as a "Center of Excellence" through the Health Resources and Services Administration's (HRSA)'s Centers of Excellence (COE) program or are a current or former recipient of the Health Careers Opportunities Program (HCOP) grant, now known as the National HCOP Academies program. Every member institution within the council is committed to advancing pipeline programs and programmatic activity that leads to diversity in the health professions.

The National Council for Diversity in Health Professions (NCDHP) is comprised of institutions with Centers of Excellence (COE) and Health Careers Opportunity Program (HCOP) grants funded by the Health Resources and Services Administration under the Title VII Health Professions Training Programs. COE/HCOP grantees are in health professions education and other institutions which excel in the development of educational pipeline programs for individuals from minority and disadvantaged backgrounds, and in the improvement of the quality of health care delivery to medically underserved communities. I am proud to put forth the following recommendations for the fiscal year (FY) 2024 appropriations process:

Minority health professional development is a cost-effective and long-term mechanism of improving health care and decreasing health disparities in minority and underserved communities. 50–80% of Under-Represented Minority (URM) physicians and other health professionals practice in shortage areas serving minority patients. Minority health professionals possess the cultural, experiential and linguistic skills needed to provide cost-effective health care to minority communities. Minority students identified, recruited, supported, admitted, and trained in the health professions in this decade will provide services into the 2060s and 2070s.

HRSA CENTERS OF EXCELLENCE RECOMMENDATION

COE award recipients serve as innovative resource and education centers to recruit, train, retain and graduate URM students and faculty at health professions schools. Programs improve information resources, clinical education, curricula, and cultural competence as they relate to minority health issues and social determinants of health. These award recipients also focus on facilitating faculty and student research on health issues particularly affecting URM groups. The goal of the program is to effectively deliver health care to underserved communities.

NCDHP recommends $47.42 million for the COE program in Fiscal Year 2024.

HRSA HEALTH CAREER OPPORTUNITIES PROGRAM RECOMMENDATION

HCOP provides opportunities for colleges and community-based health professions training and promotes the recruitment of qualified students and non-traditional students like veterans from disadvantaged backgrounds into health and allied health professions programs. As a major Federal pipeline program into the health professions, HCOP improves the acceptance, retention and matriculation rates of participating students by implementing tailored enrichment programs designed to address their academic and social needs.

NCDHP recommends $47.95 million for the HCOP program in Fiscal Year 2024.

FUNDING JUSTIFICATION AND APPROPRIATIONS HISTORY FOR HRSA'S HCOP AND COE PROGRAMS

—The Association of American Medical Colleges projects that in the U.S. there will be a shortage of nearly 120,000 primary care physicians by the year 2030. Looming workforce shortages exist not only in medicine, but also in dentistry, public health, physician assistants and other health professions. If not adequately addressed, our Nation will continue to fall short in addressing the needs of medically underserved communities as most recently exposed by the COVID–19 pandemic.

—We are seeking to restore COE and HCOP funding to FY 2005 levels. For FY 2006 the COE appropriation was cut by 65% from $33M to only $12M. Similarly HCOP was cut by 89% to only $4M. Adjusting for inflation, COEs $33M in 2005

dollars would be $45M in 2021 dollars. HCOPs $35M in 2005 would now be $47M.

—The number of COE grantees dropped from 34 (in 2005) to 19 (in 2020), and the number of HCOP grantees dropped from 74 (in 2005) to 22 (in 2020). These programs have not fully recovered. Presently there is not enough funding in either program to support a new competition-only to maintain existing programs. A significant increase is needed in COE and HCOP to increase the number of Latino, Black, American Indian and disadvantaged students recruited, admitted and graduated as culturally competent physicians and other health professionals who have a high likelihood of practicing in underserved minority communities. For example, with increased funding, COE could launch an initiative to increase the number of post-baccalaureate slots and programs that enroll previously rejected applicants in 1-year programs, with 90% being accepted to medical school, of which >95% will graduate as physicians.

As you begin the FY 2024 process, NCDHP asks that you further prioritize Title VII health professions training programs. Chairwoman Baldwin and Ranking Member Capito, please allow me to express my appreciation to you and the members of this subcommittee. With your continued help and support, NCDHP member institutions are keeping course to overcome health workforce and health disparities. Thank you for your time and consideration of these requests. We look forward to working with the subcommittee to prioritize the health professions programs in FY 2024 and the future.

[This statement was submitted by Wanda Lipscomb, Ph.D., President, National Council for Diversity in the Health Professions.]

PREPARED STATEMENT OF THE NATIONAL COUNCIL OF SOCIAL SECURITY MANAGEMENT ASSOCIATIONS

On behalf of the National Council of Social Security Management Associations (NCSSMA), thank you for the opportunity to submit this testimony regarding the Social Security Administration's (SSA's) Fiscal Year (FY) 2024 Appropriation. NCSSMA respectfully requests that Congress consider funding of no less than the Commissioner's budget request of $16.223 billion in FY 2024 for SSA's Limitation on Administrative Expenses (LAE) account.

SSA's LAE account provides resources for general operations including reducing the disability claims backlog, providing additional resources for frontline services in SSA's field offices and teleservice centers, and continued support for the agency's Information Technology (IT) modernization efforts. SSA must have appropriate funding to provide service to the American public. It is more critical now than ever for SSA to replace frontline staff to address field office backlogs, answer telephones, and help those who request our assistance. Additional funding in FY 2024 will help ensure SSA can hire much-needed staff, continue to improve and expand available service options, both online and through our 800 Number, and make it easier for the public to receive assistance from us. NCSSMA firmly believes that we must always be mindful of SSA's core mission and public obligations.

—SSA must have consistent and adequate funding to ensure the American public receives the services for which they have paid for, expect and deserve.

—Customers deserve improved telephone and online services, while still being able to request timely in-person service. The volume of customers trying to reach SSA by telephone outnumbers the capacity and stability of our current telephone system. Coupled with limited online services, the public may experience challenges trying to reach us. This includes widows/widowers and survivors who are unable to file for critical benefits online.

—SSA must also continue to address critical stewardship workloads that save billions of dollars for taxpayers. Unfortunately, the same employees who are responsible for overseeing critical stewardship and integrity workloads are the same employees processing claims for benefits, post-entitlement and other benefit actions.

THE CHANGING FACE OF SSA'S COMMUNITY-BASED CUSTOMER SERVICE

Since NCSSMA's founding, we have strongly supported community-based field offices as SSA's foundation to deliver prompt, quality service to the American public. The agency must continue to enhance the customer experience so customers can access our services across all service delivery channels as seamlessly as possible. This includes through the telephone and Internet, while always having the option to conduct business with us in person in a timely manner. We support the agency's efforts

to reassess workloads and to reform policies that require original documentation or an in-person interview. We ask that Congress work with SSA to address legislative solutions as well.

Even with the shift to more online services, field office employees must still process much of the back-end work on complex online cases including Supplemental Security Income (SSI), and assist customers who do not have access to the telephone or Internet. SSA is working to: increase the number of services and forms available online to provide more convenient, user-friendly, and secure digital self-service options; increase the number of people who can complete an internet Social Security Number Replacement Card (iSSNRC) application by expanding the option of requesting a replacement card for name change due to marriage to additional States; and improve the iAppeals online application process by consolidating medical, nonmedical, and Office of Appellate Operations online appeal applications into a single-entry point. These initiatives would enhance the customer experience for our public and permit our staff to provide in-person assistance to customers who do not have the ability to reach us through other channels.

Of significant concern to our members, because of the potential impact on customer service, is the inclusion in the President's budget request of the establishment of a national, comprehensive paid family and medical leave program to be administered by SSA. While we appreciate the confidence placed in our agency, we are concerned about how we would handle the new responsibilities and the additional resources this undertaking would require. Customer service demands currently exceed SSA's ability to deliver high quality service and integrating any new program, much less one larger than all current SSA programs combined, without sustained, dedicated funding is a recipe for disaster. For example, a program that was added to SSA's responsibilities was the Medicare Part D Low Income Subsidy Application. SSA no longer receives dedicated funding for this program. This means that staff time and resources are taken from administering SSA's core workloads such as Retirement and Disability. Based on this experience and others, we are gravely concerned that SSA would most likely be faced with another unfunded mandate after a couple of years. We welcome the opportunity to discuss our concerns and work with Congress and the Administration to ensure decisions regarding the establishment and administration of any new programs at SSA are in the best interests of beneficiaries, recipients and workers, both current and future.

SSA'S WORKFORCE: RECRUITMENT, HIRING, TRAINING AND RETENTION

We must accomplish SSA's mission against the backdrop of an employer profile that is no longer attractive to potential employees. For decades, SSA was a competitive employer. Sadly, that has changed. Our current employees are overtaxed due to a combination of workload challenges, outdated policies and technologies and current staffing levels to the point that morale on the frontlines is at an all-time low. We appreciate the emphasis the President's FY 2024 budget request places on hiring and that SSA obtained direct hiring authority in FY 2023 for certain mission-critical positions. We are hopeful these efforts and initiatives will help us address recent staffing losses.

Despite the direct hiring authority, SSA still faces daunting challenges in both recruiting and retaining employees. The pandemic only exacerbated a problem that has been growing for the past decade as employees at all levels chose to retire early or resign due to the crushing expectations placed upon them. Even when SSA can hire new employees, many leave SSA within the first year due to the low entry level pay, complexity of the training and job, lack of adequate systems and support and the lack of institutional and programmatic knowledge. SSA's policies and programs have always been complex, requiring a lengthy training program of 2–3 years. While new hires are being mentored and trained by our most experienced technicians, other employees are under increased pressure to try to do more with less. This leads to low morale, which has become endemic as shown in the recent Pulse surveys and in NCSSMA's own recent surveys of our membership.

We hope the Committee will work with other Members of Congress and the appropriate Committees of jurisdiction to assist SSA in improving its hiring and retention capabilities. SSA needs to aggressively reinvent our hiring and retention processes and consider the following: change the career ladder plans for all entry-level positions to make them more desirable and competitive; update management positions so they are more attractive; establish a clear foundation as to what positions at SSA are telework eligible with the number of days subject to customer service needs; use all currently available hiring authorities; recruit employees at the National level; and use an agency student loan repayment program.

INFORMATION TECHNOLOGY (IT) MODERNIZATION AND CYBERSECURITY

SSA's computer systems face fundamental challenges. Dedicated funding is needed for IT investments to modernize systems to the standards Congress and the public expect. SSA must continue to modernize its computer language and database infrastructure to reduce the risk of cyberattacks, service disruptions and reduced system performance. We are pleased to note that the FY 2024 President's budget request for SSA includes $50.0 million in dedicated no-year funding for SSA's Benefits Modernization efforts. We would appreciate consideration and support from Congress for this funding.

From our perspective, SSA needs to address four specific areas: modernize core agency applications; improve SSA's telephone system and associated management information; implement national document scanning and remote printing; and implement technologies that will assist our more vulnerable and hard to reach communities, including American Indians and Alaska Native, deaf and hard of hearing, blind and low-vision, non-English speaking, the unhoused, and those who live in rural locations.

SSA has the following initiatives underway that NCSSMA supports: simplify the process to apply for SSI benefits; introduce our online self-service scheduling capabilities for a limited set of services and automate more services on our website, including adding more customer-centric portals, mobile applications, and claim status information; focus on reducing the burden on the public by eliminating requirements to conduct business in person and to present hard copies of original documents, and remove requirements for signatures on documents by offering electronic signing options; implement modern Customer Relationship Management software for employees who interview the public; create and upgrade automation for routine tasks making our PCs more efficient; and develop and implement human-centered design solutions to address customer pain points and improve customer satisfaction.

FISCAL YEAR 2024 FUNDING AND BEYOND

Resource allocations in FY 2024 must be sufficient to improve the timely processing of disability claims, expand customer experience options, and ensure that SSA makes the correct payments to those who qualify while maintaining program integrity work. Resources are also necessary to advance SSA's ongoing IT/Benefits Modernization projects, while at the same time increasing the accessibility of benefits for seniors and people with disabilities.

To ensure a long-term solution, NCSSMA strongly believes that we must explore mechanisms for creating a more robust and predictable funding stream for SSA's administrative expenses. NCSSMA recommends and/or endorses the following: exclude SSA's administrative funding from any cap that sets an arbitrary ceiling on discretionary spending; remove SSA's administrative funding from the discretionary budget caps and provide a separate limit in the Budget Resolution; establish multi-year funding for critical systems investments and expenditures; and expand the definition of program integrity funding to include critical systems investments and expenditures that facilitate completion of program integrity initiatives.

CONCLUSION

NCSSMA respectfully requests Congress consider funding of no less than $16.223 billion for SSA's FY 2024 administrative expenses. This level of funding will help ensure SSA can increase frontline staffing to address backlogs, provide additional resources for frontline services and continue support for the agency's IT/Benefits Modernization efforts.

[This statement was submitted by David Lescarini, President, National Council of Social Security Management Associations.]

PREPARED STATEMENT OF THE NATIONAL ECZEMA ASSOCIATION

SUMMARY OF FISCAL YEAR 2024 APPROPRIATIONS RECOMMENDATIONS

—Provide the National Institutes of Health (NIH) with at least $50.9 billion in funding, a $3.5 billion increase over FY 2023.

—Provide funding for the individual NIH institutes and centers that manage the eczema portfolio, including $732 million at the National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS) and proportional

funding increases at the National Institute of Allergy and Infectious Diseases (NIAID).

—Provide additional, distinct funding for the emerging Advanced Research Projects Agency for Health (ARPA–H) at NIH, which would facilitate implementation of this important program without supplanting ongoing NIH research activities.

—Provide the Centers for Disease Control and Prevention (CDC) with $11.6 billion in funding, an increase of $2.4 billion over FY 2023.

—Provide $6 million in funding for the Chronic Disease Education and Awareness Program at CDC, an increase of $1.5 million over FY 2023.

Thank you for the opportunity to present testimony on behalf of the National Eczema Association and to share the experiences of the eczema community. Chairwoman Baldwin, Ranking Member Capito, and distinguished subcommittee members, thank you for continuing to invest in medical research and public health programs through the FY 2023 omnibus appropriations package. Recent years of funding increases have led to notable advances in eczema research and new opportunities for meaningful public health collaborations. As you work with your colleagues on FY 2024 appropriations, please maintain this momentum and the commitment to increase funding for medical research and public health programs that serve eczema patients and raise awareness of the wide-ranging impacts on affected individuals and their families.

About the National Eczema Association.—The National Eczema Association is the largest patient advocacy organization dedicated solely to all forms of eczema. NEA represents the voice of over 31 million affected American adults, children, and their families, and is the driving force for an eczema community fueled by knowledge, strengthened through collective action and propelled by the promise for a better future.

About Eczema and Atopic Dermatitis—Eczema is the name for a group of conditions that cause the skin to become itchy, inflamed, and have rash-like lesions. Atopic dermatitis (AD) is the most common type of eczema, affecting more than 9.6 million children[1] and about 16.5 million adults[2] of all races and ethnicities[3] in the United States. We are beginning a new era of care for eczema patients with several new FDA-approved groundbreaking therapies for AD, and dozens more in the drug discovery pipeline, that have the potential to be transformative in their ability to ease numerous physical, psychological, and quality of life burdens of eczema.[4,5,6] Research in this area is largely led by the NIH through the NIAMS and NIAID. Despite research and treatment progress in recent years, much more basic, translational, and clinical research is needed to further the scientific understanding of all forms of eczema, as recent breakthroughs have pointed to a complex, multifactorial disease pathogenesis, and marked clinical and lived experience heterogeneity, all of which impact optimal care outcomes. In addition, despite life-changing therapeutic advances, these novel treatment options are presenting emerging coverage, access, and out-of-pocket (OOP) cost barriers for the diverse eczema community. Forty-two percent of individuals affected by AD spend $1,000 or more on annual OOP costs for disease management.[7] Black race experiences, worse AD severity and the use of three or more AD therapies are associated with higher OOP costs.[8,9]

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[1] Shaw TE, Currie GP, Koudelka CW, Simpson EL. Eczema prevalence in the United States: data from the 2003 National Survey of Children's Health. J Invest Dermatol. 2011;131(1):67–73.

[2] Chiesa Fuxench ZC, Block JK, Boguniewicz M, et al. Atopic Dermatitis in America Study: A Cross-Sectional Study Examining the Prevalence and Disease Burden of Atopic Dermatitis in the US Adult Population. J Invest Dermatol. 2019;139(3):583–590.

[3] Hanifin JM, Reed ML, Eczema Prevalence and Impact Working Group. A population-based survey of eczema prevalence in the United States. Dermatitis. 2007;18(2):82–91.

[4] Drucker AM, Wang AR, Li WQ et al. The burden of Atopic Dermatitis: Summary of a report for the National Eczema Association. J Invest Dermatol. 2017;137(1):26–30.

[5] Chiesa Fuxench ZC, Block, JK, Boguniewicz M, et al. Atopic dermatitis in America study: A cross-sectional study examining the prevalence and disease burden of atopic dermatitis in the US adult population. J Invest Dermatol.2019;139(3):583–590.

[6] Silverberg J, Gelfand J, Margolis D et al. Patient burden and quality of life in atopic dermatitis in US adults. Ann Allergy Asthma Immunol. 2018;121(3):340–347.

[7] Smith Begolka, W., Chovatiya, R., Thibau, I.J. & Silverberg, J.I. Financial Burden of Atopic Dermatitis Out-of-Pocket Health Care Expenses in the United States. Dermatitis 32, S62–S70. 2021.

[8] Chovatiya, R., Begolka, W.S., Thibau, I.J. & Silverberg, J.I. Financial burden and impact of atopic dermatitis out-of-pocket healthcare expenses among black individuals in the United States. Arch. Dermatol. Res. 2021: 10.1007/s00403–021–02282–3.

Public health activities are also relatively modest with meaningful opportunities for enhanced surveillance, public awareness, and patient/healthcare provider education.

NIH Research.—Ongoing congressional support for NIH has facilitated growth in the NIH annual budget to $47.5 billion in FY 2023. As a result of additional resources and high-quality investigator-initiated research proposals, the eczema research portfolio continues to grow and will be bolstered by additional research through the Department of Defense Peer-Reviewed Medical Research Program moving forward. While the eczema portfolio is increasing, so are research costs, and this current funding translates to approximately $1.42 in annual research funding per American affected by eczema. With additional NIH support, future research can more effectively leverage new insights to undertake more ambitious projects, including timely translational research and larger clinical studies. Please consider including committee recommendations encouraging further scientific advancement at NIH and recognizing ongoing progress.

CDC Public Health Efforts- Thank you for recent support for the Centers for Disease Control and Prevention, the National Center for Chronic Disease Prevention and Health Promotion, and the Chronic Disease Education and Awareness (CDEA) Program. Presently, and despite a significant and growing U.S. disease prevalence,[10,11] as well as known health care disparities,[8,12] there are few public health efforts taking place in eczema, which has led to gaps in surveillance and critical public health information. Additional public awareness, professional education, and related efforts would be of tremendous benefit to the eczema patient, caregiver, and health care provider communities. The CDEA program provides an opportunity to infuse identified disease areas with additional needed resources and is currently supporting four novel projects through its first round of funding. Increasing CDEA funding to $6 million for FY 2024 will facilitate program growth while providing an opportunity for projects in other important disease areas, such as eczema, that are not yet supported by the CDEA program or broader CDC efforts. Moreover, the chronic disease center can take up meaningful surveillance and epidemiology activities with additional discretionary resources. Please consider including committee recommendations urging CDC to utilize additional resources to bolster public health efforts in skin diseases, and eczema specifically.

PATIENT STORIES

Ed from Hawaii: NEA Ambassador and eczema patient

Ed had a delayed diagnosis of his atopic dermatitis (form of eczema) due to a lack of health care provider resources on his remote Hawaiian island. Once he finally received the diagnosis, the course of treatment was primarily steroids. After biologics were approved for atopic dermatitis, his dermatologist was able to successfully prescribe the biologic. The biologic has been incredibly helpful, but the dermatologist determined that a non-steroidal cream in conjunction with the biologic would help Ed find additional relief. Unfortunately, the recommended treatment has been denied by his insurance and he is still appealing that decision. In the meantime, he was able to get a sample from his dermatologist, but this is not a long-term solution.

Karin from Washington: NEA Ambassador and eczema patient

Karin has had eczema since she was a child, but it was magnified this past year due to a mental health flare up. She had to withdraw from a university due to her mental health and the stress of that situation contributed to triggering a severe eczema flare. It was in this gap year that she took control of her eczema and was able to enroll in a university that was closer to home in Washington state. Her dermatologist prescribed a biologic that she was able to get filled (Karin is under her parent's insurance). Unfortunately, when her parents changed jobs, the new insurance denied Karin's biologic. From the time of the initial denial to when the pre-

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[9] Chovatiya, R., Begolka, W.S. Thibau, I.J. & Silverberg, J.I. Impact and Associations of Atopic Dermatitis Out-of-Pocket Health Care Expenses in the United States. Dermatitis. 2021. Doc: 10.1097/DER.0000000000000795.

[10] Choragudi S, Yosipovitch G. Trends in the Prevalence of Eczema Among US Children by Age, Sex, Race and Ethnicity From 1997 to 2018. JAMA Dermatol. 2023 Feb 22:e226647. doi: 10.1001/jamadermatol.2022.6647. Online ahead of print.

[11] Hou A, Silverberg JI. Secular trends of atopic dermatitis and its comorbidities in United States children between 1997 and 2018. Arch Dermatol Res. 2022 Apr;314(3):267–274. doi: 10.1007/s00403–021–02219-w. Epub 2021 Apr 4.

[12] Corbett M, Allen A, Bobo N, Foggs MB, Fonacier LS, Gupta R, Kowalsky R, Martinez E, Begolka WS, Zachary C, Blaiss MS. Proposed solutions by the American College of Allergy, Asthma, and Immunology and advocacy experts to address racial disparities in atopic dermatitis and food allergy.Ann Allergy Asthma Immunol. 2023 Mar;130(3):392–396.e2. doi: 10.1016/j.anai.2022.12.017. Epub 2022 Dec 17.

scription was ultimately approved was 8 months. This is an unacceptable amount of time to wait and caused additional anxiety, unnecessary stress and an eczema flare.

[This statement was submitted by Julie Block, President & CEO, National Eczema Association.]

PREPARED STATEMENT OF THE NATIONAL FAMILY PLANNING & REPRODUCTIVE HEALTH ASSOCIATION

Dear Chair Baldwin and Ranking Member Moore Capito,

As President & CEO of the National Family Planning & Reproductive Health Association (NFPRHA), I thank you for this opportunity to provide testimony in support of a fiscal year (FY) 2024 appropriation of $512 million for the Title X family planning program in the Office of Population Affairs (OPA). We are grateful for the committee's leadership in advocating for family planning, including proposing a game-changing $512 million for Title X in the FY 2023 bill, and urge you to take a substantial step forward again this year.

NFPRHA is a nonpartisan, nonprofit membership association that supports the work of family planning providers and administrators, especially in the safety net. NFPRHA membership includes nearly 1,000 entities that operate or fund more than 3,500 health centers that deliver high-quality family planning education and preventive care to millions of people every year in the United States. As a leading expert in publicly funded family planning, NFPRHA provides subject matter expertise to policymakers, health care providers, and the public; offers its members service delivery support aimed at providing high-quality and patient-centered care; and conducts and participates in research. As of March 2023, NFPRHA represents more than 80% of Title X grantees, including State and local health departments, federally qualified health centers, Planned Parenthood affiliates, family planning councils, and more.

As you know, Title X is the only Federal program dedicated to providing family planning services for people living with low incomes. Title X-funded health centers are lifelines in their communities, providing high-quality family planning and sexual health care, including cancer screenings, testing and treatment for sexually transmitted infections, contraceptive services and supplies, pregnancy testing, and other essential health care services. These centers are critical access points for people who often face severe structural barriers to accessing quality health care, such as people with low incomes, people with no or insufficient insurance, people of color, people who live and work in rural areas, and LGBTQ people. Indeed, six in 10 women who sought contraceptive care at Title X-funded health centers in 2016 said that provider was their only source of health care for the entire year.[1] In 2021, the program served 1.7 million people through 3,284 health centers across the country.[2]

Title X is funded at $286.5 million for FY 2023, well below the $512 million proposed in last year's Senate bill and the $737 million that researchers from the Centers for Disease Control and Prevention (CDC), OPA, and The George Washington University determined would be needed annually just to provide family planning care to low-income women without insurance.[3] This is a significant under-estimate of the true need, especially as the program now serves more than 100,000 men, and an unknown number of nonbinary people, each year. Therefore, we respectfully request $512 million for the Title X program in FY 2024. That funding level will allow the program to begin to meet this growing need and expand to reach millions more people. This funding level marks the half-way point between current funding and the CDC-identified level and also aligns with the President's FY 2024 budget.

The flat funding of this critical program for nearly a decade has significantly constrained its ability to reach communities in need. These funding limitations have been felt particularly keenly in recent years, as the network attempts to recover from a confluence of existential crises: the Trump administration's 2019 program rule, which resulted in more than 1 million service sites leaving the program and made it impossible in many situations to provide evidence-based, comprehensive care to patients; the COVID–19 pandemic, which left no facet of the health care sys-

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[1] Meghan Kavanaugh, "Use of Health Insurance Among Clients Seeking Contraceptive Services at Title X-Funded Facilities in 2016," Guttmacher Institute (June 2018).

[2] Christina Fowler, Julia Gable, and Beth Lasater, "Family Planning Annual Report: 2021 National Summary," Office of Population Affairs (September 2022). https://opa.hhs.gov/sites/default/files/2022-09/2021-fpar-national-final-508.pdf.

[3] Euna August, et al, "Projecting the Unmet Need and Costs for Contraception Services After the Affordable Care Act," American Journal of Public Health (February 2016): 334–341.

tem unharmed; and the ongoing emergency of a rapidly diminishing health care workforce amidst record inflation. Without a significant funding increase, health centers will not be able to continue offering services at current levels, let alone build capacity to serve the millions of people who want family planning and sexual health care but cannot access it, causing harm both to those individuals and the Nation's public health. For example, in 2022 dozens of grantees representing hundreds of service sites were approved by OPA but left unfunded due to insufficient appropriations. I urge you to begin to address these challenges by proposing increased appropriations for Title X this year.

I look forward to working with you to support this critical program as the FY 2024 appropriations process moves forward. If you have any questions, please contact Lauren Weiss, Director, Policy & Communications, at lweiss@nfprha.org.

Sincerely.

[This statement was submitted by Clare Coleman, President & CEO, National Family Planning & Reproductive Health Association.]

PREPARED STATEMENT OF THE NATIONAL FIREFIGHTER REGISTRY

Dear Chair Baldwin and Ranking Member Capito:

On behalf of the Nation's fire and emergency services, we write to urge your continued support for a vital program addressing the health and safety of our Nation's firefighters. As you consider the Fiscal Year (FY) 2024 Labor, Health and Human Services, Education, and Related Agencies Appropriations bill, we urge you to provide $7.125 million for the National Firefighter Registry to ensure that enrollment opens smoothly.

Studies have indicated a strong link between firefighting and an increased risk of several major cancers. However, certain studies examining cancer risks among firefighters have been limited by the scarcity of important data and relatively small sample sizes that have an underrepresentation of women, minorities, and volunteer firefighters. As a result, public health researchers are unable to fully examine and understand the broader epidemiological cancer trends among firefighters. The National Firefighter Registry is an important resource to better understand the link between firefighting and cancer, potentially leading to better prevention and safety protocols.

During the 115th Congress, both the House and Senate unanimously approved the Firefighter Cancer Registry Act (Public Law 115–194). This bipartisan legislation created a specialized national registry to provide researchers and epidemiologists with the tools and resources needed to improve research collection activities related to the monitoring of cancer incidence among firefighters.

Over the past several years, the registry has been able to make great strides, including developing an enrollment system to ensure information security and ease of access for users; obtaining the Office of Management and Budget's approval for the enrollment questionnaire; and compiling brochures, videos, and quarterly newsletters to maintain communication with the fire service regarding the status of the registry. Enrollment is now set to begin, in cooperation with fire and emergency services partners.

To ensure that the National Firefighter Registry does not face delays with regard to the collection and analysis of data pertaining to cancer in the fire and emergency services, we are requesting $7.125 million in FY2024.

Thank you for your consideration, and your continued leadership and support for America's fire and emergency services.

Sincerely,

Congressional Fire Services Institute
International Association of Arson Investigators
International Association of Fire Chiefs
International Association of Fire Fighters
International Fire Service Training Association
International Society of Fire Service Instructors
National Association of State Fire Marshals
National Fallen Firefighters Foundation
National Fire Protection Association
National Volunteer Fire Council

[This statement was submitted by Michaela Campbell, Director of Government Affairs for the Congressional Fire Services Institute.]

PREPARED STATEMENT OF THE NATIONAL HUMAN TRAFFICKING HOTLINE

Thank you, Chairwoman Baldwin, Senator Capito, and all the members of this subcommittee, for the opportunity to present written testimony on this important matter.

In February 2023, we led a bipartisan coalition of 36 attorneys general in a letter to Congressional leadership after it came to our attention that the National Human Trafficking Hotline ("Hotline"), which has been operated by Polaris since 2007, is not reporting third-party tips of adult trafficking to state law enforcement. For years, it had been our understanding that the Hotline was a helpful tool in gathering tips from good Samaritans—a tool that our law enforcement could use to gather intelligence, disrupt trafficking operations, and recover victims. In fact, for years, States and organizations spread the Hotline number as part of concerted efforts to engage the general public in a sort of "see something, say something" campaign against trafficking.

We now understand that we were wrong. The Hotline only forwards adult trafficking tips under the limited circumstance where the victim self-reports and affirmatively consents to the Hotline making the report—a practice contrary to what Polaris itself advertises. Not only do we believe this action contravenes one of Congress' intended functions of the Hotline, but we believe it disrupts the Federal-state partnership to end human trafficking and help its victims.

Possibly more alarming, some States are reporting that they receive tips from the Hotline a month, sometimes 2 months, after a tip of suspected trafficking is reported to Polaris. If the Hotline is not promptly sharing tips with law enforcement, law enforcement cannot act to help victims of trafficking. Timely information is necessary for the quick recovery of victims of human trafficking and is paramount to the entire purpose of the Hotline. Polaris's current system of reporting is hurting the very victims Polaris purports to be central to their approach.

By its own accounts, Polaris operates the Hotline to, among other things, "take tips of suspected human trafficking from community members."[1] The Office on Trafficking in Persons (OTIP) website specifically notes that the Hotline "takes tips about potential situations ... and facilitates reporting to specialized human trafficking task forces, Federal authorities, local law enforcement, and service providers throughout the country."[2]

OTIP touts that since its inception, the Hotline has provided more than 15,000 tips to law enforcement[3] and Polaris reports that its most frequent request on human trafficking cases is to "Report a Trafficking Tip."[4] According to its own statistics, of the 10,360 cases identified by the Hotline in 2021, 6,546 were from citizens reporting a suspected trafficking situation.[5] In contrast, only 3,284 were calls requesting service referrals.[6] Of the 51,073 signals, meaning contacts by call, text, web message, chat or other form of communication, 13,277 of were from victims or survivors of trafficking.[7]

The Hotline website displays several ways that citizens may submit a tip, including via phone, text, chat, or online submission.[8] Congress and many States have taken steps to ensure that the Hotline information is widely disseminated so that citizens can report suspected trafficking directly to the Hotline. Those tips are crucial to catching criminals, to recovering victims, to uncovering evidence of broader trafficking operations, and more. Those tips help local and State law enforcement to end trafficking and to help its victims.

Our offices discovered this policy of withholding third party tips from state law enforcement by happenstance. In June 2022, Mississippi Attorney General Lynn Fitch met with Catherine Chen, Chief Executive Officer of Polaris, to discuss her concerns about the lack of adult tips Mississippi was receiving from the Hotline. Ms. Chen explained that Polaris uses a victim-centered approach that takes into consideration the potential adverse consequences to victims. As further explained on its website, "Except in situations involving potential abuse of a minor or if we believe a person is in imminent danger, the Trafficking Hotline will not take action without the consent of the person in the situation."[9]

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[1] www.polarisproject.org/responding-to-human-trafficking/
[2] https://www.acf.hhs.gov/otip/victim-assistance/national-human-trafficking-hotline.
[3] Id.
[4] https://humantraffickinghotline.org/en/statistics.
[5] Id.
[6] Id.
[7] Id.
[8] www.humantraffickinghotline.org/.
[9] https://humantraffickinghotline.org/about-us/when-you-reach-us.

Ms. Chen also informed General Fitch at that time that the Hotline was beginning to transition away from serving as a tipline to concentrate more on connecting survivors with resources. In more recent discussions with Attorneys General, Polaris has, however, indicated that this has long been their policy. Regardless of whether it is a new approach or one they have purported to have had in place, we cannot stress enough how great a departure this is from our understanding of the practices and purposes of the Hotline or how serious a detriment it will be to our work to stop trafficking and aid its victims.

It is important to note that many States take the same type of victim-centered approach to suspected instances of human trafficking that Polaris says it prioritizes. For instance, the Mississippi Attorney General's Office regularly conducts joint operations with local law enforcement across the State, which invariably include opportunities for victims to be connected with the appropriate services for recovery. In fact, the training the Mississippi Attorney General's Office provides to local law enforcement and prosecutors on human trafficking investigations and prosecution is centered on victim recovery, not victim arrests.

In February 2023, when Polaris learned we were circulating a letter to Congress through the National Association of Attorneys General (NAAG), they requested a meeting with signatory members to discuss issues raised in the letter. As it has always been our intention to find a solution to this matter, at our request, NAAG convened a Zoom meeting between Polaris staff and approximately 50 staff members from attorney general offices across the United States. During the call, attorney general staff raised several concerns that Polaris's policy overlooks fundamental principles of work to disrupt trafficking operations, including:

(1) The vast majority of victims of human trafficking do not self-identify as victims. Placing the onus on the victim to give consent for law enforcement to respond to incidents of human trafficking completely overlooks those victims who do not self-identify.

(2) Law enforcement needs access to all suspected tips of human trafficking in order to gather intelligence and build cases against larger trafficking enterprises.

(3) Polaris is a non-profit, non-law enforcement provider and should not be acting as the "gatekeeper" of criminal intelligence tips. Law enforcement should have the exclusive right to determine whether a tip is legitimate, reliable and actionable.

Despite our numerous attempts to discuss our concerns with Polaris, they are resigned to their position, which we firmly believe limits the ability of State and local law enforcement to disrupt trafficking operations, rescue victims of trafficking, and connect those victims with services critical to their recovery.

Since sending our letter to Congress on February 28, 2023, we have reached out to a number of national organizations that provide human trafficking training and promote the Hotline as a tipline for citizens to report suspected human trafficking. Several of these national organizations, including Truckers Against Trafficking and the National Hotel and Lodging Association, also expressed surprise and concern by Polaris's unwillingness to recognize that their third-party reporting policy does not protect adult victims who might be recovered through interaction with the travel and transportation industries.

It appears to us that the Hotline is not performing the services it is already funded to perform. Without changes to Polaris's operating procedures, our state anti-trafficking initiatives gain little from participation in the National Hotline. As such, individual States may be forced to establish their own state hotlines, as some already have begun to do. A nationally run hotline not only achieves cost-efficiencies, but also ensures a uniform approach and allows for the collection of cross-state information with regard to human trafficking tips.

However, we cannot in good conscience continue to ask the public to share tips about trafficking in their communities if the Hotline will not give us, as law enforcement, the opportunity to address those tips. It serves no one well to do so, least of all the victims that could be helped by a tip phoned in by a good Samaritan who sees their suffering and tries to do the right thing.

Last month, Representative Laurel Lee (FL) and Representative Kathy Castor (FL) introduced H.R. 2601 (the "National Human Trafficking Hotline Enhancement Act") to address these very concerns. The act would "require entities that contract with the National Human Trafficking Hotline to cooperate with State and local law enforcement agencies when receiving tips via the Hotline." The proposed bill provides:

SEC. 2. CONDITION ON ELIGIBILITY FOR GRANTS.

(a) In General.—Section 107(b)(1)(B)(ii) of the Trafficking Victims Protection Act of 2000 (22 U.S.C. 7105(b)(1)(B)(ii)) is amended by inserting "To be eligible for a grant under this clause, an applicant shall certify that the applicant will provide, on request, such assistance, in accordance with such limitations on disclosure as may be applicable under law, and as may be practicable, to any State or local law enforcement agency with respect to information received by reason of operation of the hotline." before "The contact information".

Titles—H.R.2601—118th Congress (2023–2024): National Human Trafficking Hotline Enhancement Act, H.R.2601, 118th Cong. (2023), https://www.congress.gov/bill/118th-congress/house-bill/2601/titles. Representative Mike Kelly (PA) and Representative Darrell Issa (CA) have recently joined as cosponsors of the bill.

We applaud Representatives Lee, Castor, Kelly and Issa for seeking a solution to help restore the Hotline to full functionality in the fight against human trafficking. We respectfully request that this subcommittee consider inclusion of similar language in the appropriations bill currently before you. We would suggest that the words "on request" be amended to "on request of the States." Emphasis added. We believe that, should the language not be specific, Polaris will continue to withhold tips from law enforcement, rendering this Congressional effort ineffective.

If Polaris refuses to address this issue, efforts to engage citizens to use the Hotline in a "see something, say something" effort to end trafficking are futile and States will be forced to abandon this unified effort. We urge you, through this appropriations process, to ensure that Polaris, and/or any future organization operating the Hotline, make changes to its current tip reporting policies to begin forwarding third-party tips regarding suspected human trafficking of adults, in a prompt manner, to the corresponding State's law enforcement officials for their evaluation and response to ensure victim safety. We cannot afford to lose the benefits of this Federal-state partnership to end trafficking.

Thank you for the opportunity to submit written testimony on this important issue. We welcome the opportunity to continue to engage with members of the subcommittee on this matter.

[This statement was submitted by Attorney General Lynn Fitch (MS) and Attorney General Kathleen Jennings (DE).]

PREPARED STATEMENT OF THE NATIONAL INDIAN HEALTH BOARD

On behalf of the National Indian Health Board (NIHB) and the 574 sovereign federally recognized American Indian and Alaska Native (AI/AN) Tribal nations we serve, thank you for the opportunity to provide testimony on the Health and Human Services (HHS). Tribal nations have a unique legal and political relationship with the United States. Through its acquisition of land and resources, the United States formed a fiduciary relationship with Tribal nations whereby it has recognized a trust relationship to safeguard Tribal rights, lands, and resources.[1] In fulfillment of this Tribal trust relationship, the Supreme Court declared in 1832 that the United States "charged itself with moral obligations of the highest responsibility and trust" toward Tribal nations.[2] Congress reaffirmed its duty to provide for Indian health care when it enacted the Indian Health Care Improvement Act (25 U.S.C. § 1602) (IHCIA), declaring that it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians-to ensure the highest possible health status for Indians and to provide all resources necessary to effect that policy. Unfortunately, those responsibilities and legal obligations remain unfulfilled and Indian Country remains in a health crisis.

The Health Status of Indian Country

The Centers for Disease Control and Prevention (CDC) now reports that life expectancy for AI/ANs has declined by nearly 7 years, and that our average life expectancy is now only 65 years-equivalent to the Nationwide average in 1944.[3] With a life expectancy 10.9 years less than the National average,[4] Native Americans die

[1] Worcester v. Georgia, 31 U.S. 515 (1832).

[2] Seminole Nation v. United States, 316 U.S. 286, 296–97 (1942).

[3] U.S. Department of Health and Human Services, Centers for Disease Prevention and Control, Provisional Life Expectancy Estimates for 2021 (hereinafter, "Provisional Life Expectancy Estimates"), Report No. 23, August 2022, available at: https://www.cdc.gov/nchs/data/vsrr/vsrr023.pdf, accessed on: October 13, 2022 (total for All races and origins minus non-Hispanic American Indian or Alaska Native).

[4] Id.

at higher rates that those of other Americans from chronic liver disease and cirrhosis, diabetes mellitus, unintentional injuries, assault/homicide, intentional self-harm/suicide, and chronic lower respiratory disease.[5] Native American women are 4.5 times more likely than non-Hispanic white women to die during pregnancy.[6] Between 2005 and 2014, every racial group experienced a decline in infant mortality except for Native Americans [7] who had infant mortality rates 1.6 times higher than non-Hispanic whites and 1.3 times the National average.[8] Native Americans are also more likely to experience trauma, physical abuse, neglect, and post-traumatic stress disorder.[9] AI/ANs experience the highest rates of suicide according to a 2020 SAMHSA study,[10] with a recent, February 2023 CDC report finding that teen girls are experiencing record high levels of violence, sadness, and suicide risk.[11] Additionally, Native Americans experience some of the highest rates of psychological and behavioral health issues as compared to other racial and ethnic groups [12] which have been attributed, in part, to the ongoing impacts of historical trauma.[13]

Just Like our Life Expectancy—U.S. Spending Policy is Stuck in the Termination Era

Congress allocates more than $1 trillion in budget authority for Federal health care, the United States just disproportionately underfunds Indian Country. Just 0.22% of the budget authority within this jurisdiction was reported for the benefit of Native Americans,[14] even though the combined AI/AN population would represent the 15th most populous state, with the 12th largest landmass. The data reveals a painfully disparate reality of the investment in Tribal nations' public health and underscores the purposeful inequity that continues to result in some of the worst health statistics for AI/ANs. Including Tribal set asides will help remedy the ongoing inequities in investment and capacity that lead to these inequities in health outcomes.

The Prevention and Public Health Fund (PPHF) is a clear example of how institutionalized disparity toward Indian health permeates throughout the HHS and is maintained through the appropriations process. The PPHF is a permanent mandatory appropriation to be administered at the Secretary's discretion unless otherwise specified by Congress for the eight U.S. Public Health Service components, including the Indian Health Service (IHS). Unfortunately, and as with many resources theoretically available to IHS, the resources go to other Public Health Service agencies, largely to the Centers for Disease Control and Prevention (CDC), and largely at the direction of this subcommittee for FY 2023.

Regardless of the Fund source or authorizing provision, Congress is making an annual budget policy decision much like the dark Termination Era policy. We see this systematic isolation, sovereign infringement, forced dependence, assimilation, and termination in the annual appropriations process each year. We cannot expect Tribal communities' health to improve when they are consistently starved for resources. We cannot rely only on the Indian Health Service, but all HHS agencies

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[5] See, U.S. Commission on Civil Rights, Broken Promises: Continuing Federal Funding Shortfall for Native Americans (hereinafter "Broken Promises"), 65, available at: https://www.usccr.gov/files/pubs/2018/12-20-Broken-Promises.pdf, accessed on: November 20, 2022.

[6] Broken Promises at 65.

[7] Broken Promises at 65.

[8] Broken Promises at 65.

[9] Broken Promises at 79–84.

[10] Substance use And Mental Health Services Administration, Key Substance Use and Mental Health Indicators in the United States, Results from the 2020 National Survey on Drug Use and Health, available at: https://www.samhsa.gov/data/sites/default/files/reports/rpt35325/NSDUHFFRPDFWHTMLFiles2020/2020NSDUHFFR1PDFW102121.pdf, accessed on: March 22, 2023.

[11] Centers for Disease Control and Prevention, PRESS RELEASE: U.S. Teen Girls Experiencing Increased Sadness and Violence, available at: https://www.cdc.gov/media/releases/2023/p0213-yrbs.html, accessed on: March 22, 2023.

[12] Walls, et al., Mental Health and Substance Abuse Services Preferences among American Indian People of the Northern Midwest, COMMUNITY MENTAL HEALTH J., Vol. 42, No. 6 (2006) at 522, https://link.springer.com/content/pdf/10.1007%2Fs10597-006-9054-7.pdf, accessed on: November 20, 2022.

[13] Kathleen Brown-Rice, Examining the Theory of Historical Trauma Among Native Americans, PROF'L COUNS, available at: http://tpcjournal.nbcc.org/examining-the-theory-of-historical-trauma-among-native-americans/, accessed on: November 22, 2022.

[14] Office of Management and Budget, FY 2023 Native American Crosscut, available at: https://www.whitehouse.gov/wp-content/uploads/2022/05/FY-2023-Native-American-Funding-Crosscut_FINAL.pdf, accessed on: March 22, 2023; Pub. L. 117–328, FY2023 Consolidated Appropriations Act Explanatory Statement, available at: https://www.appropriations.senate.gov/imo/media/doc/Division%20H%20-%20LHHS%20Statement%20FY23.pdf, accessed on: March 22, 2023.

must do their part in fulfilling the Federal trust responsibility for health. Too often, Tribal nations are trapped in a Federal funding structure operating on the assumption that only State governments are worthy of base funding, essentially, assuming that we do not exist as jurisdictional sovereigns.

This subcommittee can help right this measurable injustice with a few key overarching funding principles: NIHB supports an HHS-wide 10% set aside to address historical and ongoing inequities.[15] We request that Congress provide formula-based, annually-recurring funding directly to Tribal nations and not as pass-through funding through the States or another entity. Congress should also eliminate barriers to program access such as dollar matching requirements, onerous asset collateralization, waivers of sovereign rights, and project size/parameters that favor projects that are illogical for Tribal applicants and communities. NIHB supports expanding Tribal Self-Governance at HHS and engaging in multi-agency compacting, contracting, and grant award agreements with Tribal nations that reduce or eliminate cost barriers to program application and negotiation. We are asking Congress' assistance to have HHS reduce, unify, simplify, and streamline reporting requirements to the greatest extent possible to maximize Federal investment in outcomes, instead of records keeping. Provide increased, government-wide, internal and external technical assistance and training to support the effective use of existing program resources.

The Substance Abuse and Mental Health Service Administration (SAMHSA) provides critical resources through Tribal behavioral grants and a Tribal set aside within the State Opioid Response grants, known as the Tribal Opioid Response grant set-aside. Newly established by the FY 2023 Omnibus is the Behavioral Health and Substance Use Disorder Resources for Native Americans program. This new authority is broadly supported by Tribes and Tribal organizations, and NIHB recommends the program be funded at the full authorized amount of $80 million, along with increases to other dedicated Tribal programs within SAMHSA like the Tribal Opioid Response Grants, Tribal Behavioral Health Grants, and Circles of Care program.

The Centers for Disease Control and Prevention (CDC) primarily provides funding through four cooperative agreements: Good Health and Wellness in Indian Country, Tribal Epidemiology Centers Public Health Infrastructure, Tribal Practices for Wellness in Indian Country, Tribal Public Health Capacity Building and Quality Improvement, totaling about $90 million for FY 2023. Tribal governments are public health authorities recognized by Title 42 of the U.S. Code but experience significant difficulty with access to and treatment of resources and data. Tribes and Tribal organizations received a little less than 1% of CDC resources, even though the combined AI/AN population would represent the 15th most populous state, with the 12th largest landmass. Tribal nations need increased, dedicated resources for infrastructure and capacity building, and increased resources for public health education and monitoring and assurances that Tribal data will not be shared with another public health authority without the affected Tribes' consent.

The Health Resources and Services Administration (HRSA) provides resources for Tribal Health Centers, Centers of Excellence, the National Health Service Corps, and various grants for rural health. During the March 2023 HHS Secretary's Tribal Advisory Committee meeting, a Tribal leader noted that when HRSA discussed why its application was turned down, it had a clear lack of knowledge of what the Indian Health Service was, and how Tribal nations provide complex and efficient health care delivery services. Another Tribal leader in that same meeting commented that, in review of a grant application, the information often appears redundant, but compliant with the grant notices. Tribes or Tribal organizations operating IHS contracts or compacts through the Indian Self-Determination and Education Assistance Act should be able to automatically qualify as a Health Center and applications and reporting should be streamlined.

The Administration for Community Living (ACL) provides resources for nutrition and aging programs, as well as the Native American Caregiver Support program and a recent set aside of access to elder justice support. Most of the funding is provided through the "grants for Native Americans" line item in annual appropriations, with the expanded caregiver support services funded in a separate line item titled, "Native American Caregivers Support." The ACL also provides funding for resource centers and competitive grants that make up the extremely small remainder of the grants for the benefit of Tribes from ACL.

The resources are extremely flexible and useful, but severely limited in their amount, at just $53 million in FY 2023. As an unfunded but authorized program

[15] National Indian Health Board, Resolution 22—10, available at: https://www.nihb.org/docs/12082022/22–10%20NIHB%20Resolution%20on%2010%20Percent%20Set%20Aside%20for%20Health%20Equity.pdf, accessed on: March 22, 2022.

in the IHCIA, much of the elder care and long-term service care resource burden falls on the Tribe or is wholly unmet in the community. Tribal programs at ACL do great work, they are just severely under-resourced.

Congress must continue to increase funding for Tribal programs at ACL and continue to include a Tribal set aside in funding for Adult Protective Services (APS). Consistent with NIHB Resolution 22—10 calling for an HHS-wide 10 percent set aside for Tribes and Tribal organizations, Congress should increase the amount set aside for Tribes and Tribal organizations from APS funding from five to 10 percent.

CONCLUSION

This subcommittee can break the cycle of inequity. It can stop terminating our people. Tribal nations seek no more than the duty affirmed and reaffirmed by the U.S. Constitution, treaties, statutes, court decisions, and Federal administrative law. Empowering Tribes works. Listening to Tribes works. Government-to-government collaboration works. Thank you, again, for the opportunity to provide testimony. We look forward to continuing to work with you for the betterment of the American people.

PREPARED STATEMENT OF THE NATIONAL KIDNEY FOUNDATION

The National Kidney Foundation (NKF) appreciates the opportunity to highlight the significant burden that chronic kidney disease (CKD) places on patients, families and caregivers, society, and our Nation's health care system. We respectfully request that the Chronic Kidney Disease Initiative at the Centers for Disease Control and Prevention (CDC) be increased to $15 million over the next 5 years and 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 CDC and NIDDK. These investments represent a shift in the government's strategy from one that pays for kidney disease and kidney failure 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 cost 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). Some people do not learn of their kidney disease until they are in the emergency room. By the time most kidney disease diagnosis occurs-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 5-year survival rate is only 35%—half that of the survival rate for all cancers. According to the U.S. Renal Data System, kidney 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 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, Native American or Alaska Native, Asian

American, or Native Hawaiian or Pacific Islander descent are at increased risk for developing CKD. For example, Blacks/African American people comprise 13% of the U.S. population but represent 35% of those with kidney failure, requiring 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%.

As alarming as these statistics may be, there is significant hope for individuals facing a CKD diagnosis. Simple interventions such as medical nutrition therapy, blood pressure control, diabetes control, and common, affordable drugs such as statin-based therapies can improve kidney function and CVD outcomes. Further, a new class of drugs, sodium-glucose co-transporter-2 (SGLT–2) inhibitors and nonsteroidal 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 type 2 Diabetes 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 a 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 a 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 CKD 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. Increased investment in these preventive activities would allow us to replicate this program in high-risk communities across the country. Growing the program to serve all 50 States would require a sustained investment of approximately $15 million.

Regarding 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 (eGFR) 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.

This year marks the 50th anniversary of the Medicare ESRD benefit. As we consider where we want to go over the next 50 years, NKF urges Congress to invest in a future where a majority of kidney failure cases are prevented, where dialysis is necessary only in emergency cases, and where every patient with kidney failure can access a transplant. To accomplish that, Congress must increase investment in

kidney related research at NIH, prevention, and surveillance activities through CDC, and in innovation initiatives like Kidney X.

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

PREPARED STATEMENT OF THE NATIONAL MARROW DONOR PROGRAM

Chairwoman Baldwin, Ranking Member Capito, and Committee Members, my name is Claire LaSee, and I am from Olympia, Washington. I write to you as a representative for the patients, family members, donors, volunteers, and staff of the National Marrow Donor Program(r) (NMDP). I want to thank the Committee members for last year's support for the C.W. Bill Young Cell Transplantation Program (Program) within the Health Resources and Services Administration (HRSA), Health Care Systems account. Your partnership with the Program truly saves lives. Thanks to a more than 35-year partnership, the Program has facilitated over 120,000 transplants between a matched, unrelated donor and a patient with a blood cancer or disorder. In Fiscal Year 2024, NMDP respectfully requests $35 million 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. By establishing a national bone marrow donor registry in the mid-1980s, Congress made a promise to 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.

I testify today as a bone marrow donor for NDMP through the C.W. Bill Young Cell Transplantation Program. Four years ago, I donated bone marrow to a stranger, a man with cancer. I made this donation in honor of my father, a kind-hearted and generous man, who was always ready to lend a helping hand to his friends, his neighbors, and his community. He donated blood regularly and urged me to do the same, even assuaging my initial fears by rolling up his sleeve and donating blood along side of me. My dad never talked about his good deeds, and for this reason, I did not know that he was on the National bone marrow registry until I was an adult. Eventually, I learned that he had joined the registry in the 1980's when a friend's 12-year-old niece was diagnosed with cancer. When he was not selected as her donor, he remained on the registry for decades in the hope of being able to help someone else. I happened to be visiting my parents at their home in Wisconsin when he received a letter from NMDP notifying him that he had aged off the registry. Research conducted by the NMDP shows that patients have better outcomes with younger donors. It was the first time I became aware of the registry's existence, and I was immediately inspired to join so that I would symbolically replace my father on the registry.

Unlike blood donation, in which there are four main types of blood available, bone marrow matching is more complex, based on an individual's HLA (human leukocyte antigen) type, so most patients only have a few matches on the registry. Although I never imagined I would be selected, I joined the registry with the intention of donating if I were ever selected.

In 2019, I got the call I never expected: I had matched with a man in need of life-saving transplant.

I was very passionate about saying "yes" when I received the call, but it was still scary. However, NMDP was there every step of the way, providing unwavering support, and handling all coordination such as scheduling medical appointments and arranging travel. My dedicated donor coordinator guided me through the process, answering my questions with patience. NMDP covered all the expenses, and they flew my mom out from Wisconsin to accompany me in Seattle during the donation and recovery process. Their invaluable assistance made the experience fulfilling and reassuring, ensuring I was well-prepared and supported throughout. I would do it again in a heartbeat.

My family understands the agony of waiting for a life-saving transplant, hoping for more time with our loved ones. While my father inspired me to be a bone marrow donor, he will never know that I donated. He passed away in 2017, at the age of 66, before he was able to get a lung transplant he desperately needed. I would have given anything for my dad to have been granted more time, and I hope that through my donation, I was able to provide my recipient with the opportunity to experience more of life's moments with their own loved ones-more hugs, more laughs, and more time together.

I knew my bone marrow could save my recipient's life, but I did not know it would also change mine. Since donating, I have had the amazing privilege of volunteering with NMDP as an advocacy ambassador, and sharing my story with Members of Congress, such as yourselves. My fellow volunteers and the staff at NMDP work tirelessly every day to save lives through cellular therapy so more families have more time with their loved ones.

This esteemed committee exemplifies the meaning of good work. More than any other Committee in Congress, the programs you support have the power to save lives every day, including the Program I write to you about today.

The C.W. Bill Young Cell Transplantation Program, authorized by Congress and funded by the Committee, fulfills three important missions. The first is to grow and operate the Nation's bone marrow registry, which consists of over 41 million volunteers worldwide, who stand ready to be life-saving bone marrow donors. 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 donors, to the safe delivery of the life-saving cells to the bedsides of patients for transplant—NMDP remains steadfast in its commitment to support partners in every step of the transplant process. NMDP ensures that the global network, technology, and logistical support are in place to facilitate a transplant.

The Program's second mission is to provide comprehensive support to patients and their families through its Office of Patient Advocacy. NMDP works tirelessly to improve patients' lives by providing resources, guidance, and one-on-one support throughout the transplant process—from deciding if transplant is right for them to adjusting to life after transplant.

The Program's final mission is to operate the Stem Cell Therapeutic Outcomes Database, which enables doctors to 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 funding request this year builds upon past funding support to clear a pathway for more patients to access life-saving transplant services, especially those from minority communities and those in communities geographically distant from a transplant center. The funding we seek will immediately increase the number of patients who begin the journey to receive a bone marrow transplant for a life-saving cure by increasing targeted donor recruitment efforts, expanding early intervention with community oncologists upon patient diagnosis to accelerate the path to transplant, and propelling innovation to improve outcomes and establish new treatment options.

The request also builds on a successful pilot program funded by NMDP called HLA Today. When it comes to matching human leukocyte antigen (HLA) types, a patient's ethnic background is important in predicting the likelihood of finding a match. This is because HLA markers used in matching are inherited. Some ethnic groups have more complex tissue types than others, so a person's best chance of finding a donor may be with someone of the same ethnic background. This funding will enable all searching patients, regardless of their racial/ethnic background, to find a donor ensuring equal access to transplant and equal and successful outcomes for all. HLA Today has demonstrated outstanding early results in targeted outreach to patients who have been diagnosed with a transplant-treatable disease. This free program shortens the time to transplant through a simple process of providing genetic typing for patients who are newly diagnosed with a condition for which 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 for patients in rural and other underserved areas.

In closing, I want to express my gratitude for the opportunity to share my story. I signed up to be on the Nation's bone marrow registry because I was inspired by my father's selfless spirit; I later donated bone marrow to a man in his 60's to honor my father's legacy. I know what it is like to desperately wait for your loved one to get a life-saving transplant and I empathize with patients and their loved ones as they hope someone will step up to end their wait.

Your longstanding support for this Program provides hope to people who receive life-threatening diagnoses. On behalf of those who are alive today, those who are currently searching the National bone marrow 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 allocate $35 million to fund the C.W. Bill Young Cell Transplantation Program ensuring immediate access to therapy at the point of diagnosis for all pa-

tients. Together, we can bring hope, healing, and renewed possibilities to individuals facing blood cancers and other life-threatening diseases. Thank you.

[This statement was submitted by Claire LaSee, Volunteer and Bone Marrow Donor.]

PREPARED STATEMENT OF THE NATIONAL NETWORK FOR YOUTH

The National Network for Youth is a national organization working to transform systems so that no young person in America experiences homelessness. We have built a network of over 300 community-based organizations, schools, and state associations, as well as youth with lived expertise of homelessness. With our network, we advance commonsense solutions that prevent and end youth homelessness. This testimony supports a request of $300 million in Fiscal Year (FY) 2024 funding for the Runaway and Homeless Youth Act (RHYA) program, administered by the U.S. Department of Health and Human Services. This request includes two separate programs in the appropriations table, as follows:

First Line Item: Consolidated Runaway and Homeless Youth (RHY) Programs

Description of Program: The Consolidated Runaway and Homeless Youth Act (RHYA) programs prevent trafficking, identify survivors, and provide services to runaway, homeless, and disconnected youth. The grants provided through the RHY program includes:

Basic Center Programs: provides temporary shelter and counseling services to youth who have left home without permission of their parents or guardians, have been forced to leave home, or are experiencing homelessness or housing instability, who might otherwise end up in the law enforcement, child welfare, mental health, or juvenile justice systems.

Transitional Living Programs and Maternity Group Homes: provides longer-term housing with supportive services, including Maternity Group Homes for pregnant and parenting youth

National Communications System: 24/7 national phone, text, and online communications system which connects youth and families in crisis with prevention services and reunifies families

National Technical Assistance Center: provides training and technical assistance to all RHYA grantees

Second Line Item: Service Connection for Youth on the Streets

Description of Program: The Service Connection for Youth on the Streets program is commonly called the Street Outreach Program and is funded by the Runaway and Homeless Youth Act. These funds are granted to community-based organizations to provide education, prevention, treatment, counseling, connection, and referrals to vital services to prevent sexual abuse and human trafficking for youth at-risk of and experiencing trafficking and homelessness.

This request is vital because only 25% of applicants receive a grant due to the lack of Federal funding. This demonstrates the desire of communities to serve our young people and their families who are in crisis. This is especially devastating, considering that 4.2 million youth and young adults experience homelessness every year in America (Chapin Hall). Further, Loyola University found that 1 in 5 youth experiencing homelessness are trafficked for sex, labor or both. Community-based housing options and supportive services through the Runaway and Homeless Youth Act program prevents human trafficking and serves survivors.

Runaway and Homeless Youth Act grantees are community-based organizations. They adapt and deliver services based on local needs, including rural and suburban settings (where homelessness looks different). Increased funding to RHYA is needed to help more youth and families access safety and avoid chronic homelessness as an adult.

Like other forms of social disadvantage, homelessness is not equally distributed among youth. The Chapin Hall data demonstrates that Black and Indigenous youth are the most at risk of homelessness, with Black youth 83% more likely than white youth to become homeless, and American Indian and Alaska Native youth have more than double the risk of homelessness as other youth. LGBTQ+ youth are 120% more likely to experience homelessness than non-LGBTQ+ youth. Additionally, youth who are Black or multiracial and LGBTQ+ experience the highest rates of homelessness and housing instability. There is also a disproportionate risk for homelessness among specific subpopulations, including pregnant and parenting, young people without a high school diploma, and young people involved in the child welfare or court legal system.

Youth experiencing homelessness face a particularly steep climb to adulthood. They are not plugged into networks of support needed for healthy development. RHYA programs provide the support and connection youth need to successfully transition to adulthood. These services and support are also more cost-effective than other systems (child welfare, juvenile and adult court systems) youth experiencing homelessness come into contact with.

Last reauthorized in 2018 (Public Law 115–385), Runaway and Homeless Youth Act programs provide appropriate, relevant, and readily accessible services critical to addressing episodic or longer-term homelessness among youth, including family reunification when safe and appropriate. The origin of RHYA was in 1974 as Title III of the Juvenile Justice and Delinquency Prevention Act to provide youth-specific community-based services as an alternative to involvement in the policing and incarceration systems for youth status offenders.

$300 million for the Runaway and Homeless Youth Act Program would:

—Support approximately 1,400 RHYA projects in communities across the United States that meet our young people where they are. These youth are not eligible for HUD homeless assistance due to HUD's narrow definition of homelessness and the hidden nature of homelessness among youth.

—Allow approximately 49,034 young people access to housing and connect with 70,000 youth via street outreach and drop-in centers. This is far from meeting the need, but would significantly increase our country's capacity to end youth homelessness by doubling the number of young people served. It would also provide a cost savings of more than $12 billion in fiscal costs and over $30 billion in costs to society.

—Ensure that our young people are not left out of national efforts to end homelessness. Successfully addressing youth homelessness will save money and dramatically reduce future chronic adult homelessness.

—Increase the percentage of applicants who receive funding from 25% to 50%.

[This statement was submitted by Darla Bardine, Executive Director, National Network for Youth.]

PREPARED STATEMENT OF THE NATIONAL RESPITE COALITION

Mr. Chairman, I am Jill Kagan, Chair, National Respite Coalition (NRC), a network of state respite coalitions, providers, caregivers, and national, State and local organizations. We are requesting $20 million in the FY 2024 Labor, HHS, and Education Appropriations bill for the Lifespan Respite Care Program administered by the Administration for Community Living, Department of Health and Human Services. The request reflects prominent recommendations to increase respite care options included in the National Strategy to Support Family Caregivers (Administration for Community Living, 2022), and will allow all States to receive a Lifespan Respite Grant to help family caregivers, regardless of care recipient's age or disability, access affordable respite. Additional funding will help States improve respite quality; expand the respite workforce; and use person and family-centered approaches that provide family caregivers culturally-competent, tailored information on how to find, use and pay for respite services.

The pandemic cast a harsh light on the lack of supports for the Nation's family caregivers. When congregate and group settings became too risky for older adults and people with disabilities, the importance of family caregivers to providing care at home was greatly amplified. At the same time, the availability of services, such as respite, became harder to access and remain so. The Lifespan Respite network responded with flexible respite and support options for family caregivers. During this challenging time, respite may have been the only support family caregivers received. With escalating workforce shortages, new and innovative respite options are even more critical to ensure that family caregivers can continue to provide care at home.

Respite Care Saves Money and Benefits Families. Now, more importantly than ever, delaying a nursing home placement for individuals with Alzheimer's or avoiding hospitalization for children with autism can save Medicaid billions of dollars. Researchers at the University of Pennsylvania studied records of 28,000 children with autism enrolled in Medicaid and concluded that for every $1,000 States spent on respite, there was an 8% drop in the odds of hospitalization (Mandell, et al., 2012). Respite may help delay or avoid facility-based placements (Gresham, 2018; Avison, et al., 2018), improve maternal employment (Caldwell, 2007), strengthen marriages (Harper, 2013), and reduce caregiver depression, stress and burden

linked to caregiver health (Broady and Aggar, 2017; Lopez-Hartmann, et al., 2012; Zarit, et al., 2014).

One in five full-time workers are family caregivers (Rosalyn Carter Institute for Caregivers, 2022), and at least 60 percent of family caregivers are employed (Matos, 2015; National Alliance for Caregiving and AARP, 2020). They often juggle their work and caregiving responsibilities with great difficulty. The impact on employers is significant. Higher absenteeism among working caregivers costs the U.S. economy an estimated $25.2 billion annually (Witters, 2011). Family caregivers also experience significant financial burdens that affect their overall wellbeing (AARP, 2021; National Academies of Sciences, Engineering, and Medicine, 2016). The University of NE Medical Center conducted a survey of caregivers receiving respite through the NE Lifespan Respite Program and found that 36% of family caregivers reported not having enough money at the end of the month to make ends meet, but families overall reported a better financial situation when receiving respite (Johnson, J., et al., 2018).

Who Needs Respite? Almost 40 million unpaid family caregivers of adults provide care worth $600 billion annually (Reinhard, SC, et al., 2023);); if caregivers of children with special needs are included, the number climbs to 53 million (National Alliance for Caregiving and AARP, 2020). Eighty percent of those needing long-term services and supports (LTSS) are living at home. Two-thirds of older people with disabilities receiving LTSS at home receive care exclusively from family caregivers (Congressional Budget Office, 2013).

Concerns about providing care for a growing aging population are paramount. However, caregiving is a lifespan issue. The majority (54%) of family caregivers care for someone between the ages of 18 and 75 (NAC and AARP, 2020). In addition, nearly 14 million children with special health care needs require specialized care from parents and guardians (Child and Adolescent Health Measurement Initiative, 2022). Families caring for children with special health care needs provide nearly $36 billion worth of care annually (Romley, et al., 2016).

National, State and local surveys have shown respite to be among the most frequently requested services by family caregivers (Anderson, L, et al., 2018; Maryland Caregivers Support Coordinating Council, 2015). Yet, 86% of family caregivers of adults did not receive respite services at all in 2019 (NAC and AARP, 2020). Nearly half of family caregivers of adults (44%) identified in the National Study of Caregiving were providing substantial help with health care tasks, yet, fewer than 17% used respite (Wolff, 2016). The percentage is similar for parents of children with disabilities. The Elizabeth Dole Foundation continues to recommend that respite should be more widely available to military and Veteran caregivers.

Respite Barriers and the Effect on Family Caregivers. While most families want to care for family members at home, research shows that family caregivers are at risk for emotional, mental, and physical health problems (National Academies of Sciences, Engineering, and Medicine, 2016; Spillman, J., et al., 2014). When caregivers lack effective coping styles or are depressed, care recipients may be at risk for falling, developing preventable secondary health conditions or limitations in functional abilities. The risk of care recipient abuse increases when caregivers are depressed or in poor health (American Psychological Association, nd). Parents of children with special health care needs report poorer general health, more physical health problems, worse sleep, and increased depressive symptoms compared to parents of typically developing children (McBean, A, et al., 2013).

Respite, that has been shown to ease family caregiver stress, is too often out of reach or completely unavailable. In a survey of more than 3000 caregivers of individuals with intellectual and developmental disabilities (ID/DD), nine in 10 reported that they were stressed. Nearly half (49%) reported that finding time to meet their personal needs was a major problem. Yet, more than half of the caregivers of individuals with ID or Autism Spectrum Disorder reported that it was difficult or very difficult to find respite care (Anderson, L., et al., 2018). Respite may not exist at all for those with Alzheimer's, ALS, MS, spinal cord or traumatic brain injuries, or children with serious emotional conditions.

Barriers to accessing respite include fragmented and narrowly targeted services, cost, and the lack of information about respite or how to find or choose a provider. Moreover, a critically short supply of well-trained respite providers or meaningful service options may prohibit a family from making use of a service they so desperately need.

Lifespan Respite Care Program Helps. The Lifespan Respite Care Program, the only Federal program designed to address all of the barriers to respite quality, affordability and accessibility, is a competitive grant program to States administered by ACL. The premise behind the program is both care relief and cost effectiveness. Lifespan Respite provides funding to States to expand and enhance local respite

services across the country, coordinate services to reduce duplication and fragmentation, and improve respite access and quality.

The National Strategy to Support Family Caregivers asserted that an indicator of success in implementing the strategy will be when "family, kin, and grandparent caregivers feel more confident in their ability to provide care because they have a robust array of trained respite options available that are local, convenient, and affordable." Given its unique mandate, the Lifespan Respite Care Program is the only Federal program designed to achieve this goal. States are required to establish Statewide coordinated Lifespan Respite care systems to serve families regardless of age or special need; provide planned and emergency respite care; train and recruit respite workers and volunteers; and assist caregivers in accessing respite. Lifespan Respite helps States maximize use of limited resources and deliver services more efficiently to those most in need. Increasing funding could allow funding for all States and help current grantees complete their ground-breaking work in serving the unserved, and ensuring sustainability by integrating services into statewide No Wrong Door systems for long-term services and supports.

Since 2009, 38 States and DC have received Lifespan Respite grants. We are grateful for the increase in appropriations for the program to $10 million in FY 2023. However, if we are to achieve the goals of the National Strategy, more funds are necessary.

How is Lifespan Respite Program Making a Difference? Key accomplishments of State Lifespan Respite grantees are highlighted in the ARCH National Respite Network report, In Support of Caregivers [archrespite.org/key-accomplishments]. State Lifespan Respite programs are engaged in the following innovative activities:

—Current and former Lifespan Respite grantees in AL, AR, AZ, CO, DE, ID, IL, MD, MS, MT, ND, NE, NV, NY, NC, OK, RI, SC, TN, VA, WA, and WI administer successful self-directed respite vouchers for underserved populations, such as individuals with Alzheimer's disease, traumatic brain injury, MS or ALS, adults with intellectual or developmental disabilities (I/DD), rural caregivers, or those on waiting lists for services.

—AL, IL, MD, ND, NV and NE offer vouchers for emergency respite.

—AL's voucher program found a substantial decrease in the percentage of caregivers reporting how often they felt overwhelmed with daily routines after receiving respite. Caregivers in NE's Lifespan Respite Network reported significant decreases in stress levels, fewer physical and emotional health issues, and reductions in anger and anxiety.

—Innovative and sustainable respite services funded in AL, CO, ID, MA, NY, NC, OK, SC and WI through mini-grants to community-based agencies, also have documented benefits to family caregivers. AL, AR, CO, NE, NY, RI, SC and TN implemented new volunteer or faith-based respite services with promising results.

—Respite provider recruitment and training are priorities in AL, AR, IL, MA, MT, NE, NM, NV, NY, SC, SD, VA, and WI.

State agency partnerships are changing the landscape. Lifespan Respite WA, housed in Aging & Long-Term Support Administration, partnered with WA's Children with Special Health Care Needs Program, Tribal entities and the State's Traumatic Brain Injury program to provide respite vouchers to families across ages and disabilities. The OK Lifespan Respite program partnered with the State's Transit Administration to develop mobile respite in isolated rural areas. States, including NC, NY and NV, are building "no wrong door systems" in partnership with Aging and Disability Resource Centers to improve respite access. States are developing long-term sustainability plans, but without continued Federal support, many grantees will be cut off before these initiatives achieve their full impact.

During the pandemic, social isolation and severe mental health issues among family caregivers intensified. The CDC found that "unpaid adult caregivers reported having experienced disproportionately worse mental health outcomes, increased substance use, and elevated suicidal ideation." The Lifespan Respite network responded with flexible and innovative respite options. For countless caregivers, respite became their only lifeline to supports, services, and vital human connection. OK, ND, NV, WA, VA, and WI introduced flexibility in their respite voucher programs, such as expanded eligibility and timeframes, increased flexibility in who could provide respite, and increased voucher amounts. Other Lifespan Respite grantees met the needs of family caregivers through new and creative approaches:

Alabama: Alabama Lifespan Respite, in order to increase targeted support to caregivers during the pandemic, introduced a Caregiver Wellness Initiative that increases Emergency Respite reimbursement funds and designates funds specifically for mental health counseling to caregivers currently enrolled with their reimburse-

ment (voucher) program. The intended impacts of the Caregiver Wellness Initiative include decreases in caregiver stress, anxiety, fatigue, and burnout after receiving Emergency Respite and/or mental health counseling.

Tennessee: The TN Respite Coalition awarded mini-grants for caregiver-selected items, such as personal protective equipment, tablets enabling internet access to online support groups, home exercise equipment, and movie or magazine subscriptions. Expanding ideas of traditional respite services, the Tennessee Respite Voucher Program provided respite in innovative ways that allowed for safe social distancing but maintained caregiver-provider contact that kept caregivers socially connected during times of increased stress and isolation.

No other Federal program has respite as its sole focus, serves family caregivers caring for people of any age or condition, helps ensure respite quality or choice, and supports respite start-up, training or coordination. We urge you to include $20 million in the FY 2024 Labor, HHS, and Education appropriations bill. The respite goals of the National Strategy to Support Family Caregivers will be achieved as families will be able to keep loved ones at home safely and ensure their own well-being, saving Medicaid and other Federal programs billions of dollars.

For more information, please contact Jill Kagan, National Respite Coalition at jkagan@archrespite.org.

[This statement was submitted by Jill Kagan, Chair, National Respite Coalition.]

PREPARED STATEMENT OF THE NATIONAL RURAL HEALTH ASSOCIATION

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 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, approximately 150 78dfjmni8 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 10 rural counties have no physicians at all. With far fewer clinicians per capita, the maldistribution of health care providers 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.

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 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.

[This statement was submitted by Dr. Carrie Cochran-McClain, Chief Policy Officer, National Rural Health Association.]

PREPARED STATEMENT OF THE NATIONAL SCLERODERMA FOUNDATION

THE FOUNDATION'S FISCAL YEAR 2023 L–HHS APPROPRIATIONS RECOMMENDATIONS

—$11 billion in program level funding for the Centers for Disease Control and Prevention (CDC), which includes budget authority, the Prevention and Public Health Fund, Public Health and Social Services Emergency Fund, and PHS Evaluation transfers.
  —A proportional funding increase for CDC's National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP).
  —$6 million for the Chronic Disease Education and Awareness Program which seeks to improve public health and lower healthcare costs through targeted awareness, physician education, and public health campaigns conducted in collaboration with stakeholder organizations and communities.
—At least $50 billion in program funding for the National Institutes of Health (NIH).
  —Proportional funding increases for NIH's National Heart, Lung, and Blood Institute (NHLBI); National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS); National Center for Advancing Translational Sciences (NCATS).

Chairwoman Baldwin, Ranking Member Capito and distinguished members of the subcommittee, thank you for your time and your consideration of the scleroderma community's priorities while working to craft the FY2024 L–HHS Appropriations Bill.

ABOUT SCLERODERMA

Scleroderma is a chronic connective tissue disease affecting approximately 300,000 Americans. The word scleroderma means hardening of the skin, which is one of the most visible manifestations of the condition. The cause of this progressive and potentially fatal disease remains unknown. There is no cure, and treatment options are limited.

Symptoms vary greatly and are dependent on which organ systems are impacted. Prompt diagnosis and treatment by a qualified physician may improve health outcomes and lessen the chance for irreversible damage. Serious complications of the disease can include pain, skin ulcers, anemia and pulmonary hypertension.

ABOUT THE FOUNDATION

The National Scleroderma Foundation is a 501(c)(3) charitable organization founded in 1998 to advance medical research, promote disease awareness, and provide support and education to people with scleroderma. Supported by a network of thousands of individuals across the United States, the Foundation is a leader in funding

peer-reviewed, innovative research to discover the cause, understand the mechanism, and overcome scleroderma forever.

One of the most challenging things about scleroderma is that it shows up differently in each person. Scleroderma is complicated to manage, since it does not follow one clear path. At the National Scleroderma Foundation, we know that no two scleroderma journeys are the same. We help people find the resources that are right for them so they can live better with scleroderma.

CENTERS FOR DISEASE CONTROL AND PREVENTION

Early recognition and accurate diagnosis of scleroderma can improve health outcomes and save lives. CDC in general and the NCCDPHP specifically have programs to improve public awareness of scleroderma and other rare, life-threatening conditions. Please increase funding for CDC and NCCDPHP so that the agency can invest in additional, critical education and awareness activities that have the potential to improve health and save lives. The Foundation supports the continued support of the Chronic Disease Education and Awareness Program; this program seeks to provide collaborative opportunities for chronic disease communities that lack dedicated funding from ongoing CDC activities. Such a mechanism allows public health experts at the CDC to review project proposals on an annual basis and direct resources to high impact efforts in a flexible fashion.

NATIONAL INSTITUTES OF HEALTH

NIH continues to work with the Foundation to lead the effort to enhance our scientific understanding of the mechanisms of scleroderma with the shared goal of improving diagnosis and treatment and ultimately finding a cure. Since scleroderma is a systemic fibrotic disease, it is linked to other manifestations of fibrosis such as cirrhosis, pulmonary fibrosis, and the fibrotic damage resulting from heart attack. Scleroderma is a prototypical manifestation of fibrosis, as it impacts multiple organ systems. Because of this, it is important to promote cross-cutting research across such Institutes as NIAMS and NHLBI.

Please provide NIH with a significant funding increase so the scleroderma research portfolio can continue to expand and facilitate key breakthroughs. Continued support in the following areas is critical to improving the health of people with scleroderma:

—The Trans-NIH Working Group on Fibrosis, which is working to promote cross-cutting research across Institutes.

—The Scleroderma Lung Study II, being led by NNHLBI, which is comparing the effectiveness of two drugs in treating pulmonary fibrosis in scleroderma.

—Leading efforts to discover whether three gene expression signatures in skin can serve as accurate biomarkers predicting scleroderma as well as investigations into progression and response to treatment to clarify the complex interactions of T cells and interleukin-31 (IL–31) in producing inflammation and fibrosis or scarring in scleroderma being led by NIAMS.

Every story we hear from someone living with scleroderma reminds us how disruptive and life-altering this disease is. Now more than ever, it is important it is for us to understand scleroderma and find a cure.

Patient Perspective

"My constantly aching hands begged for mercy of just one day without pain. My joints started to feel like they were being torn away from my body. Anytime I touched something cold, my hands would tingle and burn. Painful sores started appearing on my knuckles. You stole my skin color and with that went my confidence. It was like I was turning into a mummy as my skin tightened with collagen, day by day. I was beginning to need help performing small tasks. Opening a water bottle or turning a key in the door started to become difficult. Standing for long

periods of time made my hips radiate with pain. In 2012 I had to stop working at 24 years old. The definition of normal as I knew it was being torn down and built into something completely new. And so was my soul.

I now need help with everything! Getting dressed, washing my hair, cleaning, doing laundry; pretty much anything I must use my hands for. You stole my independence. I had to learn to swallow my pride and ask for help. It's a tough thing to do, especially when you're at an age that's supposed to be your prime. Friends and family around me have blossomed into caregivers and helping me has become second nature to them. It's a beautiful thing when those surrounding you automatically adapt to your disability. Support is the lifeboat that keeps me afloat."

[This statement was submitted by Mary J. Wheatley, IOM, CAE, Chief Executive Officer, National Scleroderma Foundation.]

PREPARED STATEMENT OF THE NATIONAL TECHNICAL INSTITUTE FOR THE DEAF, ROCHESTER INSTITUTE OF TECHNOLOGY

Chairwoman Baldwin, Ranking Member Capito and Members of the Committee:

I respectfully submit the FY 2024 budget request for NTID, one of nine colleges of RIT, in Rochester, New York. Created by Congress by Public Law 89–36 in 1965, NTID provides a university-level technical and professional education for students who are deaf and hard of hearing, leading to successful careers in high-demand fields for a sub-population of individuals historically facing high rates of unemployment and under-employment. NTID also prepares professionals to work in fields related to deafness. NTID students study at the associate, baccalaureate, master's and doctoral levels as part of a university (RIT) that includes more than 17,000 hearing students.

BUDGET REQUEST

On behalf of NTID, for FY 2024 I would like to request $95,900,000 for Operations. NTID has worked hard to manage its resources carefully and responsibly. NTID actively seeks alternative sources of public and private support, with approximately 26% of NTID's Operations budget coming from non-federal funds, up from 9% in 1970. Since FY 2013, NTID raised more than $14 million in support from individuals and organizations.

NTID's FY 24 request includes a $3,400,000 increase above FY 23 funding to hire additional sign language interpreters and captionists, expand STEM outreach activities to prepare deaf and hard-of-hearing middle and high school students for college and the workforce, and manage inflationary costs.

Deaf and hard-of-hearing students are pursuing the wide range of majors and career paths available to them at RIT, with students pursuing everything from a Ph.D. in Computing and Information Science to an MS in Manufacturing and Mechanical Systems Integration to a BS in Diagnostic Medical Sonography. As these students take full advantage of the more than 200 programs at RIT, the demand for skilled, specialized interpreting and captioning has increased. NTID's FY 24 appropriations request would enable us to hire 10 additional interpreters to satisfy 98% of interpreting requests and 15 additional captionists to provide captioning for both in-person and remote classes and activities, resolving the 100 hours of captioning requests each week that cannot be satisfied currently.

For FY 24, NTID hopes to increase outreach funding by $2,000,000 to expand on the work done by NTID and the NTID Regional STEM Center (NRSC). This STEM outreach serves deaf and hard-of-hearing middle and high school students by providing STEM career exploration and college preparation, dual credit courses, camps, and programming for their parents about STEM career opportunities. NTID and the NRSC also provide professional development to teachers on best practices for teaching deaf and hard-of-hearing students, professional development to interpreters on best practices for middle and high school STEM interpreting, workshops to VR counselors on best practices related to advice on opportunities in STEM education and careers, and outreach to employers on how to provide internship and career opportunities for deaf and hard-of-hearing students.

ENROLLMENT

Truly a national program, NTID has enrolled students from all 50 States. In Fall 2022 (FY 2023), NTID's enrollment was 1,135 students. NTID also serves students nationwide through Project Fast Forward, a project that builds a pathway for deaf and hard-of-hearing students to transition from high school to college in selected STEM disciplines by allowing deaf and hard-of-hearing high school students to take dual-credit courses, earning RIT/NTID college credit while they are still in high school. In FY 2023, 260 deaf and hard-of-hearing high school students enrolled in dual-credit courses at partner high schools.

NTID ACADEMIC PROGRAMS

NTID offers 21 high-quality, career-focused associate degree programs preparing students for specific well-paying technical careers. NTID also provides transfer associate degree programs to better serve our student population seeking bachelor's, master's, and doctoral degrees. These transfer programs provide seamless transition to baccalaureate and graduate studies in the other colleges of RIT. NTID also offers two bachelor's degree programs (ASL-English Interpretation and Community Development & Inclusive Leadership) as well as an MS in Secondary Education of Students who are Deaf and Hard of Hearing.

A cooperative education (co-op) component is an integral part of academic programming at NTID and prepares students for success in the job market. A co-op assignment gives students the opportunity to experience a real-life job situation and focus their career choice. Students develop technical skills and enhance vital personal skills such as teamwork and communication, which will make them better candidates for full-time employment after graduation. Last year, 209 students participated in 10-week co-op experiences that augment their academic studies, refine their social skills, and prepare them for the competitive working world.

STUDENT ACCOMPLISHMENTS

NTID deaf and hard-of-hearing students persist and graduate at rates higher than or on par with national persistence and graduation rates for all students at 2-year and 4-year colleges. For NTID deaf and hard-of-hearing graduates, over the past 5 years, an average of 95% have found jobs commensurate with their education level. Of our FY 2021 graduates (the most recent class for which numbers are available), 96% were employed 1 year later, with 67% employed in business and industry, 25% in education and non-profits, and 8% in government.

Graduation from NTID has a demonstrably positive effect on students' earnings over a lifetime, and results in a notable reduction in dependence on Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI). In FY 2012, NTID, the Social Security Administration (SSA), and Cornell University examined earnings and Federal program participation data for more than 16,000 deaf and hard-of-hearing individuals who applied to NTID over our entire history. The study showed that NTID graduates, over their lifetimes, are employed at a higher rate and earn more (therefore paying more in taxes) than students who withdraw from NTID or attend other universities. NTID graduates also participate at a lower rate in SSI programs than students who withdrew from NTID.

Using SSA data, at age 50, 78% of NTID deaf and hard-of-hearing graduates with bachelor degrees and 73% with associate degrees report earnings, compared to 58% of NTID deaf and hard-of-hearing students who withdrew from NTID and 69% of deaf and hard-of-hearing graduates from other universities. Equally important is the demonstrated impact of an NTID education on graduates' earnings. At age 50, $58,000 is the median salary for NTID deaf and hard-of-hearing graduates with bachelor degrees and $41,000 for those with associate degrees, compared to $34,000 for deaf and hard-of-hearing students who withdrew from NTID and $21,000 for deaf and hard-of-hearing graduates from other universities.

An NTID education also translates into reduced dependency on Federal transfer programs, such as SSI and SSDI. At age 40, less than 2% of NTID deaf and hard-of-hearing associate and bachelor degree graduates participated in the SSI program compared to 8% of deaf and hard-of-hearing students who withdrew from NTID. Similarly, at age 50, only 18% of NTID deaf and hard-of-hearing bachelor degree graduates and 28% of associate degree graduates participated in the SSDI program, compared to 35% of deaf and hard-of-hearing students who withdrew from NTID.

ACCESS SERVICES

Access services include sign language interpreting, real-time captioning, classroom notetaking services, captioned classroom video materials, and assistive listening services. NTID provides an access services system to meet the needs of a large number of deaf and hard-of-hearing students enrolled in baccalaureate and graduate degree programs in RIT's other colleges as well as students enrolled in NTID programs who take courses in the other colleges of RIT. Access services also are provided for events and activities throughout the RIT community. Historically, NTID has followed a direct instruction model for its associate-level classes, with limited need for sign language interpreters, captionists, or other access services. However, the demand for access services has grown recently as associate-level students request communication based on their preferences.

During FY 2022, 132,176 hours of interpreting and 32,317 hours of real-time captioning were provided to students.

SUMMARY

NTID's FY 2024 funding request ensures that we continue our mission to prepare deaf and hard-of-hearing people to excel in the workplace and expand our outreach to better prepare deaf and hard-of-hearing students to excel in college. NTID students persist and graduate at rates higher than or on par with national rates for all students. NTID graduates have higher salaries, pay more taxes, and are less reliant on Federal SSI programs. NTID's employment rate is 95% over the past 5

years. Therefore, I ask that you please consider funding our FY 2024 request of $95,900,000 for Operations.

We are hopeful that the members of the Committee will agree that NTID, with its long history of successful stewardship of Federal funds and an outstanding educational record of service to people who are deaf and hard of hearing, remains deserving of your support and confidence. Likewise, we will continue to demonstrate to Congress and the American people that NTID is a proven economic investment in the future of young deaf and hard-of-hearing citizens. Quite simply, NTID is a Federal program that works.

[This statement was submitted by Dr. Gerard J. Buckley, President, NTID and Vice President and Dean, RIT.]

PREPARED STATEMENT OF THE NATURAL SCIENCE COLLECTIONS ALLIANCE

The Natural Science Collections Alliance appreciates the opportunity to provide testimony in support of fiscal year (FY) 2024 appropriations for the Institute of Museum and Library Services (IMLS). We encourage Congress to provide robust funding for the IMLS in FY 2024, with at least $65.5 million for its Office of Museum Services.

The Natural Science Collections Alliance is a non-profit association that supports natural science collections, their human resources, the institutions that house them, and their research activities for the benefit of science and society. Our membership consists of institutions that are part of an international network of museums, botanical gardens, herbaria, universities, and other institutions that contain natural science collections and use them in research, exhibitions, academic and informal science education, and outreach activities.

Museums strengthen our National economy. They provide core educational and outreach programs to engage the public and contribute more than $50 billion to the U.S. economy every year, support more than 726,000 American jobs, and generate $12 billion in tax revenue. Museums also play an essential role in the Nation's educational infrastructure, spending more than $2 billion a year on education. It is of paramount importance to invest in museums given the enormous economic and educational contributions of these institutions.

IMLS provides funding that helps museums with public outreach programs and strengthens the capacity of museums to improve the well-being of their communities. Its Office of Museum Services (OMS) awards grants to museums for preserving and digitizing collections, educational programming, professional development, and community outreach. In addition to providing grants, the agency conducts critical research, facilitates state and regional collaboration, and supports national initiatives that benefit museums.

Investments in IMLS and its efforts to support scientific and educational advances in science collections, such as those that comprise natural history museums, are in the National interest. Scientific collections contribute to improved public well-being and national economic security. This important documentation of our Nation's heritage is irreplaceable; it cannot be reconstructed or reassembled at a later date. Specimens collected decades or centuries ago are increasingly used to develop and validate models that explain how species, including viruses, parasites, and pathogens have dispersed around the world, as well as how and when they might infect humans.

The IMLS is the primary Federal agency that supports public education programs at museums and an important source of funding for preserving scientific collections. Investments in IMLS programs that support natural science collections research and education are essential if we are to maintain our global leadership in innovation.

Scientific collections enable us to tell the story of life on Earth. There are more than 1,600 biological collections in the United States, with a significant number of these constituting the research and education resources of our Nation's natural history museums. These resources are the result of more than 200 years of scientific investigation, discovery, and inventory of living and fossil species. Scientists have collected, studied, and curated more than one billion specimens within those collections, many of which have now been digitized and the resulting data stored in easily accessible online databases that contribute heavily to research. The institutions that care for scientific collections are important research infrastructure for the United States that also provide students with hands-on training opportunities.

Natural science collections advance scientific research and education, and that informs actions to improve public health, agricultural productivity, natural resource management, biodiversity conservation, and American economic innovation and pro-

ductivity. Current research involving natural science collections also contributes to the development of new cyberinfrastructure, data visualization tools, and improved data management practices. This work also ensures critical input into policy development and implementation by several U.S. government agencies. A few examples of how scientific collections have saved lives, enhanced food production, and advanced scientific discovery include:

—Scientists used museum specimens in U.S. collections to gather data on the distribution of the mosquito Culex quadrofaciatus, which is known to carry West Nile Virus and other pathogens. They then modeled the distribution under different scenarios of changing climates to predict regions where the species may expand in the future. Predicting the spread of disease vectors such as these mosquitoes helps the health care community prepare for disease outbreaks and where they will happen.

—Researchers from Boston University documented Tau proteins in the brains of fluid preserved museum specimens of Downy Woodpecker. These proteins are also found in traumatic brain injuries in humans. Because of the life history traits of woodpeckers, the researchers argue these birds may have evolved a level of resistance to traumatic head injuries that could have implications for treatments for humans.

—Citrus bacterial canker disease wreaks havoc on fruit crops in Florida. Using plant specimens collected a century ago, scientists have analyzed the bacterium and traced its source. Knowledge of how the bacteria spreads allows scientists to develop effective control methods and to protect the U.S. citrus industry.

—When the 2001 anthrax attacks happened in the United States, specimens collected decades earlier allowed researchers from the Centers for Disease Control and Prevention to quickly identify the strain involved.

In FY 2022, Congress provided $268 million to IMLS, of which $47.6 million was directed to OMS. With this funding, OMS provided 280 grants totaling $44.6 million to museums and related organizations in 49 States, the District of Columbia, and Puerto Rico. However, the demand for grant funding from OMS is significantly higher. In FY 2022, OMS received 716 applications requesting more than $109 million, but the agency could only fund a fraction of the highly rated grant applications it received. A budget of $65.5 million or more in FY 2024 would allow OMS to increase its grant capacity for museums.

Please support robust funding for IMLS in FY 2024, with at least $65.5 million for OMS, a much needed increase of at least $10 million accounting for inflation and public need for museum services.

Thank you for your thoughtful consideration of this request and for your prior support of the Institute of Museum and Library Services.

[This statement was submitted by Gil Nelson, Ph.D., President, Natural Science Collections Alliance.]

PREPARED STATEMENT OF THE NATURE CONSERVANCY

Chair Baldwin, Ranking Member Capito, and members of the subcommittee, thank you for the opportunity to submit recommendations for fiscal year 2024 (FY24) appropriations for the AmeriCorps and Job Corps programs under the Department of Labor (DOL). The Nature Conservancy (TNC) is a nonprofit conservation organization working around the world to protect ecologically important lands and waters for people and nature. Our mission is to conserve the lands and waters upon which all life depends. TNC respectfully requests $1,300,000,000 for AmeriCorps and $1,760,155,000 for Job Corps since these investments demonstrate fiscally responsible and much-needed community resources that help a thriving labor market while also advancing environmental benefits.

TNC appreciates Congress's work over the past 2 years to pass the Infrastructure Investment and Jobs Act (IIJA) and the Inflation Reduction Act (IRA), both of which included significant investments in developing employee training and an equitable workforce. This will help strengthen our communities, create jobs, and build a more prosperous future for all. These investments complement but do not supplant the need for ongoing program funding through the appropriations process. TNC asks the subcommittee to support a sustained appropriations package that will serve as the foundation for implementing IIJA and IRA, ensuring long-term success for critical programs under the panel's jurisdiction.

The pandemic made evident the economic disparities that exist due to low-wage jobs. TNC appreciates concerns about the country's current economic scenario in which Congress must balance job growth while also addressing inflation. TNC sees investments in employee training and on-the-job training experiences as a tremen-

dous opportunity to contribute to the Nation's economy. By supporting workforce development programs like the Job Corps and AmeriCorps, we can provide career development opportunities for youth and the unemployed through conservation and restoration projects on lands across the country.

An example of the significant impacts investments in corps programs have on communities, their economies, and the environment is the work being done by the GulfCorps program. Over the last 5 years, TNC has worked extensively to develop, design, and implement a region-wide GulfCorps program—a five-state (Alabama, Florida, Mississippi, Louisiana, and Texas) conservation corps program in the Gulf of Mexico region. This program was carried out under a contract with the National Oceanic and Atmospheric Administration (NOAA) using funding from the Deepwater Horizon oil spill settlement. TNC has operated GulfCorps in partnership with NOAA, the RESTORE Council, the Student Conservation Association, The Corps Network, and local conservation corps and community development organizations.

In 2021, the RESTORE Council voted to renew the program for an additional 4 years and awarded $11.9 million to GulfCorps. The program will create more than 400 conservation jobs over 4 years in the Gulf of Mexico. From January 2018 to March 2023, GulfCorps has restored, conserved, and monitored 20,227 acres of TNC and partner lands. Additionally, over 80 percent of GulfCorps program alums have applied their experience and skills to careers in the conservation field (both within TNC and with partners).

The DOL budget levels detailed below represent a significant investment in the Nation's future. TNC asks for your support for the following requests:

DEPARTMENT OF LABOR

AmeriCorps: TNC supports no less than $1,300,000,000, which is consistent with the FY23 enacted level. The AmeriCorps program (officially known as the Corporation for National and Community Service) supports approximately 77,500 members providing service to communities across the country through local organizations and governors' state service commissions. State and national AmeriCorps programs accomplish critical projects like disaster response and recovery, infrastructure, wildfire remediation, public lands access, and disconnected youth and veteran engagement. AmeriCorps and the country's network of conservation corps aim to develop a service ethic in young people; build and support diverse, inclusive and equitable American communities; provide education and vocational training; complete significant amounts of high-quality work in communities and on our public lands and waters; and prepare participants to advance to a career in conservation.

Conservation and restoration work that AmeriCorps supports has been shown to yield a high return on investment. For example, when performing coastal restoration work, 15 jobs are created per $1 million invested, on average, and this increases to up to 30 jobs per $ 1 million invested for the more complex, labor-intensive restoration projects, according to data collected by NOAA. Similarly, every $1 invested by the U.S. Forest Service (USFS) in resource management generates $1.43 in GDP and, on average, 19 jobs are created per $1 million invested. Additionally, projects completed by AmeriCorps and the network of conservation corps will help improve and support the local economies of the communities they are located in. TNC appreciates the funding provided in FY23 for AmeriCorps and urges the subcommittee to continue strong funding for this program in FY24.

Job Corps: TNC supports funding no less than $1,760,155,000, which is consistent with the FY23 enacted level. For almost 100 years, USFS has combined land stewardship with education and training, beginning with the development of the Civilian Conservation Corps in the 1930s. The agency manages 20 percent of the DOL Job Corps through its Civilian Conservation Centers. TNC would like to see USFS participation continue to be supported by DOL at least at this level. The mission of USFS Job Corps Civilian Conservation Centers is to train eligible youth ages 16 to 24 with educational, social, and vocational skills while offering an integrated approach to address the Nation's conservation challenges. As first responders during local, State, and national disasters, USFS Job Corps students also are trained by local agency units to assist during national emergencies, including those caused by wildfires, floods, hurricanes, and tornados. Each year, Civilian Conservation Centers serve about 3,800 students, and about 85 percent of the graduates start new careers, enroll in higher education programs or join the military, according to USFS. As mentioned in the previous section, projects supported by corps programs produce a high return on investment and aid in the economic recovery of local communities. TNC supports continued robust funding for the Job Corps program and its Civilian Conservation Centers.

Thank you for the opportunity to submit TNC's recommendations for the FY24 subcommittee on Labor, Health and Human Services, Education Appropriations Bill. Please reach out if you have any questions or would like additional information.

[This statement was submitted by Sarah Murdock, Senior Director, U.S. Land and Water Policy, The Nature Conservancy.]

PREPARED STATEMENT OF NEPHCURE KIDNEY INTERNATIONAL

SUMMARY OF RECOMMENDATIONS FOR FISCAL YEAR 2024

—Provide $50 billion for the National Institutes of Health (NIH)
—Provide a proportional increase for the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) and the National Institute on Minority Health and Health Disparities (NIMHD) and support the expansion of the FSGS/NS research portfolio at NIDDK and NIMHD by funding more research into primary glomerular disease.
—Provide $11 billion for the Centers for Disease Control and Prevention (CDC) and $6 million for the Chronic Disease Education and Awareness Program.

Chairwoman Baldwin and Ranking Member Capito, thank you for the opportunity to present the views of NephCure Kidney International regarding research on focal segmental glomerulosclerosis (FSGS) and nephrotic syndrome (NS). NephCure Kidney International's mission is to accelerate research for nephrotic syndrome, FSGS, IgAN, and other rare, protein-spilling kidney diseases, and to provide education and support that will improve the lives of those affected by these conditions. As the primary advocate and catalyst among key stakeholders in the nephrotic syndrome community, NephCure strives: To support and facilitate basic science and translational research; To support and facilitate clinical research by actively supporting patient recruitment to address the ever-growing demand of clinical trials; To advocate with government bodies to provide Federal funding for nephrotic syndrome research and facilitate new treatment approvals.; To provide support, connections and education for patients and their families; To reduce the time between patient symptom presentation and the expert clinical care that these rare diseases require.

There are approximately 150 different types of rare kidney diseases, each affecting between 20,000 to 200,000 individuals nationwide. These are the most aggressive forms of kidney diseases that, if go undiagnosed or are not treated properly, often lead to kidney failure.

Unfortunately, the causes of rare kidney disease are poorly understood, and many have no FDA approved treatments. Rare kidney diseases contribute to the more than $84 billion spent on treating Medicare beneficiaries with chronic kidney disease, including the $42.9 billion spent on treating people with end-stage kidney disease (ESKD), yet there has been little to no innovation in diagnostics or upstream treatments for kidney disease patients since the 1960s when dialysis and immunosuppressants became commonplace. These treatment and diagnostic barriers, coupled with the lack of rare kidney disease awareness and education, often cause a delay in diagnosis that can result in a rapid decline in kidney function and, ultimately, kidney failure. For many rare kidney disease patients, their only options are dialysis, transplant or death. Additionally, communities of color are disproportionately affected by rare kidney diseases and face a lack of adequate diagnostics and treatment due to existing health disparities—Black Americans are5times more likely to develop ESKD than white Americans.

Patients with rare kidney disease continue to face unique challenges in diagnosis, disease management, and treatment, including unidentified causes of disease, difficulties monitoring disease progression, need for complex care, barriers to genetic testing due to accessibility issues, cost, and insurance coverage. Therefore, it is crucial that the Department of Health and Human Services continues to expand on its critical work on improving diagnostics and treatments for rare kidney disease.

ENCOURAGE FSGS/NS RESEARCH AT NIH

There is no known cause or cure for FSGS and scientists tell us that much more research needs to be done on the basic science behind FSGS/NS. More research could lead to fewer patients undergoing ESRD and tremendous savings in health care costs in the United States. NephCure works closely with NIH and has partnered with NIH on two large studies that will advance the pace of clinical research and support precision medicine. These studies are the Nephrotic Syndrome

Study Network (NEPTUNE) and the Cure Glomerulonephropathy Network (CureGN).

With collaboration from other Institutes and Centers, established the Rare Disease Clinical Research Network. This network provided an opportunity for NephCure Kidney International, the University of Michigan, and other university research health centers to come together to form the NEPTUNE. Now in its second 5-year funding cycle, NEPTUNE has recruited over 450 NS research participants and has supported pilot and ancillary studies utilizing the NEPTUNE data resources. NephCure urges the subcommittee to continue its support for RDCRN and NEPTUNE, which has tremendous potential to facilitate advancements in NS and FSGS research.

NIDDK houses the Cure GN, a multicenter 5-year cohort study of glomerular disease patients. Participants will be followed longitudinally to better understand the causes of disease, response to therapy, and disease progression, with the ultimate objective to cure glomerulonephropathy. NephCure recommends that the subcommittee continues to support the work that the CureGN initiative has accomplished towards further understanding rare forms of kidney diseases. It is estimated that annually there are 20 new cases of ESRD per million African Americans due to FSGS, and 5 new cases per million Caucasians. This disparity is largely due to variants of the APOL1 gene. Unfortunately, the incidence of FSGS is rising and there are no known strategies to prevent or treat kidney disease in individuals with the APOL1 genotype. NIMHD began supporting research on the APOL1 gene in FY13. Due to the disproportionate burden of FSGS on minority populations, it remains appropriate for NIMHD to continue to advance this research. NephCure asks the subcommittee to recognize the work that NIMHD and NIDDK are doing to address the connection between the APOL1 gene and the onset of FSGS and encourage NIMHD to work with community stakeholders to identify areas of collaboration.

As a result of the important research done through NIH, we have been able to work with FDA to establish new endpoints for clinical trials leading to more trials than ever before. This has led to the creation of the Kidney Health Gateway Clinical which will connect patients with breakthrough clinical trials and access to top Nephrotic Syndrome doctors all in one place. These crucial trials will hopefully lead to more treatment options for our patients.

CHRONIC DISEASE EDUCATION AND AWARENESS

We thank the subcommittee for the creation of the Chronic Disease Education and Awareness Program in FY2021 and encourage continued support by providing $6 million for this critical program in FY2024.

Patient Perspective—

Meet 17-year-old Macy! She was diagnosed with Nephrotic Syndrome and later FSGS when she was three. Her 13-year journey with kidney disease has been long and hard. Macy did not respond to treatments for her kidney disease and within 2 years of diagnosis, her native kidneys were damaged beyond repair and she was in kidney failure and on dialysis. At the age of five, she received a living donor kidney transplant, but her disease, FSGS came back and attacked her new kidney. It took a full year of aggressive treatments to get Macy's FSGS into remission post-transplant. For the past 10 years, Macy has taken 18 to 26 medications a day. Those medications and her kidney disease have led to multiple co-morbidities. She is currently followed by 7 specialties, has endured 30+ surgeries & been hospitalized over 100 times. Macy participates in the Beads of Courage program in which she earns different beads for each procedure, appointment, etc. The strand of beads you see in this photo are just the beads she earned in 2018! Those black beads are for pokes (lab draws, IVs, Shots) and Macy earned over 400 last year. As you can see kidney disease is tough! Although Macy continues to struggle with kidney disease and will need another transplant sooner than later, she doesn't let that stop her from living life! Macy loves dancing and musical theater, art, and hanging out with her dog Bentley!

Thank you for the opportunity to present the views of the FSGS/NS community.

[This statement was submitted by Marsha Padilla, Associate Director of Grassroots Advocacy.]

PREPARED STATEMENT OF THE NEUROFIBROMATOSIS NETWORK

Thank you for the opportunity to submit testimony to the subcommittee on the importance of funding for the National Institutes of Health (NIH), and specifically for continued research on Neurofibromatosis (NF), a genetic disorder closely linked

to many common diseases widespread among the American population. My name is Kim Bischoff and I am the Executive Director of the Neurofibromatosis (NF) Network, a national organization of NF advocacy groups. We respectfully request that you include the following report language on NF research at the National Institutes of Health within the Office of the Director account in the Fiscal Year 2024 Labor, Health and Human Services, Education Appropriations bill.

Neurofibromatosis [NF].—The Committee supports efforts to increase funding and resources for NF research and treatment at multiple Institutes, including NCI, NINDS, NIDCD, NHLBI, NICHD, NIMH, NCATS, and NEI. Children and adults with NF are at elevated risk for the development of many forms of cancer, deafness, blindness, developmental delays and autism. The Committee encourages NCI to continue to support a robust NF research portfolio in fundamental laboratory science, patient-directed research, and clinical trials focused on NF-associated benign and malignant cancers. The Committee also encourages NCI to support preclinical research and clinical trials. Because NF can cause blindness, pain, and hearing loss, the Committee urges NINDS and NIDCD to continue to support fundamental basic science research on NF relevant to restoring normal nerve function. Based on emerging findings from numerous researchers worldwide demonstrating that children with NF have a higher chance of developing autism, learning disabilities, motor delays, and attention deficits, the Committee encourages NINDS, NIMH, and NICHD to continue their support of clinical research investigations in these areas. Since NF2 accounts for some genetic forms of deafness, the Committee encourages NIDCD to expand its investment in NF2-related research. NF1 can cause vision loss due to optic gliomas. The Committee encourages NEI to expand its investment in NF1-focused research on optic gliomas and vision restoration.

On behalf of the Neurofibromatosis (NF) Network, I speak on behalf of the over 100,000 Americans who suffer from NF as well as the millions of Americans who suffer from diseases and conditions linked to NF such as cancer, brain tumors, heart disease, memory loss, and learning disabilities. Thanks in large part to this subcommittee's strong support, scientists have made enormous progress since the discovery of the NF1 gene in 1990 resulting in clinical trials now being undertaken at NIH with broad implications for the general population.

NF is a genetic disorder involving the uncontrolled growth of tumors along the nervous system which can result in terrible disfigurement, deformity, deafness, pain, blindness, brain tumors, cancer, and even death. In addition, approximately one-half of children with NF suffer from learning disabilities. NF is the most common neurological disorder caused by a single gene and is more common than Cystic Fibrosis, hereditary Muscular Dystrophy, Huntington's disease and Tay Sachs combined. There are three types of NF: NF1, which is more common, NF2, which initially involves tumors causing deafness and balance problems, and Schwannomatosis, the hallmark of which is severe pain. While not all NF patients suffer from the most severe symptoms, all NF patients and their families live with the uncertainty of not knowing whether they will be seriously affected because NF is a highly variable and progressive disease.

Researchers have determined that NF is closely linked to heart disease, learning disabilities, memory loss, cancer, brain tumors, and other disorders including deafness, blindness and orthopedic disorders, primarily because NF regulates important pathways common to these disorders such as the RAS, cAMP and PAK pathways. Research on NF therefore stands to benefit millions of Americans.

Learning Disabilities/Behavioral and Brain Function

Learning disabilities affect one-half of people with NF1. They range from mild to severe and can impact the quality of life for those with NF1. In recent years, research has revealed common threads between NF1 learning disabilities, autism, and other related disabilities. New drug interventions for learning disabilities are being developed and will be beneficial to the general population. Research being done in this area includes working to identify drugs that target Cyclic AMP, so they can be paired with existing drugs targeting RAS. Identification of new drug combinations may benefit people with multiple types of learning disabilities.

Bone Repair

At least a quarter of children with NF1 have abnormal bone growth in any part of the skeleton. In the legs, the long bones are weak, prone to fracture and unable to heal properly; this can require amputation at a young age. Adults with NF1 also have low bone mineral density, placing them at risk of skeletal weakness and injury. Research currently being done to understand bone biology and repair will pave the way for new strategies to enhancing bone health and facilitating repair.

Pain Management

Severe pain is a central feature of Schwannomatosis, and significantly impacts quality of life. Understanding what causes pain, and how it could be treated, has been a fast-moving area of NF research over the past few years. Pain management is a challenging area of research and new approaches are highly sought after.

Nerve Regeneration

NF often requires surgical removal of nerve tumors, which can lead to nerve paralysis and loss of function. Understanding the changes that occur in a nerve after surgery, and how it might be regenerated and functionally restored, will have significant quality of life value for affected individuals. Light-based therapy is being tested to dissect nerves in surgery of tumor removal. If successful it could have applications for treating nerve damage and scarring after injury, thereby aiding repair and functional restoration.

Cancer

NF can cause a variety of tumors to grow, which includes tumors in the brain, spinal cord and nerves. NF affects the RAS pathway which is implicated in 70% of all human cancers. Some of these tumor types are benign and some are malignant, hard to treat and often fatal. Previous studies have found a high incidence of intracranial glioblastomas and malignant peripheral nerve sheath tumors (MPNSTs), as well as a six-fold incidents of breast cancer compared to the general population. One of these tumor types, malignant peripheral nerve sheath tumor (MPNST), is a very aggressive, hard to treat and often fatal cancer. MPNSTs are fast growing, and because the cells change as the tumor grows, they often become resistant to individual drugs. Clinical trials are underway to identify a drug treatment that can be widely used in MPNSTs and other hard-to-treat tumors.

The enormous promise of NF research, and its potential to benefit millions of Americans who suffer from diseases and conditions linked to NF, has gained increased recognition from Congress and the NIH. This is evidenced by the fact that numerous institutes are currently supporting NF research, and NIH's total NF research portfolio has increased from $3 million in FY1990 to an estimated $28 million in FY2022. Given the potential offered by NF research for progress against a range of diseases, we are hopeful that the NIH will continue to build on the successes of this program by funding this promising research and thereby continuing the enormous return on the taxpayers' investment.

We appreciate the subcommittee's strong support for the National Institutes of Health and will continue to work with you to ensure that opportunities for major advances in NF research at the NIH are aggressively pursued. Thank you.

PREPARED STATEMENT OF THE NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

Greetings Chair Baldwin, Ranking Member Capito, and Members of the subcommittee, for the opportunity to share the Northwest Portland Area Indian Health Board funding priorities for the Department of Health and Human Services (HHS) in FY 2024 (FY24). My name is Nickolaus Lewis, and I serve as Council on the Lummi Indian Business Council, and as Chair of the Northwest Portland Area Indian Health Board (NPAIHB). I thank the subcommittee for the opportunity to provide testimony.

The NPAIHB is a Tribal organization, established in 1972, under the Indian Self-Determination and Education Assistance Act (ISDEAA), Public Law 93–638 that advocates on behalf of the 43 federally recognized Indian Tribes in Idaho, Oregon, and Washington on specific health care issues. The Board's mission is to eliminate health disparities and improve the quality of life of American Indian and Alaska Native (AI/AN) people by supporting Northwest Tribes in the delivery of culturally appropriate, high quality health programs and services. "Wellness for the seventh generation" is the Board's vision. To achieve this vision, NPAIHB delegates respectfully ask that this subcommittee consider Tribal sovereignty, traditional knowledge, and culture in all policy initiatives and funding opportunities.

These past few years saw unprecedented impact on Northwest Tribes and carries long-term effects physically, mentally, emotionally and spiritually, because of the COVID–19 pandemic. We are grateful for the diligent service of our Congressional representatives in ensuring that Tribal Nations were provided with resources, including vaccines and medical supplies, to battle this pandemic. We know that continuing this work together will improve our ability to take care of our people despite the long standing systemic and funding shortfalls to the Indian health care system. As we emerge from the pandemic, I make recommendations that will help rebuild and repair the foundational necessities for the Indian health care system.

HHHS AND ITS AGENCIES

This subcommittee must honor Tribal sovereignty and trust and treaty obligations as to HHS funding to Tribal Nations. For FY24, we ask the subcommittee to make the legislative changes needed across all HHS agencies to move away from grants and allocate funding to Tribes through Indian Self-Determination and Education Assistance Act (ISDEAA) compacts and contracts. We also request Tribal set-asides and direct funding to Tribes—not through State block grants.

We also request that this subcommittee consider the important role that Tribal Epidemiology Centers (TECs) play in the Indian health system and support funding to TECs. TECs should be funded across HHS agencies to provide support to Tribes in their area for any type of data or evaluation component, surveillance support and/or training and technical assistance. TECs know the Tribes in their area and should be given the opportunity to support Tribes in their roles as public health authorities.

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

Tribal Opioid Response. Through Tribal Opioid Response (TOR) funding, NPAIHB coordinates three current grants for the TOR consortium of which 36 Northwest Tribes are a part of (and two TOR grants that have ended). Our Tribes have developed innovative opioid programs with positive outcomes reflecting the resilience in our area. For example, Lummi Nation, and other Tribes as well, brought on success coaches (peers) for those using or in recovery and 30 of the 36 TOR consortium Tribes have made medication-assisted treatment (MAT) available. However, funding and grant period increases are needed for a more robust opioid response. In FY24, we request funding increases in: TOR to $75 million; Tribal MAT to $20 million; and 5-year grants.

Other Grant Programs. Thank you for the increases to the AI/AN Zero Suicide Initiative funding, and Tribal Behavioral Health Grants in FY 2023. For FY24, we request the following amounts for Tribal Specific Programs: fund the Tribal Behavioral Health Grant program at least $50 million—$25 million for mental health and $25 million for substance use disorder; fund the Garrett Lee Smith Suicide Prevention Tribal Set Aside at $3.5 million; fund Zero Suicide Initiative at $3 million; and fund the National Child Traumatic Stress Initiative Tribal Set Aside at $1.5 million.

Designated Resources for Youth Behavioral Health Programs. To comprehensively address the need for whole person mental health and substance use disorder services for AI/AN youth, there must be dedicated funding streams for culturally centered prevention, intervention, treatment, aftercare and transitional living support. Funding for Youth Residential Treatment Centers that provide aftercare and transitional living for both substance use disorder and mental health are a priority for Portland Area Tribes as current facilities in the area do not meet demand. For FY24, we request $25 million in funding for youth-specific outpatient and inpatient mental health and substance use programs.

OFFICE OF THE SECRETARY

Minority HIV/AIDS Fund. The Minority HIV/AIDS Fund is a significant funding source for communities of color that have not traditionally been supported by mainstream opportunities and includes important funding to Indian Health Service (IHS) for HIV, hepatitis C (HCV) and sexually transmitted infection prevention, treatment, outreach and education. Tribes in the Portland Area appreciated the relationship the Office of the Secretary has with Indian Country in MHAF work. For FY24, we request that funding for MHAF be increased to $80 million with a $20 million non-competitive Tribal set-aside. This is a step toward addressing the impact that the HIV/AIDs syndemic has in Indian Country and continuing the important program work that is already in place.

Climate Change. Climate change has significantly impacted our Northwest Tribes. Tribal communities are facing increased flooding that affects our health care operations and is continually threatened by increased forest fires. We request additional funding to support Tribal capacity building and training for Tribal communities, which grants Tribes to lead collecting and monitoring their own data. We request a 5% set aside of all climate change funding for Tribes.

CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC)

Public Health Infrastructure & Environmental Impacts. The Indian, Tribal, and Urban (I/T/U) health system is underfunded and lacks capacity to respond effectively to public health emergencies. Between this underfunding, and loss nationally of 30% of the public health workforce in the last three to 4 years and an anticipated

loss of 20–30% of the workforce in the next five to 10 years, there is a pressing need to invest in the development of a more robust public health workforce in Indian Country. We request that CDC specifically create workforce development pathway programs for AI/AN people by creating opportunities for workforce education and training, we request that at least $1 billion be directed to workforce development in Indian Country.

In addition, we can no longer allow population density as the primary consideration in the allocation of emergency preparedness resources. In FY24, we request at least $1.5 billion for a Tribal Public Health Emergency Fund established through the Secretary of HHS that Tribes can access directly for tribally declared public health emergencies.

Include Tribes in Syphilis Funding Opportunities. Tribes need direct funding to address the syphilis outbreak occurring throughout AI/AN Communities. AI/AN people have the highest rate of syphilis and congenital syphilis in the Nation. Funding and programming, for example, for disease intervention services, does not get from States to the Tribes. For FY24, we recommend $25 million investment for Tribes to address Syphilis in Tribal communities.

Fund Good Health and Wellness in Indian Country (GHWIC). The GHWIC initiative supports AI/AN communities in the implementation of holistic and culturally adapted approaches to reduce and prevent chronic disease through policy, system and environment changes. Continued funding is needed to address food access issues, food insecurity, and support traditional food (including human milk) and local food system initiatives beyond COVID–19. NPAIHB recommends the subcommittee allocate at least $40 million in FY24 to the GWHIC initiative.

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

Medicare and Medicaid Legislative Initiatives. We recommend that this subcommittee work with HHS to develop legislation that: expands Medicare Part B coverage for services furnished by peer counselors and our Community Health Aide Program (CHAP) health aides and practitioners; creates the authority for States to extend Medicaid eligibility to all AI/AN people with household incomes up to 138% of the Federal poverty level; authorizes Indian Health Care Providers (IHCP) in all States to receive Medicaid reimbursement for health care services delivered to AI/AN people under IHCIA; extends 100% FMAP permanently to States for Medicaid services furnished by urban Indian providers permanently; excludes Indian-specific Medicaid provisions in Federal law from state waiver authority; and removes the limitation on billing by IHCP for services provided outside the four walls of a Tribal clinic.

Medicare Telehealth Reimbursement. Telehealth provided a way to care for our people during the pandemic and should be made permanent to increase access. We request that this subcommittee support legislation to make all Medicare telehealth services and flexibilities permanent at the OMB encounter rate at I/T/U facilities, authorize Medicare telehealth furnished services by federally qualified health centers and rural health clinics be reimbursed at the encounter rate, expand telephone-only telehealth visits, direct physician supervision of non-physician providers be provided remotely via telephone, and expand "originating site" locations from which telehealth services can be received.

HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)

Provider Shortages and Needs. The Broken Promises Report, National Tribal Behavioral Health Agenda, National Tribal Budget Formulation Workgroup Recommendations for 2021, and the IHS Strategic Plan all detail how culturally responsive care is critical for the health and well-being of AI/AN people. There are significant vacancy rates and challenges in filling vacancies at I/T/U facilities. Some of these challenges include: the rural location of Tribal facilities, lower salaries, lack of incentives, and insufficient housing for providers.

For these reasons, we strongly recommend that the subcommittee support funding for HRSA, as follows:

—Increase Tribal Set-Aside for Loan Forgiveness Program. Increase Tribal set-asides for loan forgiveness and include mid-level health care professionals such as CHAP providers.

—Support Community Health Aide Program Expansion. For FY24, we request additional funding to support our CHAP education programs including, $4.2 million for the Dental therapy education programs with a $1.7 million earmark for Portland Area and $2.5 million to support Alaska and $5 million to build clinical classrooms to train CHAP providers throughout the Portland Area.

Grant Programs and Tribal Set-Asides. HRSA holds the responsibility for administering several programs that directly benefit geographically isolated rural communities and that address health workforce issues. While Tribes are eligible for grants, few of these program dollars get into Indian Country. We request that the subcommittee provides the following:

—Teaching Health Centers Graduate Medical Education Program. Create a Tribal set-aside within the Teaching Health Centers Graduate Medical Education program for IHS and Tribal medical residency programs.

—National Health Service Corps Loan Repayment Program. The loan repayment program has been an important tool for our Tribal health programs to recruit healthcare providers. We request 5% Tribal set aside of this funding with our midlevel providers, including all bachelor level, associates, and certificated providers eligible for loan repayment.

—For all other grants, we request a Tribal set-aside of 10% of funding for Tribes and Indian health providers. The funding should be directed to Tribes and Indian health providers in a way that places a minimal burden on them, using a mechanism developed through Tribal consultation and urban confer.

NATIONAL INSTITUTES OF HEALTH

The Native American Research Centers for Health (NARCH) national program has created many successful research projects and training opportunities for AI/AN people interested in science and health of AI/AN people. We request that NARCH be a congressionally mandated funding priority as it supports Tribal health research with the development of Tribal health leaders to design and implement research that is responsive to Tribal needs. In FY24, we recommend increased funding for the NARCH program to $20 million and request that 30% of the funding be directed to enhance AI/AN workforce development in parity with priorities of NIH institutes and centers.

Thank you for this opportunity to provide recommendations to the subcommittee on FY 2024 funding for HHS. We invite you to visit Portland Area Tribes to learn more about the communities, utilization of HHS funding, and health care needs in our Area. We look forward to working with the subcommittee on our requests.[1]

[This statement was submitted by Nickolaus Lewis, Chair, Northwest Portland Area Indian Health Board.]

PREPARED STATEMENT OF THE NURSING COMMUNITY COALITION

As the Nation evaluates lessons learned from COVID–19, we recognize how crucial Federal investments for the nursing workforce and the nursing pipeline are to our patients and the health of our Nation. Given these realities, the Nursing Community Coalition (NCC) respectfully requests that Congress continues robust and bold investments in nursing education, workforce, and research in Fiscal Year (FY) 2024 by supporting at least $530 million for the Nursing Workforce Development programs (authorized under Title VIII of the Public Health Service Act [42 U.S.C. 296 et seq.] and administered by HRSA), and at least $210 million for the National Institute of Nursing Research (NINR), one of the 27 Institutes and Centers within NIH.

The Nursing Community Coalition is comprised of 63 national nursing organizations who work together to advance health care issues that impact nursing education, research, practice, and regulation. Collectively, the NCC represents Registered Nurses (RNs), Advanced Practice Registered Nurses (APRNs),[1] nurse leaders, boards of nursing, students, faculty, and scientists, as well as other nurses with advanced degrees. As the largest segment of the health care profession,[2] nursing is involved at every point of care, which was further exemplified during the COVID–19 pandemic. Together, we reiterate the bold request for increased funding for Title VIII Nursing Workforce Development programs and NINR, especially during these unprecedented times.

Through the Nursing Lens: Providing Care to All Americans

As we continue to confront today's health care challenges and plan for tomorrow, increased Federal resources for our Nation's current and future nurses are even

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[1] For more information, please contact Candice Jimenez, cjimenez@npaihb.org.

[1] APRNs include certified nurse-midwives (CNMs), certified registered nurse anesthetists (CRNAs), clinical nurse specialists (CNSs) and nurse practitioners (NPs).

[2] United States Census Bureau. (2021) Who are our Health Care Workers? Retrieved from: https://www.census.gov/library/stories/2021/04/who-are-our-health-care-workers.html.

more imperative. As the largest dedicated funding for nursing, Title VIII programs are instrumental in bolstering and sustaining the Nation's diverse nursing pipeline by addressing all aspects of nursing workforce demand. The Bureau of Labor Statistics (BLS) projected that by 2031 demand for RNs would increase 6%, illustrating an employment change of 195,400 nurses [3] and demand for most APRNs is expected to grow by 40%.[4]

The need for nurses and APRNs is not only outlined by BLS, but can be seen in communities across the Nation, including rural and underserved areas. In fact, the American Association of Critical-Care Nurses outlined, "92% of nurses surveyed said they believe the pandemic has depleted nurses at their hospitals and, as a result, their careers will be shorter than they intended." [5] Further, the American Nurses Foundation third COVID–19 impact study found that 19% of nurses said they intend to leave their position in the next 6 months, and 27% are considering leaving.[6] If that was not enough, "more than one-fifth of all nurses reported they plan to retire from nursing over the next 5 years." [7]

Funding for Title VIII is essential as these programs connect patients with high-quality nursing care in community health centers, hospitals, long-term care facilities, local and State health departments, schools, workplaces, and patients' homes. Each program under Title VIII is unique and plays an important role in supporting our nursing workforce. For example, in Academic Year 2021–2022, the Advanced Nursing Education programs, which help APRN students and nurses to practice on the frontlines and in rural and underserved areas throughout the country, supported more than 8,800 students, many of whom were trained in medically underserved areas and primary care settings.[8] Further, as we work to create a more equitable health care system, a diverse nursing workforce is imperative. The Nursing Workforce Diversity program helped support more than 10,900 nursing students from racial and ethnic minorities who are underrepresented in the profession to become nurses and APRNs.[9]

Together, Title VIII Nursing Workforce Development programs serve a vital need and help to ensure that we have a robust nursing workforce that is prepared to respond to public health threats and ensure the health and safety of all Americans. With more than four and half million nurses throughout the country,[10] we strongly urge historic support for these programs in FY 2024. Therefore, the Nursing Community Coalition respectfully requests at least $530 million for the Title VIII Nursing Workforce Development programs in FY 2024.

Improving Patient Care Through Scientific Research and Innovation:

For more than thirty years, scientific endeavors funded at the National Institute of Nursing Research (NINR) have been essential to advancing the health of individuals, families, and communities. NINR's research is aimed at reducing the impact of social determinants of health and creating a more equitable health care system by promoting patient-centered care across the life continuum. The translational research by our Nation's nurses and scientists is essential to developing new evidence-based practices to care for all patients. It is imperative that we continue to support the necessary scientific research, which is why the Nursing Community Coalition respectfully requests at least $210 million for NINR in FY 2024.

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[3] U.S. Bureau of Labor Statistics. (2022). Occupational Outlook Handbook- Registered Nurses. Retrieved from: https://www.bls.gov/ooh/healthcare/registered-nurses.htm.

[4] U.S. Bureau of Labor Statistics. (2022). Occupational Outlook Handbook- Nurse Anesthetists, Nurse Midwives, and Nurse Practitioners. Retrieved from: https://www.bls.gov/ooh/healthcare/nurse-anesthetists-nurse-midwives-and-nurse-practitioners.htm.

[5] American Association of Critical-Care Nurses. (2021). Hear Us Out Campaign. Retrieved from: https://www.aacn.org/newsroom/hear-us-out-campaign-reports-nurses-covid-19-reality.

[6] American Nurses Foundation. (2023). Three-Year Annual Assessment Survey: Nurses Needed Increased Support from their Employer. Retrieved from: https://www.nursingworld.org/~48fb88/contentassets/23d4f79cea6b4f67ae24714de11783e9/anf-impact-assessment-third-year__v5.pdf.

[7] National Council of State Boards of Nursing and the National Forum of State Nursing Workforce Centers (2021) The 2020 National Nursing Workforce Survey. Retrieved from: https://www.journalofnursingregulation.com/article/S2155-8256(21)00027-2/fulltext.

[8] Health Resources and Services Administration. Fiscal Year 2024 Budget Justification. Pages 153–156. Retrieved from: https://www.hrsa.gov/sites/default/files/hrsa/about/budget/budget-justification-fy2024.pdf.

[9] Health Resources and Services Administration. Fiscal Year 2024 Budget Justification. Pages 157–160. Retrieved from: https://www.hrsa.gov/sites/default/files/hrsa/about/budget/budget-justification-fy2024.pdf.

[10] National Council of State Boards of Nursing. (2023). Active RN Licenses: A profile of nursing licensure in the U.S. as of February 28, 2023. Retrieved from: https://www.ncsbn.org/6161.htm.

Now, more than ever, it is vital that we have the resources to ensure our nursing workforce is ready to address the health care needs of the Nation. Investing in Title VIII Nursing Workforce Development programs and NINR are essential to meeting that need. By providing bold funding for Title VIII and NINR, Congress can continue to reinforce and strengthen the foundational care nurses provide daily in communities across the country. Thank you for your support of these crucial programs.

62 Members of the Nursing Community Coalition Submitting this Testimony

Academy of Medical-Surgical Nurses
Academy of Neonatal Nursing
American Academy of Ambulatory Care Nursing
American Academy of Emergency Nurse Practitioners
American Academy of Nursing
American Association of Colleges of Nursing
American Association of Critical-Care Nurses
American Association of Heart Failure Nurses
American Association of Neuroscience Nurses
American Association of Nurse Anesthesiology
American Association of Nurse Practitioners
American Association of Post-Acute Care Nursing
American College of Nurse-Midwives
American Nephrology Nurses Association
American Nurses Association
American Nursing Informatics Association
American Organization for Nursing Leadership
American Pediatric Surgical Nurses Association, Inc.
American Public Health Association, Public Health Nursing Section
American Psychiatric Nurses Association
American Society for Pain Management Nursing
American Society of PeriAnesthesia Nurses
Association for Radiologic and Imaging Nursing
Association of Community Health Nursing Educators
Association of Nurses in AIDS Care
Association of Pediatric Hematology/Oncology Nurses
Association of periOperative Registered Nurses
Association of Public Health Nurses
Association of Rehabilitation Nurses
Association of Veterans Affairs Nurse Anesthetists
Association of Women's Health, Obstetric and Neonatal Nurses
Commissioned Officers Association of the U.S. Public Health Service
Dermatology Nurses' Association
Emergency Nurses Association
Friends of the National Institute of Nursing Research
Gerontological Advanced Practice Nurses Association
Hospice and Palliative Nurses Association
Infusion Nurses Society
International Association of Forensic Nurses
International Society of Psychiatric-Mental Health Nurses
National Association of Clinical Nurse Specialists
National Association of Hispanic Nurses
National Association of Neonatal Nurse Practitioners
National Association of Neonatal Nurses
National Association of Nurse Practitioners in Women's Health
National Association of Pediatric Nurse Practitioners
National Association of School Nurses
National Black Nurses Association
National Council of State Boards of Nursing
National Forum of State Nursing Workforce Centers
National Hartford Center of Gerontological Nursing Excellence
National League for Nursing
National Nurse-Led Care Consortium
National Organization of Nurse Practitioner Faculties
Nurses Organization of Veterans Affairs
Oncology Nursing Society
Organization for Associate Degree Nursing
Pediatric Endocrinology Nursing Society
Preventive Cardiovascular Nurses Association
Society of Pediatric Nurses

Society of Urologic Nurses and Associates
Wound, Ostomy, and Continence Nurses Society

[This statement was submitted by Rachel Stevenson, Executive Director, Nursing Community Coalition.]

PREPARED STATEMENT OF PACER CENTER

PACER Center would like to thank the subcommittee on Labor, Health and Human Services, Education and Related Agencies (LHHS) for soliciting the views and recommendations of public witnesses on Fiscal Year (FY) 2024 funding.

PACER is a Statewide and national parent center founded in 1978 and based in Minneapolis, Minnesota. PACER's mission is to enhance the quality of life and expand opportunities for children, youth, and young adults with all disabilities and their families so each person can reach his or her highest potential. PACER is staffed primarily by parents of children with disabilities. PACER also works to strengthen engagement between families and their schools to ensure that parents can be fully involved in the education of their children.

This testimony highlights several critical issues. First, we respectfully request that the subcommittee match the President's FY 2024 request of $49.2 million for the Parent Information Centers (PIC) program, provide $25 million for the Statewide Family Engagement Centers program, match the President's FY 2024 request of $16.8 billion for Part B of the Individuals with Disabilities Education Act (IDEA) and $4.15 million for the Parent Center program funded under the demonstration authority of the Rehabilitation Act of 1973. Second, we request that report language be maintained that requires the funding of parent centers under the Rehabilitation Act of 1973 to be funded at least at the previous fiscal year's level.

IDEA PARENT INFORMATION CENTERS

PACER respectfully requests that the subcommittee provide $49.2 million for the PIC program at the U.S. Department of Education (ED). This level of funding is in line with President Biden's budget request for a $16 million increase for the program. The PIC program provides crucial assistance to families of children with disabilities, helping parents navigate the special education process and ensuring that they have the opportunity, knowledge, and skills to help their children with disabilities succeed. It also assists parents in navigating the early intervention system for infants and toddlers with disabilities and developmental delays from birth to age three.

The PIC program funds Parent Training and Information Centers (PTIs), Community Parent Resource Centers (CPRCs), and technical assistance for parent centers. Under this program, each State has at least one PTI, with a combined total of nearly 100 centers, technical assistance centers, and CPRCs targeting underserved populations. Centers funded under this program make valuable contributions at the State and local level by helping schools improve services and outcomes for students with disabilities and providing critical information on resolving disputes that may arise between schools and families.

We appreciate the $2.7 million and $3 million increases provided for the Parent Information Centers program in FYs 2022 and 2023. Prior to FY 2022, the PIC program was level funded for a decade. Despite the level funding of this program, the number of IDEA-eligible students has increased dramatically. In 2010, approximately 6.6 million students were served under IDEA. In its most recent Congressional Justification, ED estimates that nearly 7.4 million eligible students will be served in 2023. The PIC program also serves students who are eligible under Section 504 of the Rehabilitation Act. Such students numbered 1.4 million in 2017–2018 and represented 2.7 percent of school enrollment. These increased numbers have required the Centers funded under the PIC program to try to do more with less. We believe that the rising enrollment of students with disabilities warrants the requested increase in funding for the institutions such as PACER and other PTIs that provide crucial support to the families of students with disabilities.

In addition to the general increase in the number of children with disabilities and their families seeking services from centers funded under the PIC program, ED has cited rising service demands on centers. In the Administration's FY 2024 budget proposal, ED said Parent Information Centers have "seen a surge in demand over the last 2 years due, in part, to the effects of the COVID–19 pandemic." Children with disabilities were also one of the hardest hit populations during the pandemic, often having subpar access to online learning opportunities and having the most dis-

ruption to services, supports and accommodations they need to succeed academically.

STATEWIDE FAMILY ENGAGEMENT CENTERS

PACER Center also requests $25 million in funding for the Statewide Family Engagement Centers (SFEC) program to help achieve the goal of having an SFEC in every State and territory. PACER, in addition to serving as a PTI center, also serves as an SFEC and as such provides much-needed technical assistance and partnership development to States and school districts to foster meaningful engagement with families to further their children's academic and developmental progress. As with the PTI program, PACER Center appreciates the $5 million increase included for the SFEC program in the FY 2023 funding bill.

SFECs provide vital direct services to improve engagement between children, parents, teachers, school leaders, counselors, administrators, and other school personnel. While SFECs work with all parents and schools throughout their state, many, including PACER Center, focus on students of color, English learners, and recent immigrant children working to integrate into their new communities. Research has shown that family engagement in a child's education increases student achievement, improves attendance, reduces the dropout rate, and advances the emotional and physical well-being of children. Students whose families are involved in their children's academic success attend school more regularly, earn better grades, enroll in more challenging academic programs, and have higher graduation rates. The SFEC program harnesses effective practices to help schools and districts implement systematic family engagement programs that build ties between the community, families, students, and schools.

IDEA

We also request a $2.1 billion increase in Part B of the Individuals with Disabilities Education Act (IDEA), matching President Biden's FY 2024 budget proposal request for a total of $16.8 billion. IDEA funding for Part B is critical in our home state of Minnesota and around the country. The Federal resources provided to meet the guarantee of a free appropriate public education under IDEA are paramount as States and local school systems construct their annual budgets. This is especially true now as educators help children with disabilities recover lost learning time resulting from the COVID–19 pandemic. As stated above, the pandemic hit children with disabilities among the hardest and States, school districts, and schools need this significant increase in Federal resources to meet the needs of their children.

While this focus on pandemic recovery and the need for resources is more recent, IDEA's current funding level continues to fall short of a path to full funding of Part B of IDEA. The Administration's budget estimates that their call for a $2.1 billion increase will raise the Federal share to 13 percent. A funding increase at this amount will restart the program on a path to full funding.

REHABILITATION ACT PARENT TRAINING AND INFORMATION CENTERS

We also support the Administration's request to increase funding by $1.5 million under the Demonstration and Training Authority in the Rehabilitation Act of 1973 for the National Parent Training and Information Center as well as the eight Regional Parent Training and Information Centers. The Administration's FY 2023 budget request documents how existing funding levels are insufficient to support the current workload. The budget request would allow the Regional Parent Training and Information Centers to expand collaboration and enhance services to consumers in their respective regions. In addition to this increase, we urge the maintenance of report language in the FY 2024 committee report that was included with the FY 2023 appropriations and past bills that would require ED to maintain at least the prior year's level of spending on such centers.

PREPARED STATEMENT OF PATH

This testimony is submitted by Jenny Blair on behalf of PATH, an international nonprofit organization that drives transformative innovation to save lives and improve health in low- and middle-income countries. PATH is appreciative of the opportunity afforded by Chairwoman Baldwin, Ranking Member Capito, and members of the subcommittee on Labor, Health and Human Services, Education, and Related Agencies to submit a written testimony regarding fiscal year 2024 (FY24) funding for global health programs within the US Department of Health and Human Services (HHS). Given the critical role that the Center for Disease Control and Preven-

tion (CDC) plays globally to protect America and the rest of the world, this testimony respectfully requests the following funds for the CDC: increase base funding for the Division of Global Health Protection to at least $503.2 million and an additional $300 million for the Infectious Disease Rapid Response Fund; $356 million in funding for the Global Immunization Division; and, $42 million in funding for the Parasitic Diseases and Malaria program.

The vital role of the CDC in global health and security

PATH applauds Congressional appropriators for increases to the CDC's Global Public Health Protection line through the final FY 23 Omnibus appropriations bill. As the CDC completes its spend down of the emergency supplemental funding it received, increased, and sustained base funding will be critical when responding to existing and emerging threats, catching up on stalled progress, and preventing the reemergence of the cycle of panic and neglect.

The CDC is crucial in providing both the US and the world with a professional corps of trained and funded experts that can be rapidly deployed to address existing and emerging health threats. US investments through the CDC help contain diseases at the source by training epidemiologists, engaging affected communities, improving disease detection, and tracking systems, building Emergency Operations Centers (EOCs), upgrading laboratories, and more. Such efforts have allowed partner countries to greatly shorten their response times to outbreaks and epidemics—something we at PATH see first-hand through our work. For example, in Tanzania, with support from the CDC, PATH is building the capacity of local surveillance and data specialists to spot concerning disease trends, report information to the National level, and prepare for better coordination during potential disease outbreaks.

Increased funding for the CDC's Global Public Health Protection line will ensure the right expertise exists to stop outbreaks before they begin. We urge the Committee to increase base funding for the CDC's Division of Global Health Protection to at least $503.2 million to bolster capacity to prevent, detect, and rapidly respond to emerging diseases in low- and middle-income countries. An increase in base funding will allow the CDC to leverage the investments they have made from previous emergency supplemental funding packages and help put an end to the continuous cycle of panic and neglect. We also urge the Committee to add an additional $300 million for the Infectious Disease Rapid Response Fund. Increasing this fund will ensure the CDC can move quickly to control outbreaks before they spread—minimizing the need for emergency supplemental appropriations.

Protecting the United States through leadership in global health research and development

The COVID–19 pandemic demonstrated a clear need for investment in America's capacity to rapidly develop and deploy new technologies that can prevent, detect, and treat emerging global health threats. The US is a world leader in R&D for tools that address some of humanity's most pressing health problems, and we are grateful for this Committee's continued support for programs at NIH, the CDC, and BARDA. Innovations developed with support from these agencies played a critical role in protecting Americans from the threat of COVID–19.

The last 3 years also shed light on global disparities around access to lifesaving innovations. As a complement to the existing work happening across US agencies, we urge the Committee to consider investment in the Coalition for Epidemic Preparedness Innovations (CEPI), which is working to develop vaccines to prevent future epidemics and pandemics. With a mandate to support global access to vaccines, CEPI helps bridge a gap not currently met through existing US investments.

Immunization programs during COVID–19 and beyond

The CDC is also achieving complementary global health and security goals through investment in immunization, with most vaccine delivery activities overseen by the CDC's Global Immunization Division. Vaccines are among the most high-impact and cost-effective tools available today to combat infectious disease threats, including growing antimicrobial resistant diseases. The World Health Organization (WHO) estimates that global immunization programs prevent an estimated 2.5 million deaths each year among children under the age of five worldwide. These programs also bolster local health systems and enable better disease detection.

However, the COVID–19 pandemic severely disrupted global immunization programs, threatening the achievement of critical health goals, and we are already beginning to see the consequences, including significant outbreaks of measles, cholera, and polio. UNICEF and WHO have reported that in 2021 there were 25 million infants missing out on lifesaving vaccinations, the highest recorded number of unvaccinated children under 1 year of age since 2009. Over 18.2 million of those infants are zero dose children—defined as children who lack access to or are never

reached by routine immunization. Without significant investments to support struggling global immunization programs, there will be a significant rise in both cases and deaths from childhood preventable diseases. Increasing strong US support for the CDC's Global Immunization funding is critical to preventing needless deaths and additional funding would allow the CDC to reach more zero dose children. We urge the Committee to provide $356 million for the Global Immunization Division—of which $276 million should be allocated to polio eradication and $80 million for measles prevention.

Fighting to eliminate malaria

The CDC plays a critical role in the fight against malaria, as co-implementer of the President's Malaria Initiative (PMI)—alongside the US Agency for International Development—as well as through its Parasitic Diseases and Malaria program. These programs provide crucial technical assistance, with a focus on monitoring and evaluation, surveillance, community case management, and operational and implementation research—filling critical gaps not matched by any other part of the US government.

Overall, malaria prevention and treatment programs have prevented more than 10 million deaths globally since 2000. Sustained US commitment has made this progress possible. However, progress has stalled in several countries since 2015—exacerbated, especially in sub-Saharan Africa, by disruptions during the COVID–19 pandemic and other humanitarian emergencies. There were an estimated 247 million cases and 619,000 deaths from the disease in 2021, with the number of deaths nearly 9% higher than those recorded in 2019. As PMI has expanded, the CDC's mandate has grown, but its budget for malaria has not seen a substantial increase in over 15 years, threatening the CDC's ability to continue providing world-class services. To keep pace with increased demands, we urge the Committee to provide $42 million to the CDC's Parasitic Diseases and Malaria program.

An investment in health, at home and around the world

Ensuring the CDC has the funding needed to detect, prevent, and respond to future pandemics and regain ground in the fight against existing diseases will be critical to improving health around the world and in America. At PATH, we've seen the impact of US investments in lifesaving programs and tools, and we strongly urge this Committee to provide robust increases to these important programs now—before another emergency strikes.

[This statement was submitted by Jenny Blair, Manager, US & Global Policy, PATH.]

PREPARED STATEMENT OF PEDIATRICIAN AND BREASTFEEDING MEDICINE SPECIALIST

Thank you for this opportunity to submit testimony to the subcommittee. It is my view that HHS should review its policies around infant nutrition to make sure the families of the nearly four million infants born each year in America are able to access quality breastfeeding services and supplies without regard to their insurance provider or which state they may call home.

I learned early in my career as a pediatrician that new parents want to provide their infants with the best option available when it comes to feeding and nutrition. It has also been my experience that breastfeeding rates generally increase as socioeconomic status increases and formula feeding rates increase as socioeconomic status goes down. Especially for lower-income families, infant formula has been an abundantly available option, often distributed at taxpayer expense, and relied on by millions of infants not receiving breast milk.

In 2022, Kaiser Family Foundation researchers surveyed States and determined the full array of breastfeeding services and supports are covered by only about one-third of State Medicaid programs. This is troubling considering that Medicaid is the source of payment for 42 percent of births in the United States and two thirds of births among Black and American Indian and Alaska Native individuals. According to the American Academy of Pediatrics, suboptimal breastfeeding in a non-Hispanic Black population is associated with a 2.2 times excess number of child deaths compared to a non-Hispanic White population. Additionally, any breastfeeding in a non-Hispanic black infant is associated with a 17% reduction in infant mortality. Targeted interventions are needed to increase this population's breastfeeding initiation and duration rates.

Furthermore, commercial health insurance providers have implemented the Women's Preventive Services Initiative (WPSI) Breastfeeding Services and Supplies recommendations differently, resulting in many families having unnecessary limits on

their access to low-cost and high-value supports, which are not only good for moms and babies but also lead to reduced healthcare costs on a population level.

Milliman was commissioned by breast pump manufacturer Medela to produce an actuarial study in 2017 which demonstrated that comprehensive breastfeeding support is an inexpensive benefit for payers to provide. In fact, the cost of providing these benefits to the commercially insured population is around 14 cents for every $500 typical commercial insurance premium. On the Medicaid side, the cost is around 20 cents for every $500 expenditure for a Medicaid enrollee.

Breastfeeding is also known to reduce common and costly health conditions for mothers and infants. U.S. Representative Terri Sewell submitted testimony in the House of Representatives documenting that optimization of breastfeeding in the Medicaid population would amount to $518.8 million dollars per year in undiscounted direct medical savings to Medicaid through reductions of four common and costly conditions: acute otitis media, gastroenteritis, necrotizing enterocolitis, and lower respiratory tract infection requiring hospitalization. Nationally, across all socioeconomic statuses and all health care payers, improving breastfeeding rates could result in up to $17.2 billion in health related cost savings per year.

Reasons that mothers never initiate breastfeeding, or cease breastfeeding earlier than clinical guidelines would advise can vary, but the anticipation of returning to work is by far the most often cited. To maintain a milk supply, breast milk must be removed from the breast at frequent time intervals that correlate with the feeding patterns of the infant. Therefore, a breastfeeding parent who is separated from her baby for several hours or longer while working, or for any other reason, will need a high quality breast pump and other supplies that help her collect, store, and transport her milk. The recent passage of the PUMP for Nursing Mothers Act will alleviate many barriers that have prevented pumping at work. Unfortunately, this does not guarantee that high quality breastfeeding services and supplies are readily available to the pumping members of the workforce, regardless of their updated protections under the law. As a country, we have more work to do in this important policy area.

The U.S. Department of Agriculture's (USDA) Special Supplemental Nutrition for Women, Infants & Children (WIC) program is a primary source of breastfeeding support for many low-income families. It is encouraging that the Dietary Guidelines for Americans have been updated to include the first ever recommendations for Americans aged 0–2 years old, appropriately recommending that infants should be fed human milk exclusively for the first 6 months of life, in line with the American Academy of Pediatrics clinical guidelines for breastfeeding. Further progress within USDA is signaled by recently proposed changes that are coming to the WIC program policies and food packages, but there is still much room for improvement.

The table below is derived from the FY2021 WIC Breastfeeding Data Local Agency Report and depicts clearly that most infants dependent on WIC for nutritional support are not receiving any breast milk, let alone exclusively fed breast milk as clinical best practices recommend. States listed are represented by Members of the subcommittee.

State	Fully Formula-Fed	Fully Breastfed
Alabama	87.3%	5.5%
Arkansas	86.1%	7.9%
Louisiana	86.0%	4.4%
Mississippi	85.1%	3.5%
West Virginia	83.2%	10.8%
South Carolina	79.1%	7.1%
Wisconsin	76.7%	13.2%
Rhode Island	73.8%	7.4%
Illinois	70.4%	7.6%
Kansas	69.5%	15.5%
New Hampshire	64.8%	18.4%
Connecticut	63.8%	9.0%
Florida	62.5%	11.6%
Oregon	61.3%	28.8%
Washington	58.1%	23.0%
Hawaii	52.0%	22.4%
NATIONAL	66.0%	12.0%

It is critical that WIC become a reliable source of breastfeeding resources across the country, as many State Medicaid agencies that do not cover breastfeeding serv-

ices and supplies often direct enrollees to their state WIC agency. For this practice to be successful, Health and Human Services (HHS) should actively seek better coordination with USDA to ensure that breastfeeding supplies and services are available from at least one agency in every State.

Beyond coordination around access points between WIC and Medicaid, HHS can contribute significantly to improving breastfeeding rates by working to improve the WPSI Guideline for Breastfeeding Services and Supplies to improve clarity around specific health plan coverage requirements. To reach their breastfeeding goals, mothers need access to quality equipment and comprehensive support before, during, and after pregnancy to ensure successful preparation, initiation, and continuation of breastfeeding.

Many important questions about coverage requirements and guidelines remain unanswered. Specific requests have been issued to HHS through past House appropriations report language (H. Rept. 117–403, H. Rept. 116–62, H. Rept. 115–862, and H. Rept. 115–244), and HHS should evaluate and respond to these outstanding requests from Congress related to its role in the provision of infant nutrition support in the United States. Without specific guidance, a number barriers to accessing supplies and services exist that may prevent individuals from reaching their breastfeeding goals.

First, there are no clear guidelines around the type or quality of breast pumps that must be covered, leaving families at risk of being given an inexpensive, low-quality pump that will not sufficiently establish or sustain a breast milk supply. Mothers who perceive or actually experience a low milk supply are much more likely to supplement with formula or cease breastfeeding altogether.

Second, there needs to be more clarity around when, and how often, a breast pump may be provided to a pregnant member. Some plans exploit this by refusing to cover a pump until within 30 days of the due date; if a baby were to be born early, a mother may not have her pump available when she needs it to help initiate and establish her milk supply. Furthermore, some plans limit how often a member may receive a new breast pump, such as setting a lifetime maximum benefit (e.g., only one pump, ever) or setting frequency limits (e.g., only one pump every 3 years) which can mean that a mother will not have an appropriate, quality breast pump available for each infant she births. Finally, some plans only cover a breast pump when certain Medical Necessity criteria are met—such as the baby having a cleft palate, or the mother having an inverted nipple—which most families will not meet, excluding them from accessing the equipment they need.

Third, coverage for lactation support and education services is inconsistent. For example, some plans require that members only use in-network providers even when there are no in-network providers available or accessible within a reasonable distance. Families who access support from the providers available to them may have their claims denied. Some families are sent to WIC as a resource, even if they are not eligible for WIC benefits, or if that WIC agency does not offer the benefits needed.

These issues create devastating coverage gaps that leave families unsupported in their efforts to feed their infant breast milk. Disparities and inequities among low-income families are further exacerbated by these gaps, and are seen in the dramatically lower rates of breastfeeding within that population. As a wealthy, developed country, we can and must do a better job supporting all families, but especially those with limited means, who are trying to provide the best nutrition to their children. In light of the recent formula shortage crisis in our country, it could not be more imperative to improve the ways we ensure families have what they need to breastfeed should they choose to do so.

[This statement was submitted by Dr. Jennifer Thomas, MD, MPH, IBCLC, FABM, FAAP, Pediatrician and Breastfeeding Medicine Specialist.]

PREPARED STATEMENT OF THE PERSONALIZED MEDICINE COALITION

Chairwoman Baldwin, Ranking Member Moore Capito, and distinguished members of the subcommittee, the Personalized Medicine Coalition (PMC) appreciates the opportunity to submit testimony on the National Institutes of Health (NIH) fiscal year (FY) 2024 appropriations and to highlight the importance of NIH-funded research to personalized medicine. PMC is a nonprofit education and advocacy organization comprised of more than 220 institutions from across the health care spectrum who support this growing field. We appreciate the sustained, robust funding for NIH provided by this subcommittee in recent years, which has allowed NIH to continue building the foundation of scientific knowledge underpinning personalized medicine. Continuing this momentum will be essential to support further discovery

of targeted health care interventions that can improve patients' lives. As the subcommittee begins work on the FY 2024 Labor, Health and Human Services, Education and Related Agencies appropriations bill, we request at least $50.924 billion for NIH's base program level budget. This $3.465 billion increase over the comparable FY 2023 program level will allow meaningful growth of nearly 5 percent.

Personalized medicine, also called precision or individualized medicine, is an evolving field in which physicians use diagnostic tests to determine which medical treatments will work best for each patient or use medical interventions to alter molecular mechanisms that impact health. By combining data from diagnostic tests with an individual's medical history, circumstances, and values, health care providers can develop targeted treatment and prevention plans with their patients. Personalized medicine promises to help detect the onset of disease, pre-empt its progression, and improve the quality, accessibility, and affordability of health care.[1] By further investing in biomedical research, Congress can help advance a brighter future where personalized medicine is one day available and accessible for all patients and health systems.

I. THE ROLE OF NIH IN PERSONALIZED MEDICINE

Decades of NIH-funded biomedical research on the genetic and biological underpinnings of disease have contributed to the development of personalized treatments benefitting patients today. In fact, as of 2022, this research has helped inform the development of more than 300 personalized treatments[2]and over 166,000 genetic testing products.[3] These numbers continue to grow, with personalized medicines accounting for more than a quarter of all new drugs approved by the Food and Drug Administration (FDA) for each of the last 8 years.[4] Nearly half of new personalized treatments are approved for indications outside of oncology. Continued progress cannot be taken for granted. To ensure that scientists and innovators maintain this momentum, Congress must support policies that encourage the advancement of the field and commit to funding NIH's basic and translational research over multiple years.

II. RESEARCH ACCELERATING PERSONALIZED MEDICINE

NIH is leading much of the scientific discovery for personalized medicine, which begins with basic research that generates fundamental knowledge about the molecular basis of a disease and with translational research aimed at applying that knowledge to develop a treatment or cure. Many NIH institutes and centers are contributing research informing the development of personalized medicine approaches. A robust base budget for NIH in FY 2024 would protect the agency's foundational role in the identification and development of treatments, technologies, and tools for personalized medicine.

The *All of Us*™ Research Program, for example, was launched in 2018 to collect genetic and health information from one million volunteers as part of a decades-long research project. The *All of Us*™ Research Program will enable new discoveries over time with a goal of improving population health through the identification of risk factors and biomarkers to allow more efficient and accurate diagnosis and screening, more rational use of existing therapeutics, and the development of new treatments. As of March 2022, over 475,000 individuals have consented to participate in the program, with more than 326,000 being fully enrolled.[5] More than 80 percent of the enrolled individuals are from groups historically underrepresented in research.[6] Ultimately, the scope of the program's impact will depend upon the extent to which it engages participants, who will be asked to share data over the long term. Additional funding for NIH will help secure the future of this promising program.

Cancer care, too, has been and will continue to be profoundly influenced by new personalized medicine approaches for detecting and treating early- and late-stage diseases. Over the past decade, personalized treatments harnessing the immune system have driven declines in mortality for lung cancer and melanoma. Targeted

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[1] http://www.personalizedmedicinecoalition.org/Userfiles/PMC-Corporate/file/PMC__The__Personalized__Medicine__Report__Opportunity__Challenges__and__the__Future.pdf.

[2] http://www.personalizedmedicinecoalition.org/Userfiles/PMC-Corporate/file/PMC__The__Personalized__Medicine__Report__Opportunity__Challenges__and__the__Future.pdf.

[3] https://doi.org/10.1002/ajmg.c.31881.

[4] https://www.personalizedmedicinecoalition.org/Userfiles/PMC-Corporate/file/Personalized__Medicine__at__FDA__The__Scope__Significance__of__Progress__in__2021.pdf.

[5] https://www.joinallofus.org/newsletters/2022/march.

[6] https://officeofbudget.od.nih.gov/pdfs/FY23/br/Overview%20of%20FY%202023%20Presidents%20Budget.pdf.

therapies, cell-based immunotherapies, and liquid biopsy tests are becoming the hallmarks of a new era of personalized medicine as they are integrated into the standard of care for cancer patients. Ongoing programs promise continued advances. The Cancer Moonshot, for example, aims to transform the way cancer research is conducted by fostering collaboration and data sharing. Since the Cancer Moonshot was launched in 2016, over 70 programs and consortia have been supported and more than 250 research projects have been funded.[7] Significant infrastructure for conducting cancer research and sharing resources has been established.[8] And at the National Cancer Institute (NCI), researchers are studying the potential of multi-cancer early detection (MCED) tests designed to find evidence of cancer wherever it occurs in the body from a simple blood draw. NCI's large national trials on MCED tests will begin enrolling participants in 2024. Additional base budget funding for NIH will help NCI sustain progress toward the Cancer Moonshot's goal of "ending cancer as we know it."

Basic and translational research also offer opportunities for personalized medicine beyond oncology, especially for rare diseases. Although individually rare, rare diseases collectively affect an estimated 25 to 30 million Americans. In recent decades, advances in genomics have helped researchers identify the molecular causes of 6,500 rare diseases. Programs at the National Institute for Advancing Translational Science (NCATS) have helped shift the scientific approach to researching rare diseases from one disease at a time to many. Pooling patients, data, experiences, and resources promises to lead to more successful clinical trials sooner for rare disease patients. More needs to be done, however, to accelerate the development of treatments for the 95 percent of rare diseases with no FDA-approved treatment; to strengthen the innovation of diagnostics to shorten the average 6.3-year long diagnostic odyssey patients face; and to lower the nearly $1 trillion annual economic burden of rare diseases.

Other patients are living with highly prevalent diseases where personalized medicine can offer better treatments or a cure. For example, the Alzheimer's Association estimates that more than six million Americans are living with Alzheimer's disease, whose genetic and molecular complexities are not fully understood. To help address the issue, NIH funded the creation of a Precision Aging Network (PAN) that could transform the way we think about the aging brain. PAN brings together researchers from across the country to better understand how and why people experience brain aging differently, with the ultimate goal of developing more effective treatments and interventions targeted to the individual. To reduce the time between the discovery of potential drug targets and the development of new drugs, NIH continues to lead the Accelerating Medicines Partnership (AMP) for Alzheimer's disease and other initiatives. AMP has identified over 500 drug targets and maintains partnerships to enable a personalized medicine approach to researching new treatments.[9] Other ongoing AMP projects aim to facilitate the development of gene therapies for rare diseases as well as treatments and diagnostics for type 2 diabetes, Parkinson's disease, schizophrenia, and kidney and heart diseases. A boost to the NIH base budget would go a long way toward ensuring the continued success of these programs.

Ensuring that scientific breakthroughs in personalized medicine are impactful to all patients will require the inclusive and equitable representation of patients with diverse characteristics and health needs in research and clinical trials. Multiple NIH activities are underway to improve research policies and incorporate diverse perspectives into solving scientific problems. The UNITE Initiative and the National Human Genome Research Institute (NHGRI)'s 2020 Strategic Vision, for example, promise to play a key role in addressing disparities, as does research led by the National Institute on Minority Health and Health Disparities (NIMHD).

IV. CONCLUSION

PMC appreciates the opportunity to highlight NIH's importance to the continued success of personalized medicine. We believe that continued Federal investment in NIH-supported research will bring us closer to a future in which every patient benefits from an individualized approach to health care.

[This statement was submitted by Cynthia A. Bens, Senior Vice President, Public Policy, Personalized Medicine Coalition.]

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[7] https://doi.org/10.1016/j.ccell.2021.04.015.
[8] https://www.cancer.gov/research/annual-plan/directors-message.
[9] https://www.nih.gov/research-training/accelerating-medicines-partnership-amp/alzheimers-disease.

PREPARED STATEMENT OF THE PHYSICIAN ASSISTANT EDUCATION ASSOCIATION

The PA Education Association (PAEA), representing the 300 accredited PA programs in the United States that graduate more than 10,000 students each year, appreciates the opportunity to submit the following testimony on the Association's funding priorities for Fiscal Year (FY) 2024. As the issue of health care workforce shortages has grown increasingly dire in communities throughout the country, a vigorous Federal response to this crisis has become urgent. While Congress has long provided support for health workforce development programs that invest in curriculum development, clinical education, and other needs, funding levels have not kept pace with inflation in recent years, thereby limiting the potential of these programs to meaningfully shape the size, distribution, and diversity of the National health workforce.

To address critical provider shortages, PAEA joins with the Health Professions and Nursing Education Coalition, a national alliance of more than 90 organizations, to request a total of $1.51 billion in FY24 for the Title VII health professions and Title VIII nursing workforce development programs administered by the Health Resources and Services Administration (HRSA). This funding level, a notable increase from the $885 million allocated for Title VII and VIII in FY23, would more accurately reflect the scale of the National health workforce crisis and ultimately ensure all patients have access to high-quality care.

THE ROLE OF PAS IN RESPONDING TO WORKFORCE CHALLENGES

Throughout the history of the profession, PAs have uniquely been called upon during times of national workforce shortages given the accelerated training model in PA education and the capabilities of PA graduates once they enter practice. The PA program curriculum, taking place at the graduate-level, consists of approximately 1 year of classroom-based training followed by at least 1 year of clinical rotations in a wide array of specialties and settings. During their clinical year, students complete rotations in family medicine, emergency medicine, surgery, pediatrics, women's health, and behavioral health, among other electives. This provides all PA graduates with the education necessary for high-quality practice in the specialties that their communities need the most.

As projected health workforce shortages have continued to grow, the number of PA programs has risen significantly in the past decade, growing from 149 in 2010 to 300 as of 2023. However, the potential of this impressive growth assumes an adequate supply of clinical training sites necessary for students to progress to graduation. Nearly 85% of PA programs indicate that their existing clinical training sites continue to take fewer students than prior to the pandemic.[1] As the FY24 appropriations process takes place, restoring and expanding the supply of clinical training sites must be a top priority to ensure an adequate supply of providers.

Currently, few opportunities exist with the potential to bolster clinical site supply at the scale necessary to meet workforce demand. The Primary Care Training and Enhancement—Physician Assistant Rural Training program, which explicitly allows grantees to pay preceptors to train students in rural communities to expand access to placements, is a model that Congress should significantly expand through the appropriations process. However, since the PCTE–PAR competition's creation, only 7 PA programs nationwide receive funding under this program, far below the level necessary to significantly shift workforce supply and distribution patterns. In order to meaningfully increase the supply of primary care PAs entering the workforce, it is critical that increased funding for this program be prioritized.

Beyond the Primary Care Training and Enhancement program, an additional source of support to expand clinical education capacity is Area Health Education Centers (AHECs), which facilitate clinical placements for PA and other health professions students in underserved areas through community-academic partnerships. In academic year 2021–2022, AHEC grantees facilitated over 28,000 clinical rotations for health professions students with approximately 70% taking place in medically underserved communities and 57% occurring in primary care settings.[2] To ensure an adequate supply of clinical training sites for students, PAEA urges the subcommittee to support a funding level of $98 million for PCTE grants and $86 million for AHECs in FY24.

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[1] Physician Assistant Education Association. (2021). COVID–19 Rapid Response Report 3. https://paea.edcast.com/insights/ECL-c621408d-c82a-43f5-a067-75a03494d8be.

[2] Health Resources and Services Administration. (2023). Justification of Estimates for Appropriations Committees. https://www.hrsa.gov/sites/default/files/hrsa/about/budget/budget-justification-fy2024.pdf.

PROMOTING HEALTH EQUITY

In addition to ensuring an adequate supply of health professionals, Congress must also prioritize long-standing representation gaps in the composition of the future health workforce as a means of promoting health equity. Due to formidable socioeconomic barriers, students from marginalized communities have historically been significantly underrepresented across health professions education. As of 2019, only 3.9% of first-year PA students identify as Black or African American and 9.1% identify as Hispanic or Latino.[3] Addressing the National health workforce crisis requires significant new investments to reduce these disparities and ensure access to high-quality care in underserved communities.

To promote the availability of culturally competent care for patients, Congress can act by increasing funding for HRSA's existing training for diversity programs, which address the unique needs of underrepresented minority students at each stage of their path to becoming a health professional. The Health Careers Opportunity Program (HCOP), for example, introduces the possibility of becoming a health professional to students at the K–16 level while providing enrichment and direct exposure to health professions programs that equips them for ultimate success in matriculation. In academic year 2021–22, HCOP grantees provided this type of support to 4,640 students, 68% of whom were underrepresented minority students.[2]

Beyond the matriculation phase, HRSA programs also work to ensure that students have the financial support necessary to successfully complete their programs. The Scholarships for Disadvantaged Students (SDS) program provides financial aid critical to ensuring students progress to graduation. In academic year 2021–22, SDS supported more than 2,670 disadvantaged health professions students with 65% being from underrepresented minority communities.[2] To reflect the scale of the current health workforce crisis PAEA urges the subcommittee to fund HCOP and SDS at a level of $30 million and $103 million, respectively, for FY24.

COMBATING MATERNAL MORTALITY DISPARITIES

Ensuring that the United States has a health care workforce reflective of current and future needs requires Congress to dedicate particular attention to recent public health trends. In 2021, maternal mortality rates spiked nearly 40% over the previous year's level with 1,205 women dying.[4] Black or African American women continue to be disproportionately affected by this crisis with a mortality rate of 69.9 deaths per 100,000 live births—over 2.5 times the rate of non-Hispanic white women.[4] To address this growing epidemic, Congress must ensure that there is a sufficient supply of diverse, well-trained obstetrics providers in the communities most impacted by maternal health disparities.

Shortages of clinical training sites impacting PA programs nationwide are particularly acute in the field of women's health, obstetrics, and gynecology. Nearly 75% of PA programs indicate that it is either harder or much harder to secure clinical rotations in obstetrics/gynecology than prior to the COVID–19 pandemic.[1] To respond to this challenge, Congress should fully fund the Rural Maternal and Obstetric Care Training demonstration program authorized in the FY22 omnibus appropriations law. This program will ensure that PA education and other health professions programs have an adequate supply of training opportunities in rural communities. PAEA urges the subcommittee to provide $5 million for this purpose in FY24.

FISCAL YEAR 2024 RECOMMENDATION

As the issue of workforce shortages continues to challenge communities nationwide, Congress must provide funding for health workforce development efforts commensurate with the scale of this crisis. PAEA joins the Health Professions and Nursing Education Coalition in requesting $1.51 billion in funding for the Title VII health professions and Title VIII nursing workforce development programs in FY24. The Association thanks the subcommittee for the opportunity to submit testimony and looks forward to the opportunity to serve as a resource to members and staff.

[This statement was submitted by Sara Fletcher, PhD, Chief Executive Officer, Physician Assistant Education Association.]

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[3] Physician Assistant Education Association. (2020). By the Numbers: Student Report 4: Data from the 2019 Matriculating Student and End of Program Surveys. https://paeaonline.org/wp-content/uploads/imported-files/student-report-4-updated-20201201.pdf.

[4] Centers for Disease Control and Prevention. (2023). Maternal Mortality Rates in the United States, 2021. https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2021/maternal-mortality-rates-2021.htm.

PREPARED STATEMENT OF THE PHYSICIANS COMMITTEE FOR RESPONSIBLE MEDICINE

On behalf of the Physicians Committee for Responsible Medicine, thank you for the opportunity to submit this written testimony regarding the Appropriations report language request described below for the National Institutes of Health (NIH), Office of the Director. The Physicians Committee is a 501(c)(3) nonprofit organization with nearly one million supporters worldwide that works to make medical research more effective and ethical. As the subcommittee crafts the FY 2024 Labor, Health and Human Services, Education, and Related Agencies Appropriations bill, the Physicians Committee asks that you please consider the following provision to ensure the proper care and use of cephalopods in federally funded research and allow Federal and public accountability of the expenditure of taxpayer dollars for cephalopod research.

CEPHALOPOD USE IN RESEARCH AND EXCLUSION FROM WELFARE REGULATIONS

Cephalopods, including the squid, octopus, cuttlefish, and nautilus, are a highly intelligent [1] class of marine invertebrate animals, and evidence shows that they can experience pain, distress, and suffering.[2] They are also highly sensitive animals, requiring precise conditions and specialized handling to ensure their physical health and survival when kept in captivity.[3] The NIH and the National Science Foundation actively fund cephalopod model development [4] and there is evidence that their use is increasing, as noted in the media [5] and reflected in the number of research papers published about cephalopods in the NIH's publication database, PubMed, over time (Figure 1). The Public Health Service Policy on Humane Care and Use of Laboratory Animals (PHS Policy) defines animal as "any live, vertebrate animal used or intended for use in research, research training, experimentation, or biological testing or for related purposes," [6] hence excluding cephalopods and other invertebrates from the measures that it requires to ensure the appropriate care and use of laboratory animals. This report language request would direct the NIH to include cephalopods in this definition.

[1] Jennifer A. Mather and Michael J. Kuba, "The Cephalopod Specialties: Complex Nervous System, Learning, and Cognition," Canadian Journal of Zoology 91, no. 6 (June 2013): 431–49, https://doi.org/10.1139/cjz-2013-0009.

[2] Robyn J. Crook, "Behavioral and Neurophysiological Evidence Suggests Affective Pain Experience in Octopus," IScience 24, no. 3 (March 19, 2021): 102229, https://doi.org/10.1016/j.isci.2021.102229; Ryan B. Howard et al., "Early-Life Injury Produces Lifelong Neural Hyperexcitability, Cognitive Deficit and Altered Defensive Behaviour in the Squid Euprymna Scolopes," Philosophical Transactions of the Royal Society B: Biological Sciences 374, no. 1785 (September 23, 2019): 20190281, https://doi.org/10.1098/rstb.2019.0281; Giorgia della Rocca et al., "Pain and Suffering in Invertebrates: An Insight on Cephalopods," American Journal of Animal and Veterinary Sciences 10, no. 2 (June 15, 2015): 77–84, https://doi.org/10.3844/ajavsp.2015.77.84.

[3] Graziano Fiorito et al., "Guidelines for the Care and Welfare of Cephalopods in Research -A Consensus Based on an Initiative by CephRes, FELASA and the Boyd Group," Laboratory Animals 49, no. 2__suppl (October 1, 2015): 1–90, https://doi.org/10.1177/0023677215580006.

[4] "RePORTER Project Details: 1R35GM147273–01, 'A New Animal Model to Elucidate Mechanisms of Gene Regulation and Embryonic Patterning,'" accessed March 22, 2023, https://reporter.nih.gov/search/IIWK0lt12kGxh6xbXcUJvA/project-details/10499622; "NSF Award Search: Award # 2220587, 'EDGE FGT: Creation of a Genetically Tractable Cephalopod Model Using the Hummingbird Bobtail Squid,'" accessed March 22, 2023, https://www.nsf.gov/awardsearch/showAward?AWD__ID=2220587&HistoricalAwards=false.

[5] Nell Greenfieldboyce, "Why Octopuses Might Be The Next Lab Rats," NPR, June 3, 2019, sec. Shots—Health News, https://www.npr.org/sections/health-shots/2019/06/03/727653152/why-octopuses-might-be-the-next-lab-rats; Rachel Nuwer, "An Octopus Could Be the Next Model Organism," Scientific American, March 1, 2021, https://doi.org/10.1038/scientificamerican0321-12.

[6] U.S. Department of Health and Human Services National Institutes of Health Office of Laboratory Animal Welfare, "Public Health Service Policy on Humane Care and Use of Laboratory Animals," 2015, https://olaw.nih.gov/policies-laws/phs-policy.htm.

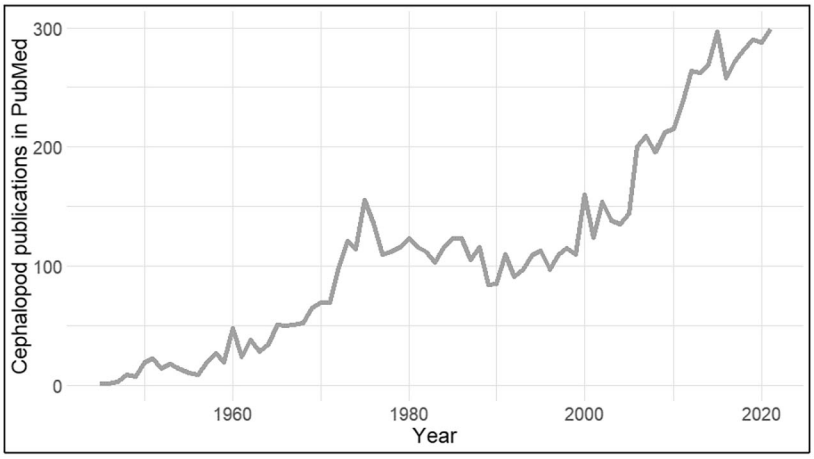


FIGURE 1. CEPHALOPOD PUBLICATION TRENDS IN PUBMED OVER TIME.[7]

The PHS Policy requires all PHS-conducted or supported research to adhere to certain care standards and accountability measures for the treatment and use of animals. Because cephalopods are excluded from the PHS Policy: (1) researchers who use cephalopods are not required to justify their use nor provide certain details of their use, like pain management considerations, euthanasia methods, and living conditions; (2) Institutional Animal Care and Use Committees, which oversee the use of animals in PHS-conducted or supported activities, are not required to report PHS Policy noncompliances or serious deviations from the guidelines laid out in the Guide for the Care and Use of Laboratory Animals[8] to the NIH Office of Laboratory Animal Welfare, which holds the authority to restrict or suspend research activity involving animals; and (3) researchers are not required to provide average daily inventory numbers and species of cephalopods in Animal Welfare Assurances. Accordingly, any oversight and protections for cephalopods are left up to individual researchers and institutions on a voluntary basis with no avenue for public or Federal accountability.

Regulating the use of cephalopods in research is standard practice in many other countries including the United Kingdom, Canada, New Zealand, Australia, Switzerland, Norway, as well as the European Union. Existing resources establish guidelines for the care and welfare of cephalopods in research[9] and can be used to update the PHS-mandated Guide for the Care and Use of Laboratory Animals.[10] Furthermore, 19 Members of the House of Representatives[11] and four Senators[12] raised this issue to the Agency in 2022 by sending letters requesting that the PHS Policy definition of animal be updated to include cephalopods. This requested report language would ensure that the U.S. keeps pace with internationally recognized standards of care for animals in research and that the NIH upholds its obligation to ani-

[7] National Institutes of Health, PubMed, July 21, 2022, https://pubmed.ncbi.nlm.nih.gov/. Search query: (cephalopod OR squid OR octopus OR cuttlefish OR nautilus) AND "animals".

[8] National Academy of Sciences, "Guide for the Care and Use of Laboratory Animals, Eighth Edition," 2011, https://grants.nih.gov/grants/olaw/guide-for-the-care-and-use-of-laboratory-animals.pdf.

[9] Fiorito et al., "Guidelines for the Care and Welfare of Cephalopods in Research -A Consensus Based on an Initiative by CephRes, FELASA and the Boyd Group."

[10] National Academy of Sciences, "Guide for the Care and Use of Laboratory Animals, Eighth Edition."

[11] Physicians Committee for Responsible Medicine, "Nineteen Lawmakers Request Protections for Cephalopods Used in Research," 2022, https://www.pcrm.org/news/news-releases/nineteen-lawmakers-request-protections-cephalopods-used-research.

[12] Senator Cory Booker, "Booker, Whitehouse Lead Colleagues in Urging HHS and NIH to Extend Humane Care Handling Standards to Cephalopods," 2022, https://www.booker.senate.gov/news/press/booker-whitehouse-lead-colleagues-in-urging-hhs-and-nih-to-extend-humane-care-handling-standards-to-cephalopods.

mal welfare by establishing necessary protections for cephalopods in a timely manner.

To ensure accountability for the care and use of cephalopods in research, the Physicians Committee requests that the subcommittee adopt the following report language:

Cephalopod Research.—The Committee recognizes that there are no federally required welfare standards for the use of cephalopods in federally-funded research because all invertebrate animals are excluded from the Public Health Service (PHS) Policy on the Humane Care and Use of Laboratory Animals, which provides certain welfare standards for vertebrate animals. The Committee acknowledges the growing evidence that cephalopods are an especially intelligent class of invertebrates capable of experiencing pain, that their use in research is increasing, and that numerous other countries have acted to afford them humane treatment when used in government-funded research. Due to cephalopods' current exclusion, there is no avenue for accountability over the justification of their use, the details of their use—such as methods of anesthesia or euthanasia—and other important research considerations. The Committee directs the NIH to amend the current definition of "animal" in the PHS Policy as any live, vertebrate animal or cephalopod used or intended for use in research, research training, experimentation, or biological testing or for related purposes.

[This statement was submitted by Catharine E. Krebs, Ph.D., Medical Research Specialist, Physicians Committee for Responsible Medicine.]

PREPARED STATEMENT OF THE PLATELET DISORDER SUPPORT ASSOCIATION

SUMMARY OF FISCAL YEAR 2024 RECOMMENDATIONS

—Please provide the National Institutes of Health (NIH) with $50.9 billion to facilitate continued growth in rare disease research activities and advancement of the immune thrombocytopenia research portfolio.
  —Please provide proportional increases for the National Institute of Allergy and Infectious Diseases (NIAID), the National Heart, Lung, and Blood Institute (NHLBI), and the National Center for Advancing Translational Sciences (NCATS) to facilitate and sustain scientific progress.
  —Please provide a separate, meaningful increase to advance and adequately support the emerging Advanced Research Projects Agency for Health (ARPA–H).
—Please provide the Centers for Disease Control and Prevention (CDC) with $11.6 billion to support public health efforts for the rare disease community.
  —Please continue to systematically provide meaningful funding increases for the Chronic Disease Center at CDC, and please support $6 million in funding (a $1.5 million increase) for the line-item CDC Chronic Disease Education and Awareness (CDEA) program to ensure additional cooperative agreements are available for stakeholders.

Chairwoman Baldwin, Ranking Member Capito, and distinguished members of the subcommittee, thank you for the opportunity to present the views of the Platelet Disorder Support Association (PDSA) and the community of individuals impacted by ITP. Thank you for the meaningful investment in medical research and public health programs through the FY 2023 omnibus appropriations package. As you work with your colleagues on appropriations and related items for FY 2024, please continue to invest in NIH and CDC to facilitate new opportunities in research and public health, particularly for ITP and other rare diseases. Please consider PDSA a resource moving forward.

ABOUT PDSA

Patient-founded in 1998 to educate and empower those impacted by ITP and other rare platelet and bleeding disorders, PDSA is now a powerful force serving and unifying the global community of patients, practitioners, caregivers, advocates, and key disease stakeholders. We remain committed to building awareness, educating the global community, and providing critical connections and resources that empower patients to take charge of their disease and encourage practitioners to exercise patient-centered medical care. We focus our efforts in the core mission areas of research, patient education and support, and advocacy and awareness.

ABOUT ITP

ITP is an acquired disorder in which the body's immune system destroys healthy platelets, leaving the patient at risk for frequent, serious, and potentially life-threatening bleeds. An estimated 50,000 people in the U.S. are currently living with this rare autoimmune condition.

Patients with ITP face a complex set of challenges. ITP is a heterogeneous disease associated with significant morbidity not limited to bleeding. Due to variability in its underlying pathobiology and natural history, management of disease can be unpredictable despite the availability of several therapies with different mechanisms of action. Once diagnosed, ITP patients experience a range of physical and emotional challenges as they seek to monitor their platelet counts, balance treatment side effects, and manage the fear and frequent reality of relapse.

PATIENT STORIES

Barbara—Coral Gables, FL

"For us, not a minute goes by without thinking about how ITP affects your life," said Barbara Pruitt from Florida, a 62-year-old woman living with chronic refractory ITP. Diagnosed at age 4, she has only experienced remission for 3 months, immediately following her splenectomy when she was 7 years old. Since 1961, she has tried every drug and treatment available, but none have been successful, leaving her platelet count in the single digits for the past 25 years and living with the four aspects of ITP that affect her the most: fear, guilt, fatigue, and depression. "You wake up with fear every day," she said, continuing, "This fear cannot evade you, and for good reason. Am I gonna' die today? Will I have an accident? What if I have to go to the hospital? Will the ER doctors know how to treat someone like me? What if I need surgery? Nothing works for me! Maybe I should just stay home.... The fear makes you worry about having a 'normal' life."

Marcia—Balsam Lake, Wisconsin

Since being diagnosed with ITP in 2013, Marcia Freed of Balsam Lake, Wisconsin, has pushed through the ongoing twists and turns of this rare bleeding disorder. At the age of 65, an annual exam revealed a low platelet count. Her doctor indicated she may have immune thrombocytopenia (ITP) and, admittedly having limited experience and knowledge on the bleeding disorder, referred her to a hematologist immediately. "I remember trying to wrap my head around what my doctor was telling me. There was no brochure, no information, nothing to help me understand what was happening. I worried myself sick."

A visit to the hematologist confirmed the diagnosis—and so began Marcia's decade-long journey with ITP, and the overwhelming emotional and physical punch it packed. "I felt so lost. But PDSA saved me. I can't say enough about what this organization has done for me. I read their magazines front to back, I follow their news, and listen to all their webinars. This is why I'm so committed to PDSA's patient support groups—no one should have to feel alone like I did. Others in my support group agree. They thought they were dying, too. They had no hope...and that's why PDSA exists. They're working hard for us to get to the bottom of this disease."

Trish—Medinah, Illinois

A flush of petechiae and unexplained bruising was the first sign of trouble for Trish Santaromana of Medinah, Illinois. Initial visits with her physician didn't offer much comfort, and a first harrowing blood draw panicked all involved when needle pokes initiated bleeding that wouldn't stop. Frightened and perplexed, Trish was sent home without answers and told to wait for test results. It didn't take long for her world to turn upside down. Her doctor's office called later that night and directed Trish to get to the hospital as soon as possible explaining that her platelet count was a dangerously low 6,000 and she was at great risk for a life-threatening spontaneous bleed. She was admitted to the hospital immediately and spent the remainder of the week in uncertainty, undergoing a multitude of tests while trying to grasp the serious nature of the situation. Days into her hospital stay, Trish was finally diagnosed with ITP and started on a high dose of prednisone to recover her platelet count. She recalls her reaction, "I felt very isolated and alone with this diagnosis and wondered if I'd be okay. Would I receive the proper treatment? What did my future hold?" Today, 21 years later, Trish's continuing ITP journey has taken her on a roller coaster of changing treatments, multiple hospital stays, numerous surgeries, and additional, complicating health conditions including hypertrophic cardiomyopathy, autoimmune kidney disease, and osteoporosis.

Beth—Norwalk, Connecticut

Like most, Beth Siegelbaum's ITP diagnosis came as a surprise. She first learned that her platelet count was low back in the 1990s. Her physician said not to worry, but kept an eye on it with regular blood draws and she seemed to be getting along just fine. In 2000, Beth's platelets dropped to 22,000. As she recalls, the physician told her to "hightail it to a hematologist for further testing." From that moment on, ITP became an integral part of Beth's existence—something she had to closely monitor and manage in order to preserve her health. With little information available, Beth went through a variety of treatments to improve her platelet count. "The challenge was to find a treatment that worked that didn't have bad side effects," she recalls. Beth was given prednisone and several other treatments, including IVIG, which worked initially but produced diminishing returns as time went on—requiring an increased frequency of infusions to maintain her platelet count. A splenectomy was considered, but she ultimately decided against it. Today, 23 years later, Beth remains on NPlate®, administered weekly via injection, to manage her ITP.

Peyton—Topeka, Kansas

Peyton VandeVelde of Topeka, Kansas, was diagnosed with ITP when she was just 3 years old. For the past 7 years, she has endured countless treatments (including steroids, IVIG, NPlate®, Promacta®, Rituxan®, and mycophenolate) and hospitalizations due to her ITP. She has also missed a lot of school and has been forced to quit sports and physical activities as it is no longer safe for her to participate. Now 10-years-old, Peyton and her parents' frustration continues to grow as they feel their options are running out. "We've had to review our options again—some of which we considered last resort; you know, the ones you really don't want to try. Splenectomy was brought up—and to us that's our last resort. Kids still contract a lot of viruses so we'd like to postpone that possibility for as long as we can. Plus, there's also no guarantee that a splenectomy will work." With a platelet count steadily below 10,000, Peyton's ITP remains unresolved. "It's so hard to see your kid go through the trial of different medications—her little body has been through so much in just the last 2 years. We continue to pray that something will work."

FY 2024 Recommended Report Language

CENTERS FOR DISEASE CONTROL AND PREVENTION

PUBLIC HEALTH APPROACH TO BLOOD DISORDERS PROGRAM

Platelet Disorders and Public Health Approach to Blood Disorders.—The Committee provides $XX million for the Public Health Approach to Blood Disorders program and directs CDC to utilize additional resources to implement innovative activities dedicated to supporting patients with immune thrombocytopenia (ITP) and other rare platelet disorders, in a manner similar to programming and activities available for sickle cell and hemophilia.

NATIONAL INSTITUTES OF HEALTH

NATIONAL HEART, LUNG, AND BLOOD INSTITUTE

Immune Thrombocytopenia [ITP].—The committee applauds NHLBI for its strong leadership and emerging vision for the Division of Blood Diseases and Resources. NHLBI is encouraged to sustain its focus in ITP and other rare blood disorders, including through community collaborations and partnerships with other Institutes and Centers, to sustain scientific progress in this important area.

[This statement was submitted by Caroline Kruse, President and CEO, Platelet Disorder Support Association.]

Prepared Statement of the Population Association of America/ Association of Population Centers

Thank you, Chair Baldwin and Ranking Member Capito for this opportunity to express support for the National Institutes of Health (NIH), National Center for Health Statistics (NCHS), Agency for Healthcare Research and Quality (AHRQ), Institute of Education Sciences (IES), and Bureau of Labor Statistics (BLS). These agencies are important to the members of the Population Association of America (PAA) and Association of Population Centers (APC) because they provide direct and indirect support to population scientists and the field of population, or demographic, research overall. In FY 2024, we urge the subcommittee to adopt the following fund-

ing recommendations for agencies under its jurisdiction: $50.924 billion, NIH; $215 million, NCHS; $500 million, AHRQ; $900 million, IES; and $868.5 million, BLS. In addition, we urge the subcommittee to accept report language, previously submitted, regarding population research programs and surveys supported by the National Institute on Aging (NIA) and Eunice Kennedy Shriver National Institute on Child Health and Human Development (NICHD) at the NIH.

NATIONAL INSTITUTES OF HEALTH

Population, or demographic, research is the study of populations and how or why they change. The health of our population is fundamentally intertwined with the demography of our population. Recognizing the connection between health and demography, NIH supports population research programs primarily through the NIA and the NICHD. As members of the Ad Hoc Group for Medical Research, PAA and APC recommend the subcommittee continue to prioritize NIH funding by endorsing an appropriation of $50.924 billion for the NIH, a $3.465 billion increase over the agency's comparable FY 2023 program level. In addition, we urge the Committee to ensure that any funding for the new Advanced Research Project Agency for Health (ARPA–H), supplements, rather than supplants, the essential foundational investment in the NIH. Finally, we ask that NIA and NICHD, as components of the NIH, receive commensurate funding increases (7.3 percent over their FY 23 levels) in FY 2024.

NATIONAL CENTER FOR HEALTH STATISTICS

As members of the Friends of NCHS, PAA and APC thank the subcommittee for providing the agency with a meaningful funding increase in FY 2023. We ask that the subcommittee build on this momentum in FY 2024 to ensure that NCHS, as the Nation's principal health statistics agency, can enhance its capacity to provide more timely, high-quality, granular data on the health of the U.S. population. Population scientists rely on large NCHS-supported health surveys, especially the National Health Interview Survey and National Health and Nutrition Examination Survey, to study demographic, socioeconomic, and behavioral differences in health and mortality outcomes. They also rely on the vital statistics data that NCHS releases to track trends in fertility, mortality, and disability. NCHS health data are an essential part of the Nation's statistical and public health infrastructure. In order for NCHS to continue monitoring the health of the American people and to allow the agency to make much-needed investments in the next generation of its surveys and products, PAA and APC, as members of the Friends of NCHS, recommend the agency receive $215 million in FY 2024, which is $28 million above its FY2023 appropriation. In addition, our organizations urge the subcommittee to reiterate its support for the agency's participation in the Centers for Disease Control (CDC) Data Modernization Initiative (DMI). NCHS should benefit from DMI funds, as the Committee intended, and apply them to make long overdue and necessary systematic and technological upgrades as well as facilitating enhanced use of Electronic Health Records. PAA and APC are especially supportive of NCHS using additional funding to improve the quality of vital statistics to inform research regarding the underlying causes of mortality and health disparities across different populations and geographies.

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

As members of the Friends of AHRQ, PAA and APC support providing the agency with $500 million in FY 2024, which is $126.5 million above ARHQ's FY 2023 enacted level. AHRQ funds research that focuses on the delivery of effective and efficient medical care, including prevention of dangerous and deadly medical errors. AHRQ is attracting attention as an increasingly important scholarly setting and potential source of grant support for population scientists. In addition, population scientists use data from the agency's health services research surveys and electronic health records to inform their own studies and research training activities.

BUREAU OF LABOR STATISTICS

Population scientists who study and evaluate labor and related economic policies use BLS data extensively. The field also relies on unique BLS-supported surveys, such as the American Time Use Survey and National Longitudinal Surveys, to understand how work, unemployment, and retirement influence health and well-being outcomes across the lifespan. As members of the Friends of Labor Statistics, PAA and APC are grateful to the subcommittee for providing the agency with steady increases since FY 2018-especially after years of flat funding. We are also pleased that

the subcommittee included language in its FY 2023 report expressing support for a new youth cohort for the National Longitudinal Survey of Youth (NLSY). As the subcommittee knows, the current NLSY 1979 and 1997 cohorts cannot provide adequate information about teens and young adults entering the labor market. PAA and APC are enthusiastic about the new NLSY cohort and urge the subcommittee to sustain its support for its development. We urge the subcommittee to provide BLS with $868.5 million in FY 2024 and to adopt, once again, report language expressing support for the new NLSY cohort.

INSTITUTE OF EDUCATION SCIENCES (IES)

The Institute of Education Sciences (IES) plays a critical role in supporting research used in developing and examining the effectiveness of education programs and curricula. The National Center for Education Statistics (NCES), the statistical arm of IES, provides objective data, statistics, and reports on the condition of education in the U.S. Population scientists rely on NCES surveys to conduct research on an array of topics, such as linkages between educational access/attainment to health outcomes of specific populations, economic well-being, and incarceration rates. As members of the Friends of IES, we urge the committee to provide the agency with at least $900 million in FY 2024, and to ensure that NCES receives, at a minimum, the President's request, $316 million, which is approximately $9 million over the agency's FY 2023 level. Additional funding for NCES is necessary to not only support its programs, but also needed to address the agency's ongoing staffing crisis.

Thank you for considering our support for these agencies as the subcommittee drafts the FY 2024 Labor, Health and Human Services and Education Appropriations bill.

[This statement was submitted by Mary Jo Hoeksema, Director, Government and Public Affairs.]

PREPARED STATEMENT OF THE PULMONARY HYPERTENSION ASSOCIATION

PHA'S FISCAL YEAR 2024 L-HHS APPROPRIATIONS RECOMMENDATIONS

—At least $50 billion in program level funding for the National Institutes of Health (NIH).

—Proportional funding increases for NIH's National Heart, Lung, and Blood Institute (NHLB)

Chairwoman Baldwin and Ranking Member Capito, and distinguished members of the Subcommittee, thank you for your time and your consideration of the priorities of the pulmonary hypertension (PH) community as you work to craft the FY2024 L-HHS Appropriations bill.

ABOUT PULMONARY HYPERTENSION

Pulmonary hypertension (PH) is high blood pressure that occurs in the arteries of the lungs. It reflects the pressure the heart must apply to pump blood from the heart through the arteries of the lungs. As with a tangled hose, pressure builds up and backs up forcing the heart to work harder and less oxygen to reach the body. PH symptoms generally include fatigue, dizziness and shortness of breath with the severity of the disease correlating with its progression. If left undiagnosed or untreated it can lead to heart failure and death. In recent years, innovative treatment options have been developed and approved for PH. The effectiveness of current treatment options depends on accurate diagnosis and early intervention.

ABOUT PHA

Headquartered in Silver Spring, Md., the Pulmonary Hypertension Association (PHA) is the country's leading PH organization. PHA's mission is to extend and improve the lives of those affected by PH. PHA achieves this by connecting and working together with the entire PH community of patients, families, health care professionals and researchers. The organization supports more than 150 patient support groups; a robust national continuing medical education program; a PH clinical program accreditation initiative; and a national observational patient registry.

HEALTH RESOURCES AND SERVICES ADMINISTRATION

Due to the serious and life-threatening nature of PH, it is common for patients to face drastic health interventions, including heart-lung transplantation. To ensure HRSA can continue to make improvements in donor lists and donor-matching please provide HRSA with an increase in discretionary budget authority in FY2024.

NATIONAL INSTITUTES OF HEALTH

Please provide NIH with meaningful increases—including at least $50 billion in program funding in FY2024—to facilitate expansion of the PH research portfolio and continued improvement in diagnosis and treatment. NHLBI and PHA have partnered on a groundbreaking clinical study, the Redefining Pulmonary Hypertension through Pulmonary Vascular Disease Phenomics (PVDOMICS) program (RFA–HL–14–027 and RFA–HL–14–030). By collecting information from nearly 1,200 participants with various types of PH, subjects at risk for PH, and healthy controls, PVDOMICS hopes to find new similarities and differences between the current WHO classifications of PH. This research is intended to lead to identification of both endophenotypes of lung vascular disease and biomarkers of disease that may be useful for early diagnosis or for assessment of interventions to prevent or treat PH.

Data from the original cohort is currently being prepared for publication and the rich resources of PVDOMICS have spurred many presentations at national and international meetings. With its novel approach to enrollment and data analysis, PVDOMICS is poised to change our thinking about pulmonary hypertension and its classification in the upcoming years.

PROPER HEALTH COVERAGE AND ACCESS

The PH community is concerned that the Centers for Medicare and Medicaid Services (CMS) is allowing insurance payers to refuse to accept charitable copay and premium assistance on behalf of patients with complex, chronic and life-threatening conditions like PH. Because of breakthroughs in research, PH patients can utilize life-sustaining treatments that allow them to manage this potentially fatal condition and lead relatively normal lives. When patients are denied access to financial assistance they are forced to choose between necessities: between dramatically shortening their lives by giving up medication to afford housing and food or continuing medication while starting their families on the road to bankruptcy. We aware of the subcommittee's continued requests for an explanation of this practice targeting rare disease patients. We ask that this subcommittee once again ask CMS to explain these decisions and encourage them to fix this problem that is greatly affecting the rare disease community. PHA also asks the subcommittee to urge CMS to increase incentives for the supply of oxygen that affects all oxygen modalities including both liquid and portable supplies. This increased flexibility will increase patient's quality of life at home and in their communities.

PATIENT PERSPECTIVES

Chandani's son was diagnosed with severe PH in July 2020 at the age of two. Chandani is a physician herself and so she understands all too well the seriousness of her son's prognosis. Since his diagnosis, her son's medical care team has tried progressively increasing therapies in a stepwise fashion, which is often required by insurance companies but is known to lead to worse outcomes than when patients are allowed to immediately begin the treatment prescribed by their doctor. Currently, Chandani's son is receiving three oral drugs in addition to a subcutaneous infusion, all for PH. He has not been responsive to these therapies which unfortunately indicates a poor prognosis. Currently, without a transplant, her son has a 60% chance of survival over the next 5 years, and if he were to receive a double-lung transplant, it would statistically add 2.7 years to his life. Studies show that self-reported quality of life for patients with pulmonary hypertension ranks worse than cancer patients. Research and treatment are vitally needed for this disease that has such a fatal prognosis and a poor quality of life.

Barbara has lived with PH for 21 years and with the treatment of liquid oxygen, she has managed to develop a comparatively active life filled with volunteer work and visits with her children and grandchildren. However, that changed in April 2021 when Barb's Medicare-contracted oxygen supplier stopped delivering liquid oxygen without notice. Instead, they began providing compressed oxygen gas tanks. Liquid oxygen tanks are light enough to be carried hands-free strapped to the back and hold a sufficient volume of oxygen to provide a continuous stream for 6–8 hours at a time so that Barb is able to breathe easily while still walking around. By con-

trast, compressed oxygen tanks are heavier and hold a smaller volume of oxygen, so they sustain her for only a fraction of the time that liquid oxygen tanks do. To carry a compressed oxygen tank with her, she must wheel it behind her or struggle with the weight and bulk of the tank if attempting to carry them on her back and change them out every couple of hours. These new limitations to her lifestyle due to the loss of appropriate treatment for her PH have caused a steep decline in her mood and quality of life and she has quickly become depressed; at a recent visit with her physician, she was told "I've never seen you this bad." The mobility and ease that using a liquid oxygen tank provides Barb is the difference between struggling to complete one errand in a day, versus running multiple errands, feeling capable of going out to have lunch with friends, or being able to comfortably visit her seven grandchildren. Barb contacted 30 suppliers within a 100-mile radius of her home searching unsuccessfully for anyone else to provide her with the correct treatment for her PH condition. In her efforts to find out more about the loss of access to liquid oxygen, Barb has heard from many other PH patients from across the country who are experiencing the same situation. This restriction of access to liquid oxygen represents a collective loss in quality of life for the community of PH patients that could have long-lasting and far-reaching consequences for an already serious, degenerative disease.

Thank you again for your consideration of the PH community's priorities as you develop the FY2024 L–HHS Appropriations bill.

PREPARED STATEMENT OF ERRIANNA QUALLO

Greetings, I am Errianna Quallo, a first-year Marketing scholar and Political Science researcher at the University of Florida. I am also the former Florida TRIO Pre-Collegiate SGA president and a proud FAMU TRIO Talent Search alumna. Before TRIO, I was a cheerleader, a student government representative, a straight-A student, and a community service volunteer in high school.

Although I had a wide array of accolades and a 4.0 unweighted GPA, those facts were not enough to secure my admission to a competitive college, nor were they enough to solidify the funding I desperately needed to attend college. To showcase my experiences and stand out amongst highly competitive applicants, I needed high ACT and SAT scores, transformational college essays, and a resume to reflect my accomplishments holistically.

Unfortunately, as a low-income, southside high school student hoping to become a first-generation college student, I knew none of that vital information. I needed access to college preparatory resources that catered to students like me. Luckily, I was introduced to the FAMU TRIO Talent Search program just before the beginning of my 11th-grade year, which equipped me with the key to the door of educational opportunity.

During the height of the pandemic in the summer of 2020, I joined the TRIO Talent Search program. Through free virtual meetings consisting of ACT Bootcamps, personal statement essay writing workshops, financial aid workshops, and personal development workshops, I gained permission to take hold of my educational future and prepare for the college application process in my 11th-grade year. The FAMU TRIO Talent Search Program poured knowledge into my life, watering the seeds of hope for my educational future. I attained a 28 on my first ACT and received a $1000 scholarship in the spring of 2021 at the end of my 11th-grade year.

Through continued support from TRIO, I applied to nine colleges. I received acceptances from all nine colleges, accumulating over one million dollars in combined award aid offers from all of those colleges. I also became a valedictorian at my school. I earned over $17,000 in community-based scholarships, some of which I discovered because the FAMU TRIO Talent Search program advisors shared them with me. Outside of college and scholarship applications, the FAMU TRIO Talent Search program provided access to in-person college tours and immersive educational experiences in Panama City Beach, Florida, New Orleans, Louisiana, Baton Rouge, Louisiana, and Los Angeles, California, all of which were free of charge to me. Those experiences provided by TRIO helped me realize that the adversities I faced did not define my future. I no longer had to imagine a future confined by financial instability; instead, I could imagine a future outside the stereotype of a black, low-income student.

I currently attend one of the country's top five best public universities on a full-ride scholarship, where I have many opportunities to explore my intellectual curiosity. The values seeded in me while I was in the FAMU TRIO program were life-changing, completely transforming the trajectory of my life and what I thought was possible for someone like me. I am a firm believer that TRIO works!

PREPARED STATEMENT OF REFUGEE COUNCIL USA

Chairwoman Baldwin, Ranking Member Capito, and members of the subcommittee, thank you for this opportunity to submit these funding and oversight recommendations for Fiscal Year (FY) 2024 on behalf of Refugee Council USA's 32-member organizations. Refugee Council USA (RCUSA) is dedicated to refugee protection, welcome, and integration, and strives to represent the interests of refugees, refugee families, and volunteers and community members across the country who support refugees and resettlement. RCUSA recommends FY 2024 funding levels of $11,188,500,000 for the Department of Health and Human Services' (HHS) Refugee and Entrant Assistance (REA) account.

The REA account funds the Office of Refugee Resettlement (ORR) within HHS' Administration for Children and Families (ACF). ORR funding provides critical Federal investments in the States and local communities that welcome refugees and is a crucial component of fostering refugee integration and economic contributions. In addition to new refugee arrivals, ORR provides essential services to refugees who have arrived in recent years, asylees, Cuban and Haitian Entrants, Iraqi and Afghan recipients of Special Immigrant Visas (SIVs), trafficking and torture survivors living in the United States, certain Amer-Asians, Afghan humanitarian parolees who arrived under Operation Allies Welcome, certain Ukrainian humanitarian paroles, and unaccompanied refugee and immigrant children.

RCUSA recommends an increase for the Transitional Medical Assistance (TAMS) program to $1,650,000,000 to fund critical initial assistance to refugees and other new arrivals, programs for vulnerable unaccompanied refugee children, and the highly effective Matching Grant program, which leverages public funds with private donations, empowering refugees to secure employment within 8 months. RCUSA also recommends increases for Refugee Support Services (RSS) programs to $950,000,000; for domestic and foreign-born trafficking survivor services to $50,000,000; for torture survivor assistance to $28,000,000; and for unaccompanied children to $8,000,000,000. We support the President's Budget Request's inclusion of a contingency fund—and recommend the use of this fund across all ORR-eligible populations—appropriated at $500,000,000. We also recommend the creation of a mental health services fund to assist all ORR populations, appropriated at $10,500,000.

Robust Appropriations to Support the Rapid Rebuild and Expansion of the Resettlement Network

Throughout the previous administration, the U.S. Refugee Admissions Program (USRAP) was steadily dismantled: refugee admissions decreased by 80 percent and one-third of all resettlement offices in the U.S. closed. From the outset, the Biden administration committed to rebuilding a robust and innovative USRAP and set an ambitious refugee admissions goal of 125,000 for FY 2022 and FY 2023. (It is likely that the admissions goal will again be set at 125,000 for FY 2024). New and urgent demands on resettlement service providers quickly followed. Since the U.S. military withdrawal from Afghanistan, over 75,000 U.S.-affiliated and at-risk Afghans have been welcomed into the United States under Operation Allies Welcome. The domestic network of resettlement agencies was quickly mobilized to receive and support the integration of this newly arrived Afghan population. There are currently more than 300 resettlement offices providing Reception & Placement (R&P) services to refugees—more than a 35 percent increase from 199 offices at the beginning of 2021.

Seven of the 10 voluntary agency networks are faith-based and harness the energy of many faith communities to help welcome newcomers to their new communities. These community organizations ensure the provision of a core set of services during someone's first months in the U.S., including the provision of food, housing, clothing, employment services, follow-up medical care, and other necessary services. After this initial period, ORR funds integration services through both the States and resettlement providers around the country.

Once refugees arrive in the U.S., they are supported in orienting to their new community, learning English, enrolling their children in school, and finding employment. With this crucial support, they often are not only able to support themselves and their families but also become contributors to their new communities, integrating with and bringing innovation to our neighborhoods—such as by starting businesses.

Critical needs within the REA account include, but are not limited to:

Legal Services and Housing Assistance for All ORR Populations, including Afghans Arriving under Operation Allies Welcome

In FY 2022 and FY 2023, Congress provided supplemental funding authorizing ORR to provide legal services for newly arrived Afghan evacuees. Evacuated Af-

ghans are distinct from other groups served by ORR given that tens of thousands arrived with humanitarian parole and rely heavily on legal counsel to file asylum claims, post-arrival Special Immigrant Visa applications, and other forms of immigration relief. Similarly, the supplemental funding for Afghans also authorized housing assistance, critical to ensuring safe and stable housing during times of high arrivals. It remains imperative that Afghans, who will continue to be served by ORR into FY24, continue to have access to legal services and housing assistance. This is particularly important, as the tens of thousands of evacuated Afghans will need help filing re-parole applications, as the vast majority have not been able to submit their asylum or SIV claims (in large part due to insufficient staff capacity).

The U.S. legal system is a complex process for any refugee or newly arrived individual to navigate, and in particular for vulnerable ORR populations. Authorizing ORR to provide legal services and housing assistance for all ORR populations would be instrumental to meeting the needs of populations who rely on counsel in a variety of respects, including to navigate U.S. immigration law (such as for family reunification petitions); to respond to the housing challenges that are particularly acute for new arrivals; and to ensure equity across all populations.

While resettlement agencies across the country are practiced at assisting refugees in adjusting their immigration status, the expansion of ORR's mandate to include a number of new populations by nationality has strained its resources and led to inequities for ORR populations who rely on, but have not yet received, legal representation or robust housing assistance. RCUSA recommends that Congress authorize housing and legal assistance for all ORR populations, and ensure that robust funding for these types of services is integrated into the Refugee Support Services (RSS) line item.

Mental Health Services and Accompanying Study

A large proportion of populations eligible for ORR services have experienced trauma. For many, such as survivors of torture, their eligibility for services is defined by the severity of the trauma they endured. As service providers increase the number of clients they serve who have experienced protracted displacement crises and have particularly acute mental healthcare needs, access to mental health services is an essential resource that must be available to all individuals served by ORR programs. Linking them to effective, comprehensive mental health care is a necessity—a prerequisite—for many to be able to find true refuge and stability in their new homes.

In recent years there has been a significant expansion in ORR's mandate to serve those in need of mental health services. There have also been ongoing challenges associated with the effective provision of mental health care to ORR populations. These include longstanding challenges with providing culturally and linguistically appropriate and accessible services, and an increase in individuals in need of specialized or intensive care. There is a need to find new programs, resources, and staffing to respond to the changing and growing mental health care needs of ORR-eligible individuals recovering from trauma. RCUSA recommends $10,000,000 to fund a pilot program for mental health services, accompanied by a $500,000 study to elucidate a path forward toward providing more comprehensive and effective mental health services to those who need it most.

Trauma-Informed Care for Unaccompanied Children

Unaccompanied children (UC) are immigrant children who arrive in the U.S. without legal guardians and who require special protections. Care for unaccompanied children is mandated by the Trafficking Victims Protection Reauthorization Act (TVPRA) and governed by the TVPRA; the Homeland Security Act of 2002; and the Flores Settlement Agreement. ORR is the legal caretaker of unaccompanied children until they can be reunited with family. ORR funds a network of shelters where UC stay while reunification happens and ORR's primary goal is the safe and secure placement of each child with a sponsoring family.

In FY 2022, 128,000 unaccompanied children arrived in the United States-an all-time high. RCUSA's recommendation of $8,000,000,000 will provide for an increased number of beds in licensed facilities. The increased arrivals over FY 2021 led to the use of both influx facilities and Emergency Intake Sites due to lack of online licensed bedspace. While the pandemic took many beds offline, ORR still needs to increase licensed placements. This funding will allow the necessary network growth in small-scale shelters, which are much better suited to meeting the needs of UC.

This critical funding will also provide universal access to post-release services (PRS) for both children and their sponsors. Post-release services are bridging services that assist children and sponsors in adjusting to their new lives together after reuniting. We know that trauma responses from migration or home-country experi-

ences often manifest after the initial "honeymoon" period ends, and access to social workers and community services is critical in these cases. Historically, around 25 percent of UC have received PRS; ORR intends to ensure 100 percent of UCs can receive PRS.

In closing, RCUSA urges Congress to adopt the above funding levels to expand welcoming capacity and provide critical investments for refugees and other populations who are integrating into local communities. Thank you for your consideration.

PREPARED STATEMENT OF ALANA RENNIX

Upward Bound has changed my life in the following ways: I have grown. The resources I have received empowered me, and I have received unique opportunities that I otherwise would not have experienced with this program. I empathize with students and young adults who have never experienced the true beauty of a TRIO program. In many ways, TRIO is extraordinary because it is a systematic response to educational inequality. Students receive tools to go to college and experience the beautiful possibilities of the world around them that they would never have dreamed of before. TRIO has allowed me to create lifelong friendships, attend college, and chase my dreams. I will forever be thankful for the mentors that believed in me, and the program that taught me that anything is possible.

[This statement was submitted by Alana Rennix, Upward Bound Alum, Davis and Elkins College, WVA.]

PREPARED STATEMENT OF RESEARCH!AMERICA

On behalf of Research!America, thank you for this opportunity to submit testimony on Labor, Health and Human Services, Education, and Related Agencies appropriations for Fiscal Year 2024 (FY24). Research!America is a non-profit, non-partisan advocacy alliance. Our more than 300 organizational members work to elevate the priority assigned to speeding the pace of medical and public health progress.

In the interests of the American people and in light of a pandemic that has taken more than 1.1 million American lives, we ask that you markedly increase resources for the National Institutes of Health (NIH), the Advanced Research Projects Agency for Health (ARPA–H), the Centers for Disease Control and Prevention (CDC), the Biomedical Advanced Research and Development Agency (BARDA), and the Agency for Healthcare Research and Quality (AHRQ) in FY24. These Federal agencies fight diseases that harm and kill Americans and people across the globe. There is no mission more urgent.

THE NATIONAL INSTITUTES OF HEALTH

NIH supports research that is conducted at universities, colleges, academic health centers, independent research institutes, and small businesses in all 50 States. That research uncovers knowledge, or targets, that the private sector translates into preventative, diagnostic, therapeutic and curative measures. This seemingly simple, public-private sector process is anything but, and the medical progress it achieves is astounding. Whether the measure is lives saved, health protected, or quality of life restored, medical progress serves individuals and society in both measurable and immeasurable ways.

Robust funding for NIH is crucial not only to the health of the American people, but to strengthening our economy and maintaining the global leadership status of the U.S. in science and technology. In FY22 alone, increases to the NIH budget generated $94.2 billion in nationwide economic activity. NIH is the largest funder of biomedical research in the world. According to a January 2023 national survey commissioned by Research!America, an overwhelming majority of Americans across the ideological spectrum believe it is important for the U.S. to be a global leader in science and technology. Yet, 77% are concerned that China could surpass the U.S. as the leading global science and technology power. Americans want to maintain this leadership role, and 62% believe Congress should invest more taxpayer dollars to achieve it.

As it stands, less than one percent of the Federal budget is allocated for medical research, NIH's purchasing power remains below what it was in 2003, and the agency can only fund about one in five of the promising research proposals it receives. We request that the Committee propel our Nation into a demonstrably faster era of life saving medical progress by allocating a 10% ($4.7 billion) increase for NIH in FY24.

NIH FOGARTY INTERNATIONAL CENTER

Charged with training promising young scientists and building research capacity and partnerships in the interests of the U.S., the Fogarty International Center is the only NIH entity focused exclusively on advancing U.S. research in the increasingly strategically significant global health arena. FIC-trained researchers have contributed to combating some of the greatest global health threats of our time, including COVID–19, Ebola, HIV–AIDS, and dangerous, drug-resistant strains of TB. Fogarty-trained researchers have also contributed meaningfully to progress against Alzheimer's and other noncommunicable diseases prevalent in the U.S. Despite the overwhelming evidence of impact, FIC has the smallest budget of any Center or Institute within the NIH, representing less than one-quarter of 1% of the Institutes' overall budget. An increase of $112 million for FIC would be a meaningful step toward elevating the Center to the priority merited by its contributions to the health and security of our Nation. We request that the Committee supplement a 10% increase across NIH Centers and Institutes with an additional $112 million to redouble FIC's efforts and impact.

THE ADVANCED RESEARCH PROJECTS AGENCY FOR HEALTH

ARPA–H is gearing up to play a unique and important role in our Nation's R&D ecosystem. It is charged with launching DARPA-like projects (intensive, large-scale, "fast-to-fail") with the potential to shatter the boundaries of medical progress. ARPA–H is "disease-agnostic;" evaluating projects not by the health threat they address, but by the promise they hold for overcoming major challenges impeding medical progress. The Committee allocated $1.5 billion to ARPA–H in FY23, and the agency has made its first funding announcements. We fully support the Committee in ensuring ARPA–H is allocated robust resources for the high impact role it is positioned to play in the R&D ecosystem. We request that the Committee also reinforce the need for safeguards to prevent commingling of funds between ARPA–H and NIH. We understand that ARPA–H is contributing to a management fund for shared administrative functions. However, to ensure NIH and ARPA–H can meet the Committees' separate and distinct expectations for each agency, NIH should refrain from devoting dollars from its separate budget to fund joint projects partially or fully with ARPA–H.

THE CENTERS FOR DISEASE CONTROL AND PREVENTION

The CDC is a Georgia-based team of public health workers from all over the United States working to protect Americans from deadly and debilitating health threats. CDC partners with local communities to prevent, detect, and contain public health threats that pose risks to us all. From tracing foodborne illnesses to containing "MRSA" outbreaks in high schools to investigating cancer clusters to combating global health threats, individuals at CDC focus on preventing, detecting, and minimizing the harm public health threats cause. Unfortunately, CDC's budget is dangerously insufficient given the range of responsibilities it fulfills as part of our Nation's health, healthcare, and homeland security systems. As the agency evolves its operations to meet responsibilities that only grow over time, we ask the Committee to allocate $11.58 billion for the CDC in FY24, a $2.36 billion increase over FY23.

BIOMEDICAL ADVANCED RESEARCH AND DEVELOPMENT AGENCY

BARDA is charged with fulfilling responsibilities that require more resources than their current budget provides. Tasked with securing the development of critical medical countermeasures for deployment and stockpiling, BARDA plays a unique and important role in our Nation's national security and public health systems. Insufficient funding for BARDA compromises our Nation's ability to protect the American people in the event of biological, chemical, or nuclear warfare or a global public health crisis. The reality is that another pandemic will descend on our Nation, tensions with competitor nations are rising, and the need for a broad portfolio of medical countermeasures has never been more apparent. Our nation cannot afford the time and dollars lost when active projects focused on chemical, biological, radiological, or nuclear (CBRN) threats must be abandoned or paused to provide funding for new and urgent infectious threats. As it stands, BARDA is not funded to meet its unique responsibilities against infectious threats like COVID–19 and Ebola. The agency must also draw down funds to meet its responsibilities in the area of antimicrobial resistance (AMR), an escalating threat to the American people and populations across the globe. To strengthen BARDA and fill these persistent funding gaps, we request an increase in BARDA's base budget of $1.59 billion in FY24, in-

clusive of a $316 million (15%) boost for CBRN and other existing funding streams, $775 million for emerging infectious threats, and $500 million for AMR.

THE AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

The value of medical progress hinges on accessible, affordable healthcare: if Americans can't access or are not well served by the healthcare system and the care that system provides, medical progress doesn't translate into health progress. Further, every dollar wasted to inefficiencies in healthcare needlessly contributes to rising healthcare costs. AHRQ and the health services and primary care research it supports play a crucial role in our Nation's R&D ecosystem by ensuring medical progress becomes healthcare progress.

Unfortunately, against the healthcare challenges our Nation faces, AHRQ is significantly under-resourced. The U.S. spends more on healthcare on a per capita basis than any other OECD nation, yet we lag other nations across a range of key health indicators. Dramatic geographic variation in health delivery and outcomes, as well as persistent disparities across different racial and ethnic groups, is a destabilizing force and unjust reality in the U.S. that can and should be addressed. Equipping AHRQ with the necessary funding is a crucial, yet often overlooked, part of improving health and healthcare. We request the Committee allocate $500 million for AHRQ in FY24, a $127 million increase over FY23.

Thank you for considering our testimony, and for your efforts, and those of your respective staff members, on behalf of us all.

Sincerely.

[This statement was submitted by Ellie Dehoney, Senior Vice President of Policy and Advocacy, Research!America.]

PREPARED STATEMENT OF THE RESTLESS LEGS SYNDROME FOUNDATION

Chairwoman Baldwin, Ranking Member Capito, and distinguished members of the subcommittee, as you work to develop the fiscal year (FY) 2024 Labor-Health and Human Services Appropriations bill, thank you for considering the views of the community of physicians, researchers, patients, and caregivers affected by Restless Legs Syndrome (RLS). Please keep the needs of this community in mind, especially as you continue to work to address the opioid crisis.

ABOUT THE RLS FOUNDATION

The Restless Legs Syndrome Foundation is a nonprofit § 501(c)(3) organization dedicated to improving the lives of men, women, and children living with this often-devastating neurological condition. The Foundation works to increase awareness, improve treatments, and support research to find a cure. From a few volunteers meeting in a member's home in 1992, the Foundation has grown steadily; it now has members in every State, local support groups, and a track record that includes nearly $2 million provided to support translational research.

ABOUT RLS

Restless legs syndrome (RLS) is essentially an irregular biological drive, like hunger or thirst, that forces affected individuals to keep moving, thus reducing their ability to rest. Patients with this disease experience a deep, viscerally irritating sensation in the legs that continues to increase until they are literally forced to move their legs or get up and walk; and this sensation only abates so long as the individual keeps moving. RLS is best characterized as a neurological, sensory-motor disorder with symptoms that are triggered from within the brain itself. It is estimated that up to 5 to 7 percent of the U.S. population may have RLS, of which half will have moderate to severe stages of the disease. RLS impacts men, women, and children, though it is 3 to 4 times more common in women and twice as common in older Americans.

Due to the inability to sleep and work, RLS can cause disability, depression, and suicidal ideation, as well as increased risk for co-morbid conditions such as heart attack, stroke, and Alzheimer's. There is no cure, and the current standard of care features several medications, which do not provide life-long coverage. One of the established effective treatment options for this disease is low-total- daily dose opioid medication; a class of medication used when all other drug classes have failed due to augmentation, inadequate efficacy, or adverse side-effects. Research and clinical experience indicate that the dose of opioids typically used to manage RLS effectively

without addiction or drug tolerance issues is significantly lower than dosages used to treat chronic pain.

FISCAL YEAR 2024 APPROPRIATIONS RECOMMENDATIONS

The RLS Foundation joins the broader medical research community in thanking Congress for continuing to support the National Institutes of Health with sustainable growth. Please continue to advance scientific progress through proportional funding increase for FY 2024 and overall funding for NIH's at $50 billion.

In this regard, please provide proportional funding increases for all NIH Institutes and Centers, including, but not limited to the National Institute of Neurological Disorders and Stroke (NINDS), the National Heart, Lung, and Blood Institute (NHLBI), the National Institute on Drug Abuse (NIDA), and the National Institute of Mental Health (NIMH). Research on RLS and similar neurological movement disorders is directly related to efforts targeting the opioid epidemic, as many patients with these disorders utilize very low total daily doses of opioid therapies to manage their condition. Additionally, related sleep disorders research activities impact many conditions and are studied across various Institutes and Centers at NIH.

Please provide $5 million for the National Neurological Conditions Surveillance System (NNCSS) for FY 2024. The NNCSS at the Centers for Chronic Disease Control and Prevention (CDC) collects and synthesizes data to help increase our understanding of neurological disorders and to support further neurologic research. RLS remains a severely misunderstood and underdiagnosed neurological disorder, and increased surveillance is vital to improving patient outcomes.

Please provide at least $6,000,000 for the Chronic Diseases Education and Awareness Program at the Centers for Disease Control and Prevention (CDC). With the cessation of the National Healthy Sleep Awareness Project (NHSAP), CDC presently has no active public health activities dedicated to sleep or sleep disorders, even though sleep affects nearly every body system and many chronic diseases. Please allow the valuable scientific and public health efforts started during the NHSAP to continue.

RLS AND THE OPIOID CRISIS

While you consider the Committee's work to address the opioid epidemic through this fiscal year's appropriations bill, the RLS Foundation asks that you protect the needs of patient communities who depend on appropriate access to low total daily doses opioid therapy to manage their debilitating condition. RLS is not a chronic pain condition, and many in our community utilize these medications to treat underlying neuropathology issues and not sensations of pain. Studies have shown that appropriate access to these therapies allows patients to live productive lives without an increased risk of developing opioid use disorder. As you consider various legislative proposals and work with Federal agencies, please consider the needs of patients who rely on the regular use of low total daily doses of opioids to manage RLS by supporting a diagnosis-appropriate safe harbor for RLS patients, so they do not face arbitrary barriers.

I would like to share with you the experience of Stephen Smith from Colorado, a RLS Foundation Discussion Board Moderator. Like all those with RLS, night can bring a feeling of dread. Is this going to be one of those nights when my RLS acts up and I don't get any sleep, or will it just be one of those standard nights when my sleep is just poor? About a year ago, I had one of those nights when my RLS acted up and I knew that I wasn't going to get any sleep at all. So, I called my doctor's night service and was instructed to go to the local hospital's Emergency Room and to tell them to call my doctor. Contrary to hospital policy, the ER doctor decided not to call and also didn't understand RLS or my insomnia complaints. But he jumped on my depressed feelings from insufficient sleep combined with my RLS pacing, which he assumed was agitation, and the opioid that I take for RLS. He then incorrectly concluded I had a drug problem and was suicidal despite being told that I was not. So, he placed me under a 72-hour psychiatric hold and sent me to a psychiatric hospital 3 hours away. I was shipped 180 miles confined to the back seat of a car with raging RLS. The psych hospital didn't carry one of my RLS meds, Tramadol, and forced me to go into withdrawal rather than go to the effort to replace it. The abrupt withdrawal from Tramadol led to hours of shakes and sweats followed by even more hours of RLS-like pacing for the second night in a row. Since Tramadol also acts as an SNRI anti-depressant, the abrupt withdrawal caused me to develop SNRI Withdrawal Syndrome. This caused migraine headaches, severe anxiety and depression, nightmares and dreams centered on the horrible experience of being involuntarily confined to the psych hospital due to a neurological disorder. These symptoms went on for months and required drug treatment for anxiety and

psychotherapy for the severe depression. So, now nightfall brings a feeling of trepidation. Is this going to be another night when my RLS acts up or I cannot fall asleep? If I do manage to sleep, will I once again dream of the nightmare of being confined to the psych hospital all due to failure of several doctors to understand RLS or to even listen to their patient who is trying to educate them?

Thank you again for the opportunity to share the views of the RLS community.

[This statement was submitted by Karla M. Dzienkowski, RN, BSN, Executive Director, Restless Legs Syndrome Foundation.]

PREPARED STATEMENT OF ROTARY INTERNATIONAL

Chairwoman Baldwin, Ranking Member Moore Capito, and members of the subcommittee: Rotary appreciates the opportunity to encourage continued funding for FY24 to support the polio eradication activities of the U.S. Centers for Disease Control and Prevention (CDC). The CDC is a spearheading partner of the Global Polio Eradication Initiative (GPEI), an unprecedented model of cooperation among national governments, civil society and UN agencies which reaches the most vulnerable children through safe, cost-effective polio immunization. Rotary International requests $276 million for the polio eradication activities of the CDC, within the Global Health account, to capitalize on unprecedented low levels of endemic polio virus transmission which has been threatened by reduced population immunity levels following the COVID–19 pandemic. These funds will support the GPEI's priority of stopping all forms of polio virus transmission through high quality immunization campaigns. These funds will also provide vital support for surveillance activities which provide confidence in both the presence and absence of polio virus transmission. The 300,000 members of Rotary clubs in the US appreciate the United States' generous support and longstanding leadership toward a polio free world. Continued US leadership will help achieve a polio free world—a value-added achievement with broader global health benefits.

AN URGENT OPPORTUNITY TO ACHIEVE ERADICATION

The CDC's leadership within the Global Polio Eradication Initiative (GPEI) has contributed toward a 99.9 percent decline in global polio cases since 1988. Five of the six regions of the world have been certified free from the wild polio virus. Eradication efforts have also successfully wiped out two of the three wild poliovirus strains. Today, Pakistan and Afghanistan are the only two countries in the world with endemic transmission of wild polio virus, and the virus has been cornered to a limited area in both countries.

However, ongoing challenges threaten over thirty years of progress, the US investment of more than US$4.5 billion, and the current window of opportunity to eradicate polio. In 2022, a 3-year-old girl from Malawi was identified as having contracted the first case of wild polio in Africa since 2016. The virus that infected this child originated in Pakistan. Eight cases related to this virus were also confirmed in neighboring Mozambique between March and August of 2022. The unprecedented flooding caused by Cyclone Freddie represents a new threat to the spread of polio and other infectious diseases. Perhaps most disturbing, the United States saw the first case of polio paralysis in decades, and virus was detected in the wastewater of several counties in New York. This potential outbreak was contained, and no further cases were identified. It is a reminder that polio anywhere is a threat everywhere, even in the United States.

Outbreaks of variant poliovirus (VDPV) also continued in 2022. These outbreaks can occur if the weakened strain of the poliovirus contained in the oral polio vaccine (OPV) circulates among under and unimmunized populations for a prolonged period, and they have increased following setbacks in population immunity in the wake of the COVID–19 pandemic.

Poliovirus transmission, either due to wild poliovirus or variant poliovirus, is now primarily affecting just seven subnational geographic areas, which together now account for 90% of all new polio cases worldwide. Conflict and instability is a key characteristic in nearly all of these areas, jeopardizing progress and hampering efforts to conduct polio eradication activities.

CDC'S VITAL ROLE IN GLOBAL POLIO ERADICATION PROGRESS

The United States is the leader among donor nations in the drive to eradicate polio globally. Congressional support to CDC has been key in progress and has supported the following essential polio eradication activities:

Global leadership on surveillance and disease detection:

CDC's Atlanta laboratories serve as a global reference center and training facility, providing expertise in virology, diagnostics, and laboratory procedures, including quality assurance, and genomic sequencing of samples obtained worldwide, and training virologists in advanced poliovirus research and public health laboratory support. CDC also provides the largest volume of operational and technologically sophisticated lab support to the 145 laboratories of the Global Polio Laboratory Network (GPLN). CDC also developed a method to directly detect poliovirus from patient stool specimens. In 2022, in addition to sequencing samples from around the world, the CDC's polio laboratory determined genetic linkage between wastewater specimens in New York State, Canada, the United Kingdom and Israel. CDC's polio lab also tested more than 2,000 wastewater samples from the New York state area. Virus was last detected in New York state in March of 2023.

Essential technical capacity and program management expertise:

CDC builds in-country capacity through the international assignment of technical staff on direct 2-year assignments to WHO and UNICEF to assist polio-endemic and polio-reinfected priority countries. CDC also provides technical support through the Stop Transmission of Polio (STOP) program. STOP provides expertise on polio surveillance, data management, campaign planning, implementation and evaluation, program management, and communications in high-risk countries.

Vital country capacity:

In Pakistan, CDC supports several officers and consultants to assist with data analysis, visualization, impact assessment and interpretation to support field vaccination teams, provincial and district Emergency Operations Centers, and the Federal Ministry of Health.

FISCAL YEAR 2024 BUDGET REQUEST

Rotary respectfully requests $276 million in FY2024 for the polio eradication activities of CDC. These funds will enable the CDC to intensify efforts in Pakistan, Afghanistan, and key geographies to interrupt wild poliovirus transmission, provide aggressive and rapid response to outbreaks of variant poliovirus, and enhance surveillance activities. CDC's technical and management expertise is vital to supporting these objectives in polio endemic, outbreak and at-risk countries, building country level capacity to prevent future outbreaks and capacity to quickly identify and respond to outbreaks.

Increased funding is needed to address three specific areas critical to protecting existing progress and capitalizing on the window of opportunity to stopping transmission of all polio viruses: Outbreak Response, Surveillance and Vaccine Procurement.

Outbreak Response:

Increased funding is needed to improve outbreak response planning and execution improvements such as:

—utilizing and expanding existing in country government coordination mechanisms to establish polio control rooms, enabling the use of real-time data for decision-making and an incident management structure to streamline emergency operations;

—accelerating emergency outbreak response through the establishment of incident command structures at global, regional and country level to guide and direct outbreak response;

—digitizing the entire outbreak response, from planning to campaign monitoring and utilizing an evidence-based approach for clear assessments of response coverage and quality, including age and sex disaggregated monitoring data; and

—ensuring a stronger role for women in outbreak response operations through increased participation in outbreak response oversight, management, supervision and delivery.

Surveillance:

Investments to improve surveillance include implementation of a direct detection strategy as well as investment in lab infrastructure and data information management to increase regional and country capacity to detect and respond to outbreaks and improve the quality and timeliness of surveillance. Active surveillance, enhanced use of community-based surveillance in hard-to-reach areas; and expanded use of environmental surveillance are also high priorities. Surveillance has been key to the recent detection of polio viruses in settings considered to be long polio-free, underscoring the importance of ensuring robust and diverse surveillance mecha-

nisms to provide confidence in both the presence and absence of polio virus transmission.

Vaccine Procurement:

Additional funds will support procurement of vaccines, including the novel oral polio vaccine (nOPV2), a tool that has been demonstrated to accelerate control of circulating vaccine derived polio type 2. Since March of 2021, over 500 million doses of nOPV2 have been administered across 23 countries.

BENEFITS OF POLIO ERADICATION

Since 1988, tens of thousands of public health workers have been trained to manage massive immunization programs and investigate cases of acute flaccid paralysis. Cold chain, transport and communications systems for immunization have been strengthened. The global network of 145 laboratories and trained personnel established by the GPEI also tracks measles, rubella, yellow fever, meningitis, and other deadly infectious diseases including COVID–19 and will do so long after polio is eradicated. $27 billion in health cost savings has resulted from eradication efforts since 1988. Investing in polio eradication now may cumulatively save an estimated $33.1 billion by 2100 in the form of reduced costs of surveillance and vaccination. The costs to control polio at today's low levels, plus costs to treat the survivors, would be over $1 billion per year for decades to come. Polio eradication is a cost-effective public health investment with permanent benefits. As many as 200,000 children could be paralyzed annually in the next decade if the world fails to capitalize on the more than $18 billion already invested in eradication.

PREPARED STATEMENT OF THE RYAN WHITE MEDICAL PROVIDERS COALITION

My name is Dr. Christa Nevin, and I serve as Director of the University of Alabama at Birmingham (UAB) 1917 Clinic. I am pleased to submit testimony on behalf of the Ryan White Medical Providers Coalition (RWMPC), a national coalition of medical providers and administrators who work in healthcare agencies supported by the Ryan White HIV/AIDS Program funded by the HIV/AIDS Bureau at the Health Resources and Services Administration (HRSA). I want to thank the subcommittee for increasing FY23 funding for several parts of the Ryan White Program that support access to HIV care and treatment, as well as for increasing funding for the Ending the HIV Epidemic (EHE) initiative at both HRSA's HIV/AIDS Bureau and Bureau of Primary Health Care as well as at CDC's Division of HIV Prevention. These increases will help ensure access to effective, comprehensive HIV care and treatment through the Ryan White Program nationwide as well as help targeted EHE initiative jurisdictions increase access to HIV testing, prevention, care, and treatment services critical to reducing HIV transmission and achieving the bipartisan goal of ending the HIV epidemic in the U.S. Increasing funding for the Ryan White Program parts in FY24 would help jurisdictions nationwide continue to deliver comprehensive, effective HIV care and treatment, and engage and retain new patients in a challenging environment impacted by rising care and workforce costs. To sustain access to critical services, I request $231 million (a 10.5% increase) in FY24 for Ryan White Part C, which supports approximately 350 HIV medical clinics nationwide.

RWMPC also requests funding for HRSA's and CDC's EHE initiatives to expand access to HIV prevention, care, and treatment. This funding includes $330 million for the Ryan White Program EHE initiative to provide additional HIV care and treatment; $207.3 million for the Bureau of Primary Health Care EHE initiative to support HIV prevention services; and $495 million for the EHE initiative at CDC to expand access to HIV prevention, including $200 million for a national PrEP initiative to expand access to Pre-Exposure Prophylaxis (PrEP), a medication that prevents HIV, nationwide.

It is important that increases for Ryan White Part C and the EHE initiatives be new, additional funding and not a repurposing of current resources. Pressures on the medical system and its providers, including Ryan White clinics, is significant and limited resources cannot be stretched further.

The UAB 1917 Clinic Has Expanded Access to HIV Prevention, Care, & Treatment

The University of Alabama at Birmingham (UAB) 1917 Clinic has served as the leading source of HIV primary care in Alabama since 1988 and is a Ryan White Part C grant recipient. The program remains the largest HIV provider in the State and now serves over 3,600 individuals living with HIV, most with complex medical and psychosocial needs. Reflective of the community we serve, 65% of clients are

Black, 30% white and 3% identify as Hispanic. More than half (56%) of our clients live below the poverty line. Like other HIV clinics across the US, ours serves an increasingly aging population, with a high burden of co-morbid illnesses such as cancer, cardiovascular disease, and metabolic complications. Additionally, approximately two-thirds of our clients have at least one mental health diagnosis and many have comorbid substance use disorder that can further complicate engagement and retention in HIV care. Despite these challenges, more than 90% of our patients are virally suppressed and more than 90% have been seen by a medical provider in the last 12 months. These positive outcomes are made possible by Ryan White Part C funding that allows us to provide comprehensive medical and social support services, including antiretroviral therapy (ART), subspecialty medical care, nutrition, temporary housing, and transportation services.

Unfortunately, we continue to see a steady influx of newly diagnosed persons (approximately 20 patients per quarter in 2022) consistent with national data showing increased incidence of HIV in the Southeast. This emphasizes the importance of continued HIV prevention efforts. In addition to HIV treatment, the 1917 Clinic also supports HIV Pre-Exposure Prophylaxis (PrEP) services. We have 75 active patients, most of whom are male (93%), white (71%), 25–44 years of age (53%), and privately insured (100%). While we are proud of these efforts, these demographics do not reflect the HIV epidemic, and more support is needed to get this critical and effective HIV prevention tool to the people who need it.

Ryan White Part C Clinics are Effective Medical Homes that Save Lives & Reduce Costs

The Ryan White HIV/AIDS Program of the Health Resources and Services Administration (HRSA) is critical to ensuring that individuals with HIV have access to the care and treatment needed to stay healthy and stop HIV transmissions. The program serves more than 575,000 clients in communities across the Nation, with the demand for services rising. Ryan White Part C directly funds approximately 350 community health centers and clinics that provide comprehensive HIV medical care, serving more than 300,000 patients each year.

These clinics are the primary method for delivering HIV care to rural jurisdictions—approximately half of all Part C providers serve rural communities. The program's comprehensive services engage and keep people in HIV care and treatment. This is critical, because HIV disease is infectious, so identifying, engaging, and retaining individuals living with HIV in effective care and treatment saves lives and benefits public health by stopping HIV transmission when individuals are virally suppressed.

In 2021, nearly 90% of Ryan White patients were virally suppressed—a 29% increase in the program-wide viral suppression rate since 2010. In 2022, 92% of 1917 Clinic patients were virally suppressed. The Ryan White Part C program's comprehensive services engage and keep people in HIV care and treatment—98% of HIV patients are on antiretroviral therapy at the 1917 Clinic. Early, reliable access to HIV care and treatment helps patients with HIV live healthy and productive lives and is more cost effective. A study from the University of Alabama at Birmingham (UAB) 1917 Clinic found that patients treated at later stages of HIV disease required 2.6 times more health care dollars than those receiving earlier treatment meeting Federal HIV treatment guidelines.

Cuts to the Ryan White Program Would Jeopardize Health, Increase Costs, and Worsen Workforce Shortages

Funding for the core parts of the Ryan White Program, such as Part C, has been mostly flat for the past 12 years, resulting in reduced resources because of rising costs and medical inflation. Despite these limited resources, Ryan White clinics have responded to increased demand for care, delivering effective services to a growing number of patients. However, funding has been stretched to capacity and workforce bandwidth limits have been reached. If Congress cuts current funding, it will reduce provider capacity to deliver the multidisciplinary, comprehensive care that has helped to significantly improve the health of people living with HIV as well as the Nation's public health by reducing the number of new HIV cases. Some clinics would close or limit their hours, resulting in fewer patients being served or longer wait times for crucial care, and most clinics would reduce services, especially critical support services such as transportation and nutrition support that engage patients in care and provide them sufficient food to take required medication. Backtracking on the services that have enabled the Ryan White Program's critical success not only would reduce individual and public health outcomes, but also would increase long-term health care costs.

Cuts also would have a major impact on an already depleted HIV health care workforce. Ryan White Program workforce costs have risen in recent years due to HIV workforce shortages that have been compounded by the critical role that the ID and HIV workforce played in the COVID–19 pandemic response. Reducing funding would exacerbate HIV workforce shortages, limiting the care capacity of Ryan White Program clinics. Additionally, it would reduce the impact of the AIDS Education and Training Centers (AETCs) that deliver HIV workforce development and HIV prevention and treatment clinician consultation services essential to rural and other underserved areas. Cuts would reduce the capacity of AETCs to provide consultation services just as demand for these services is growing due to the increase in "health care deserts" created by hospital closures and worsening geographic disparities.

Funding to Support Recruitment and Retention of Infectious Diseases and HIV Medical Providers is Paramount to Help Respond to Worsening Workforce Shortages

I also urge Congress to provide $50 million for the Bio-preparedness Workforce Pilot Program. The pilot was authorized last year in the final FY23 omnibus appropriations bill as part of the PREVENT Pandemics Act. It created a loan repayment program to help ensure the U.S. has an equitably distributed Infectious Diseases (ID) and HIV workforce to respond to HIV and other infectious diseases and improve pandemic and emergency preparedness. The pilot is the first loan repayment program available to health care professionals providing ID or HIV services in health professional shortage areas, with underserved patient populations, and at certain federally funded facilities and clinics, including Ryan White clinics and VA facilities.

The new program would help address the shortage of clinicians caring for people living with HIV and draw more health care professionals to high need areas. It is estimated that nearly 80% of U.S. counties do not have a single ID physician. A study of the HIV workforce in 14 southern States found that more than 80% of those States' counties had no HIV clinicians. The ID workforce is integral to nearly all aspects of health care and to preventing and responding to public health threats, including antimicrobial resistance, bacterial and fungal infections associated with the opioid epidemic, and persistent epidemics including HIV and viral hepatitis.

CDC's EHE Initiative, including a National PrEP Program, Will Help End the HIV Epidemic

I request $495 million for CDC's EHE initiative, including $200 million for a national PrEP initiative to advance the bipartisan goal of ending the domestic HIV epidemic. While 1.2 million individuals could benefit from Pre-Exposure Prophylaxis (PrEP), a highly effective form of HIV prevention available as a pill or a long-acting injection, only 25% have been prescribed PrEP. Low PrEP access and uptake prevents the Nation from preventing thousands of new HIV infections each year as well as the substantial lifetime costs associated with each new infection. A recent article published in the Journal of Law Medicine and Ethics estimated that every 1,000 monthly PrEP prescriptions would cost $80,000.[1] Six thousand monthly prescriptions would cost less than $500,000, the lifetime value of just 1 prevented HIV infection. A strong national PrEP program would help to improve health and reduce costs by increasing ready access to affordable PrEP medication and required medical services. Congress included resources for a national PrEP initiative in its final FY2023 Consolidated Appropriations Act, and it should build upon this down payment in FY24 to expand the initiative to communities nationwide.

SSP Services Are Needed to Prevent Overdose and Infectious Diseases Outbreaks

I also request $150 million for CDC's Infectious Diseases and Opioid Epidemic (IDO) program to address the infectious diseases consequences of the drug epidemic by expanding access to overdose prevention and syringe services programs (SSPs). The U.S. drug crisis has dramatically increased overdose deaths and infectious diseases outbreaks with a 46% increase in overdose deaths since January 2020 and spikes in viral hepatitis and HIV infections throughout the U.S. among people who inject drugs. SSPs serve as first responders by effectively preventing drug overdoses and new HIV, hepatitis, and other infections. They provide naloxone and other overdose prevention, and connect people to medical care and support, including Substance Use Disorder treatment. A recent study showed that overdose deaths not only cost lives, but also over $1 trillion per year to the U.S. economy. Funding for

[1] Killelea A. Financing and Delivering Pre-Exposure Prophylaxis (PrEP) to End the HIV Epidemic. 2022.

the IDO program would provide resources to reduce overdoses and the spread of infectious diseases—saving lives and reducing costs.

Research at NIH

Finally, I request continued robust funding for HIV research at NIH. Investments in HIV/AIDS research are essential to ending HIV as an epidemic, improving HIV prevention and treatment, and developing a cure and vaccine. The return on investment in HIV research extends beyond HIV, contributing to improvements in hepatitis C and cancer therapies, among others.

Conclusion

Thank you for your time and consideration of this testimony. If you have questions, please don't hesitate to contact me or RWMPC Convener, Jenny Collier, at jcollier@colliercollective.org.

[This statement was submitted by Christa Nevin, MD, Director, University of Alabama at Birmingham 1917 Clinic and Steering Committee Member, Ryan White Medical Providers Coalition.]

PREPARED STATEMENT OF SAFE STATES ALLIANCE

Safe States Alliance, a 700+ member national association dedicated to strengthening the practice of injury and violence prevention, appreciates the opportunity to provide testimony in support of injury and violence prevention (IVP) programs at the Centers for Disease Control and Prevention's (CDC) National Center for Injury Prevention and Control (NCIPC). Safe States Alliance requests consideration of the following priorities in the FY2024 Labor, Health and Human Services and Education Appropriations bill:

Building Capacity

Expand and Strengthen State Prevention Capacity

—Provide $12.7 million to help move toward the goal of ensuring all States, territories and the District of Columbia are funded under the Core State Injury Prevention Program (Core SIPP) which provides baseline support to state injury and violence prevention programs.
—Allocate $18 million for the Injury Control Research Centers to conduct interdisciplinary research and provide training for the future injury and violence prevention workforce.
—Expand funding for the Preventive Health and Health Services (PHHS) Block Grant to $175 million to provide flexible support for state specific public health priorities.
—Preserve funding allocated through the Prevention and Public Health Fund and ensure that sufficient resources exist to support injury and violence prevention efforts.

Prevent Unintentional Injuries

Motor Vehicle-Related Injuries and Deaths

—Provide $15.5 million to collect and analyze health- and crash-related data, employ evidence-based strategies to increase occupant protection, reduce impaired and distracted driving, support teen driving/graduated driver licensing, and provide state/tribal-specific technical assistance to identify and evaluate interventions.

Older Adult Falls

—Provide $6 million to expand clinical fall prevention, such as the Stopping Elderly Accidents, Deaths, and Injuries (STEADI) program; provide training to health care professionals; increase surveillance and educate the general public.

Prescription Opioid Misuse and Overdoses

—Provide $550 million to support the Overdoes Data to Action program, fund research, provide training, and assure all States, territories and the District of Columbia can coordinate efforts to reduce prescription drug overdoses through surveillance; convening partners; identifying, implementing and evaluating prevention strategies; and working with clinical providers to reduce prescription drug overdose.

Traumatic Brain Injuries (TBI)

—Provide $11.75 million to expand TBI surveillance and prevention efforts including developing and implementing a national concussion surveillance system; identifying

Prevent Violence

—Provide $34.5 million to enhance the National Violent Death Reporting System (NVDRS) after its recent expansion to all 50 States.

—Provide $35 million to CDC for research on the causes and prevention of firearm-related violence and injuries.

—Provide $100 million to support domestic violence, intimate partner violence, teen dating violence and rape prevention, including the National Intimate Partner and Sexual Violence Survey (NISVS), DELTA FOCUS, and Rape Prevention and Education (RPE) program.

—Provide $268 million for youth violence prevention-related investments, including $250 million for a new Community Violence Intervention Initiative (CVI).

Excellence in Youth Violence Prevention

—Provide $80 million to support comprehensive State and Tribal suicide prevention strategies and expand research to improve data collection and prevention strategies.

BACKGROUND

In 1985, the Institute of Medicine (IOM) first called attention to the lack of recognition and funding for injury and violence prevention (IVP) as a public health issue in the United States. Although some progress has been made, injuries and violence continue to have a significant impact on the health of Americans and the healthcare system, as more people ages 1–44 die from injuries than from any other cause, including cancer, HIV, or the flu.

As a leading authority, NCIPC protects Americans by:

—Tracking data and trends on fatal and nonfatal injuries;

—Researching what works to prevent injuries and violence and putting it into practice;

—Funding programs and activities to prevent overdose, suicide, adverse childhood experiences (ACEs), and more;

—Collaborating with partners to raise awareness; and,

—Providing Americans information to protect themselves, their families, and communities.

Each year 192,000 people die because of violence and unintentional injuries. Specifically, NVDRS and Core SVIPP are State-based programs that fund State efforts to prevent deaths from violence and injuries. Not only are injuries the leading cause of death for children and adults between the ages of 1 and 44, injuries and violence cost the U.S. $4.2 trillion each year.

NVDRS AND CORE SIPP

The NCIPC administers a wide range of data collection and prevention programs including NVDRS and the Core SIPP. NVDRS is a State-based surveillance system that links information from multiple data sources-death certificates, state/local medical examiner, coroner, and law enforcement records-to create a more complete picture of the circumstances surrounding violent deaths. One of the hallmarks of the system is that it does not require the collection of any new data; it simply supports centralization of data already collected when a violent death occurs. The system tracks deaths caused by child abuse, domestic abuse, suicide, and homicide, which enables States to develop effective strategies to address root causes and implement prevention programs. Furthermore, the NVDRS allows the public health research community to access a rich data set that can be analyzed to study the circumstances that lead to violent deaths in our communities.

The Core SIPP is the sole Federal program that supports States as they build the 'core' infrastructure required to design and implement injury and violence prevention programs. States use this funding stream to build, strengthen, and maintain their injury and violence prevention programs with a focus on making the best use of the data, designing, implementing, and evaluating prevention programs, and affecting public behavior and knowledge on these issues.

Unfortunately, only 23 States (growing to 26 with a $1 million increase in FY23) currently receive Core SIPP support due to nearly two decades of level funding. Additionally, grants have been capped at $250,000 per State for the past decade, which results in limited dollars to support growing state violence and injury prevention

needs. The issues of injury and violence are a national problem and additional funding in FY 2024 will help move Core SIPP towards a national program that invests in 'core' functions of a State health department injury and violence prevention division.

CONCLUSION

Preventable injuries and violence exact a heavy burden on Americans through premature deaths and disabilities, pain and suffering, medical and rehabilitation costs, disruption of quality of life for families, and disruption of productivity for employers. Strengthening investments in public health IVP programs is a critical step to keep Americans safe and productive for the 21st century. Safe States Alliance would like to thank the Committee for consideration of this testimony.

[This statement was submitted by Richard Hamburg, Executive Director, Safe Sates Alliance.]

PREPARED STATEMENT OF SAFER FOUNDATION

Thank you, Chairwoman Baldwin, Ranking Member Moore Capito, and members of the subcommittee, for inviting me to submit testimony on behalf of the Safer Foundation. My name is Kevin Brown and I serve as the Sr. Director of External Affairs & Community Partnerships for the Safer Foundation. For 50 years, Safer has provided comprehensive workforce development and reentry services for individuals with criminal legal histories seeking employment. There is dignity in work, and Safer Foundation believes that individuals who have made mistakes should have the opportunity to be self-sufficient and contribute to their families and communities through gainful, living wage employment. Clients come to Safer Foundation because they want and need to work, and Safer helps clients discover career path employment that is personally fulfilling and that pays a living wage.

A critical Federal program that supports these efforts is the Reentry Employment Opportunities (REO) program (also known as the Reintegration of Ex-Offenders (RExO) program) within the Department of Labor's Employment & Training Administration. I thank the subcommittee for providing REO with $115 million in FY23. Given the need to train people for the jobs our economy requires in industries such as health care, technology, and logistics; to help employers identify the qualified workers they need now; and to help people with criminal legal histories find living wage employment to support successful, long-term reentry, I urge the subcommittee to provide $170 million for the REO program in FY24.

Authorized by section 169 of the Workforce Innovation and Opportunity Act (WIOA), the REO program provides workforce preparation and reentry services for both adults and young people. REO includes a set-aside to provide services to prepare youth who are justice-system involved and/or who have not completed school or other educational programs for employment. Research has found that incarceration reduces a formerly incarcerated person's earning potential by more than 52 percent,[1] making workforce development services essential for long-term employment and reentry success. In light of the costs of the criminal legal system at the State, local, and Federal levels, the REO program is crucial to incubating community-based models of successful reentry through employment.

REO is the only Federal program that focuses specifically on workforce development and employment for people with records. Significant funding cuts and caps to non-defense discretionary programs, like REO, would undo bipartisan programs that achieve long-term reentry success and improve public safety. As the economy recovers and workforce needs continue to evolve and change, it is essential to ensure that the significant number of people with criminal legal histories has the reentry supports and workforce training needed to achieve gainful employment and long-term reentry success. Developing this pool of trained, talented, and motivated workers also will help fill the workforce gaps employers currently face, especially in sectors with critical worker shortages. For these reasons, Congress should continue funding and significantly expand the program in FY24 to $170 million.

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[1] Craigie Terry-Ann; Grawert, Ames; Kimble, Cameron, Stiglitz, Joseph (2020); Conviction, Imprisonment, and Lost Earnings: How Involvement with the Criminal Justice System Deepens Inequality: https://www.brennancenter.org/our-work/research-reports/conviction-imprisonment-and-lost-earnings-how-involvement-criminal.

Employment Reduces Recidivism and Improves Reentry Outcomes

1 in 3 adults in the United States has a criminal record that interferes with their ability to find a job.[2] Research shows that sustained, living wage employment and life skills are critical components to long-term reentry success. One study found that individuals who were employed and earning higher wages after release were less likely to return to prison within the first year.[3] The REO program improves reentry success by working with individuals to overcome employment barriers with training for jobs in local high-demand industries through career pathways and industry-recognized credentials and by providing needed reentry supports. Increasing REO funding would expand access to these comprehensive workforce development and reentry services that are especially needed now to ensure that the U.S. doesn't leave a third of its adult workforce on the table on account of a past arrest or conviction record.

Safer's REO-Supported Services Increase Employment by Working with Both Employers and Employees

Safer Foundation offers comprehensive workforce development and reentry services that train individuals, address their reentry obstacles and needs, and help them obtain sustained employment. This holistic approach has rendered outstanding results for both participants and employers. In 2006, decades of experience and success led Safer to become one of the original REO grantees.

In addition to working with reentering individuals and their communities, Safer works closely with employers to identify what types of trained employees are needed. As recently as November 2022, the National Federation of Independent Business (NFIB) found that 59% of businesses owners reported hiring or trying to hire. 92% of those hiring or trying to hire reported few or no qualified applicants for available positions. Small businesses are reporting that labor quality remains their top operating problem with 37% percent of owners have openings for skilled workers.

One of REO's greatest successes is helping participants find and retain jobs in one of three top industries: (1) construction; (2) food and hospitality; and (3) transportation, logistics, and warehousing. According to Associated Builders and Contractors, the construction industry is facing a labor shortage and must hire an additional 545,000 workers this year beyond its typical pace in order to meet expected demand. Additionally, the Logistics Group industry trends for 2023 lists labor market strains as a continued trend. Employment is one of the most critical factors for long-term reentry success—the REO program connects returning residents to work to support themselves and their families; reduces recidivism resulting in increased public safety; and helps employers hire the skilled and qualified workers they need.

Safer's Training to Work (T2W) program, that was funded in part with a REO grant, improved long-term employment prospects for clients at Safer's Adult Transition Centers (ATC). Participants received case management, education, and training that led to industry-recognized credentials for in-demand employment, such as forklift operation, welding, computer numerical control (CNC) operation, licensed commercial driving (CDL) occupations, and Microsoft technologies training. Given the program's strong employer and credentialing components, REO is uniquely positioned to assist local organizations in developing and providing services that meet the needs of both the local business community and reentering individuals. Increasing REO funding in FY24 to $170 million, including funding for earn and learn apprenticeship opportunities for in demand skills development, would expand these efforts and help provide employers with more qualified employees who are trained, talented, motivated to work.

Safer's REO Grant Produced Outstanding Employment Outcomes and Reduced Recidivism

Safer's REO grant for the Training to Work (T2W) program significantly outperformed employment targets and dramatically reduced recidivism. For the first cohort of REO T2W participants, 69% of participants obtained employment—15% higher than the grant's employment target. Given the success of this first cohort of participants, T2W was expanded to include a second cohort who did even better with an employment rate of 78%—30% higher than the grant's target. Safer's REO T2W grant also reduced recidivism rates beyond original targets. T2W's first participant cohort had an 11% recidivism rate, and its second participant cohort had a 9%

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[2] "Research Supports Fair-Chance Policies" (March 2016), National Employment Law Project, footnote 1 on p. 7. Available at http://www.nelp.org/publication/researchsupports-fair-chance-policies.

[3] Visher, C., Debus, S., & Yahner, J. Employment After Prison: A Longitudinal Study of Releasees in Three States. Washington, DC: Urban Institute (2008).

recidivism rate—75% and 80% lower respectively than the National recidivism rate of 44%.[4]

Safer's REO grant for their Advancing Careers & Employment program also saw great outcomes with 577 enrolled clients. The ACE program provided workforce development, education, trauma-informed case management, and occupational training to adults (25 and older) who had been released from incarceration within 180 days or who were currently under supervision. Of the enrolled clients 93% developed an employment plan and 60% completed job training in the areas of carpentry, commercial driving, IT, hospitability, and solar panel installation.

Program evaluation has shown that such success is related to the comprehensive service model that REO grantees such as Safer provide. Effective, comprehensive services can include interventions such as relationship building between staff and participants, employment verification, trauma-informed training, life skills training, employment preparation, mentoring, intensive case management, strong training provider relationships and support, family involvement, and post-release follow-up and support. These comprehensive services are cost-effective—a recent study found that in Illinois the average cost associated with just one recidivism event is $151,662. Another study found that individuals who were employed and earning higher wages after release were less likely to return to prison within the first year. By increasing and improving employment outcomes, the REO program invests in formerly incarcerated people and their families, provides for a more equitable recovery, and improves public safety.

Investments in REO as a Reentry and Workforce Development Programs Will Help Ensure a More Equitable Economic Recovery

Black people and other people of color are disproportionately impacted by the criminal legal system. Black people are incarcerated at more than 5 times the rate of white people. In 2018, the incarceration rate of Black men was 5.8 times higher than that of white men, and Black young men ages 18–19 years old were 12.7 times as likely to be incarcerated as white young men in the same age group. In 2018, Black women were almost twice as likely to be incarcerated as white women, and Black girls were 3 times more likely to be incarcerated than white girls.

Upon release, these disparities persist as a result of systemic and institutional racism and discrimination; collateral consequences of conviction that ban or limit legal access to employment, licensure, and education supports; and a limited investment in resources for the large number of people returning each year who come back to their communities without the basic support and tools needed for long-term success. Providing Federal resources for workforce development and reentry helps to ensure greater success and helps to address unfair barriers that exist as a result of systemic racism and inequities that disadvantage individuals directly impacted by the criminal legal system. Reentry and workforce development programs, such as REO, are critical to ensuring a more equitable economic recovery for people with criminal legal histories, especially Black people and people of color who are disparately impacted by the criminal legal system.

CONCLUSION

By making effective workforce development and reentry services a priority, we fulfill labor market demands, contribute to the economy, and build strong and safe communities. Given the extensive employment and reentry needs nationwide, as well as the significant return on investment related to reduced incarceration costs and reduced crime costs borne by victims, families, and communities, I urge Congress to allocate $170 million to the REO program in FY24.

Thank you so much for your time and consideration of this important program. If you have questions or need additional information, please don't hesitate to contact me at Kevin.Brown@saferfoundation.org or Jenny Collier at jcolliercollective.org.

[This statement was submitted by Kevin Brown, Sr., Director of External Affairs & Community Partnerships, Safer Foundation.]

PREPARED STATEMENT OF SAVE THE CHILDREN

Chairwoman Murray, Vice Chair Collins, and honorable Members of the subcommittee, thank you for the opportunity to provide testimony on behalf of Save the

[4] Durose, Matthew R., Alexia D. Cooper, and Howard N. Snyder, Recidivism of Prisoners Released in 30 States in 2005: Patterns from 2005 to 2010 (pdf, 31 pages), Bureau of Justice Statistics Special Report, April 2014, NCJ 244205.

Children about the critical investments in the Departments of Health and Human Services and Education to ensure robust investments in children.

Save the Children works every day to give children a healthy start in life, the opportunity to learn, and protect children in crisis. Save the Children works in some of the poorest communities in rural America, and in 2022, Save the Children's programs directly reached 900,000 children across 47 States, including distribution of over 5 million meals.

HEALTH AND HUMAN SERVICES ADMINISTRATION

Child Care and Development Block Grant (CCDBG)—Request: $12.4 billion (an additional $4.38 billion)

Families continue to struggle to afford child-care, while childcare providers operate on razor thin margins. Despite significant investments in recent years, fewer than 1 in 7 eligible families received a subsidy under CCDBG. The impending expiration of American Rescue Plan funds mean that a robust expansion to the base CCDBG budget is needed to help States avoid damaging funding cliffs and support families who are facing ever increase costs.

Head Start and Early Head Start—Request: $17.47 billion (an additional $5.47 billion)

Head Start and Early Head Start are key to providing and expanding comprehensive early care and education to our country's most vulnerable children. Head Start currently serves just 36% of eligible preschoolers, and Early Head Start serves 11% of eligible infants and toddlers. Alongside the continued need to reach more children, the Head Start workforce faces significant challenges and staffing shortages as programs struggle to pay competitive wages; this request includes adequate cost-of-living adjustment to help programs ensure well-qualified staff.

Preschool Development Grants Birth to Five (PDG B–5)—Request: $500 million (an additional $185 million)

Expanded investments in Preschool Development Grants will enable more children to take advantage of early learning opportunities that encourage their learning and growth. Through PDG B–5, Congress has the unique opportunity to foster state-led early learning initiatives, which is particularly necessary as States continue to recover from the pandemic.

Infant and Early Childhood Mental Health (IECMH)—Request: $37.5 million (an additional $22.5 million)

Young children at high risk of mental health and psychosocial disorders require specialized early intervention to promote a healthy future. IECMH improves program quality, bolsters identification and referral, and helps reach families directly to support infants and children.

Project AWARE—Request: $244 million (an additional $22 million)

Smart investments for student mental health services will help promote children's healthy development, provide support to students with significant behavioral and mental health needs, and prevent youth suicide and violence. Through Project AWARE, Congress can help support young people through the Nationwide mental health crisis.

Project AWARE Section 7134- Request: $25 million (an additional $13 million)

School Mental Health grants provide trauma informed care in school settings. Section 7134 funding allows rural school districts to provide supplemental care to students experiencing trauma.

CDC Firearm Injury and Mortality Prevention Research—Request: $35 million (an additional $22.5 million)

A recent CDC report showed that the United States experienced a historic rise in gun deaths in 2021, affecting all age groups. In particular, gun violence recently passed car accidents as the leading cause of death for American children. Continued support of Federal research at the CDC is critical to addressing this growing crisis.

NIH Research to Prevent Firearm Injury and Mortality -Request: $25 million (an additional $12.5 million)

Federally funded public health research has a proven track record of reducing public health-related deaths, whether from motor vehicle crashes or smoking. This same approach should be applied to increasing gun safety and reducing firearm-related injuries and deaths, including suicides. Children deserve investment in their safety.

OFFICE OF REFUGEE RESETTLEMENT (ORR)

Asylum Case Management Pilot Program and Study—Request: $51.3 million (an additional $51.3 million)

A pilot program for asylum seeker case management would provide much-needed community support services including legal, housing, transportation, education, social, food security, healthcare, medical, and mental health services for children and families. Congress should also fund a study to examine the impact of case management, legal representation, and other integration services on the well-being of asylum seekers.

Increased funding for Legal Services, Child Advocates, and Post-Release Services—Request: report language

There is a clear need to increase funding for legal services, child advocates, and post-release services for unaccompanied children in Federal custody. All children should receive legal representation in custody status determinations and legal service providers and child advocates to advocate for and preserve children's rights. Many unaccompanied children have valid claims for relief from deportation; and all children have a right to a fair hearing in immigration court. Legal service providers play a critical role in helping children understand their rights while in Federal custody and in navigating the immigration system.

Ombudsperson for Immigrant Children in Federal Custody—Request: $10 million (an additional $10 million)

Congress should support the creation of the Office of the Ombudsperson for Immigrant Children in Federal Custody, within the Department of Health and Human Services, to provide ongoing oversight and recommendations for the health, safety, and efficient release of children in government custody. The Ombudsperson would have the power to monitor compliance with all applicable laws and investigate claims of abuse, neglect, or mistreatment of immigrant children.

Restrictions on Use of Unlicensed Facilities—Request: updated bill and report language

Congress should ensure that no funds shall be used to house unaccompanied children in unlicensed facilities unless the ORR net capacity is at or exceeds 95 percent for a period of 3 days. Additionally, specific requirements for facilities that remain in operation for more than three consecutive months are needed, such as one on-duty Youth Care Worker for every eight children and monthly monitoring visits.

DEPARTMENT OF EDUCATION

21st Century Community Learning Centers (CCLC)—Request: $2.09 billion (an additional $761 million)

Every day 11.3 million children are alone after school and are unsupervised for an average of seven hours per week. Parents of more than 19.4 million youth say their children would participate in an afterschool program if one were available in their community. Programs like 21st CCLC help working families, keep young people safe during the hours after school when juvenile crime peaks, and improve academic achievement.

Education for Homeless Children and Youth—Request: $800 million (an additional $671 million)

This program provides critical emergency wrap around services for children to receive transportation, enrichment programs, health care, and before & after school program access.

Individuals with Disability Education Act (Part B, Section 619)—Request: $502.6 million (an additional $82.6 million)

IDEA preschool formula grants provide free appropriate public education available for children aged 3–5 with disabilities. While not fully funded, the number of young children with disabilities served has increased by 25% in the past two decades.

Individuals with Disability Education Act (Part C)—Request: $932 million (an additional $392 million)

IDEA part C is key to providing early intervention services for infants and children, expanded investments will help improve program availability for a growing number of children with disabilities from birth- 2 years old.

CONCLUSION

On behalf of Save the Children, and our advocates across the country, I want to thank the subcommittee for its continued leadership and bipartisan work on these programs. I ask that you continue to make a robust investment in children in FY24, increasing access to opportunity, and ensuring a more prosperous America for generations to come.

[This statement was submitted by Christy Gleason, Vice President of Policy, Advocacy, and Campaigns, Save the Children.]

PREPARED STATEMENT OF SCHOOLHOUSE CONNECTION

SchoolHouse Connection is a national organization working to overcome homelessness through education. We work in partnership with schools and communities to ensure that children and youth experiencing homelessness have full access to quality learning, birth through higher education, so they will never be homeless as adults, and the next generation will never be homeless. This testimony supports a request for $800 million in FY 2024 funding for the McKinney-Vento Act's Education for Homeless Children and Youth (EHCY) program, administered by the U.S. Department of Education.

Homelessness among children, youth, and families is widespread and growing in rural, suburban, and urban communities. In the 2020–2021 school year, approximately 2.2% of all K12 students, or 1.1 million students nationwide, were identified as homeless by public schools. While total public school enrollment decreased by 3 percent for all students during the 2020–2021 school year, it fell by 14 percent for students experiencing homelessness, indicating a disproportionate impact of the pandemic on school disengagement. Members of this subcommittee can find Federal education data on children and youth experiencing homelessness in their own States at these online searchable data profiles.

Homelessness creates unique barriers to educational access and attainment, including being unable to meet enrollment paperwork requirements; high mobility resulting in lack of continuity and absenteeism; lack of transportation; lack of supplies; hunger, fatigue, and poor health; and emotional crises/mental health issues. As a result of these barriers, homelessness has a negative impact on academic achievement that is over and above poverty: the 2019–2020 national average graduation rate for homeless students was 68.2 percent, which is 13 percentage points below other economically disadvantaged students, and nearly 18 percentage points below all students.

The chronic absence rate of students experiencing homelessness is more than double the rate of all students (41.9 percent compared to 20.3 percent), and was exacerbated greatly by the pandemic.

Students who experience homelessness also face multiple learning challenges. They are disproportionately students with disabilities (20 percent of all homeless students, compared to 15 percent of the overall student population) and also disproportionately English learners (18 percent of all homeless students, compared to 10 percent of the overall student population).

Recently released Centers for Disease Control data show that, compared with students who were stably housed, high school students experiencing homelessness were more likely to engage in risky sexual behaviors, substance use, and suicide ideation and attempts, and to experience violence. These findings highlight the urgent need to proactively identify students experiencing homelessness; ensure their access and stability in school as required by Federal law; and closely examine and revise school-based health and mental health efforts to ensure that students experiencing homelessness are prioritized and can access support.

The EHCY program is the only Federal education program that removes barriers caused by homelessness. Under the EHCY program, every school district must designate a liaison to help identify children and youth experiencing homelessness, ensure school access and stability, provide direct services, and coordinate with community agencies to meet basic needs. EHCY subgrants are used for outreach and identification, enrollment assistance, transportation, school records transfer, immunization referrals, tutoring, counseling, school supplies, professional development for educators and community organizations, housing and service navigators, early childhood support, and assistance transitioning to postsecondary education. No other Federal program has the responsibility for and expertise in finding, engaging, stabilizing, and serving students who experience homelessness.

Nationally, only 19.5% of LEAs receive EHCY subgrants due to lack of funding, which limits the ability of schools to identify homeless students, ensure their access

to school, and connect them to community supports. The likelihood of under identification is much higher in schools without dedicated homeless education funding. In addition to under-identification challenges, many children and youth experiencing homelessness attend schools that receive no dedicated support to meet their unique needs. Nationally, 42% of students identified as homeless—471,134 students—attended a school district in the 2020–2021 school year that did not receive any dedicated funding to support their needs through the EHCY program.

There are some encouraging trends. The number of school districts receiving dedicated homeless education funding more than doubled as a result of a bipartisan amendment to the American Rescue Plan Act that dedicated $800 million to the identification and support of children and youth experiencing homelessness. This means many schools that have never received specific support to respond to student homelessness are now able to do so.

The EHCY program also has a long history of bipartisan support: over the past thirty-six years, it has received varying levels of funding increases regardless of which party controlled one or both chambers of Congress. Nevertheless, the EHCY program also suffers from being extremely small relative to the scale of homelessness, which continues to grow due to the current housing, addiction, immigration, and mental health crises.

Despite these ongoing crises, the President's FY 2024 budget does not request any additional funding for the EHCY program. Without additional EHCY funding, more than 80 percent of school districts will continue to lack dedicated support to identify and support children and youth experiencing homelessness. This means that many of our Nation's most vulnerable students will not have the most basic access to education. And without such access, these students cannot benefit from any of the other Federal, state, or local education investments—leaving them without a true opportunity to thrive. The failure to prioritize many of the most marginalized children and youth jeopardizes our Nation's recovery and pushes those who are furthest from opportunity even further away from the support they need to graduate from high school, transition to career or college, and live healthy lives.

$800 million is less than 2% of the Federal K12 education budget, yet provides basic educational access and stability to a population that exceeds 2% of all K12 students—students who otherwise cannot benefit from other local, State, and Federal education investments. An appropriation of $800 million also would allow EHCY subgrants to reach at least half of all school districts nationwide. Ensuring access to EHCY support is an important part of creating a school system that meets the needs of all our Nation's children and youth.

[This statement was submitted by Barbara Duffield, Executive Director, SchoolHouse Connection.]

PREPARED STATEMENT OF SHAWANO AREA UNITED WAY

Nonprofits play a critical role in enriching our civil society and strengthening communities across the Nation. They are also an economic engine—nonprofits are the third-largest employer in the U.S., accounting for more than 12.5 million workers and 10% of the private workforce.

They not only provide essential services and programs for Wisconsin residents; they also provide the foundation for economic growth by offering child and senior care, educational supports, career development and adult education, and workforce development. For-profit businesses cannot find the skilled workers they need without a thriving nonprofit sector.

Although it plays a critical role in economic growth, the nonprofit sector is not able to access the timely wage and employment data available to every other industry. The Bureau of Labor Statistics provides nonprofit sector data only every 5 years, meaning that nonprofits are still extrapolating from 2017 data, without any comprehensive research that factors in the COVID–19 pandemic, inflation, technology advances or other factors affecting the current employment landscape.

According to the National Council of Nonprofits, "The labor market is active: more than 11 million jobs were posted in May 2020 and roughly 4.3 million workers quit or changed jobs that month, according to the Bureau of Labor Statistics. That agency does not specify nonprofit jobs, so nonprofits are forced to rely on anecdotal evidence to determine whether job applicants are taking work in the for-profit or governmental sectors, and which subsectors, if any, are close to their pre-pandemic employment levels."

By contrast, for-profit companies have access to quarterly wage and employment data that enables them to track real time employment totals and wage information,

and benchmark their outcomes against larger trends, while helping policymakers understand challenges and craft responsive policy.

According to its mission statement in the 2020–2025 strategic plan, the BLS "measures labor market activity in the U.S. economy to support public and private decision making." This mission simply cannot be achieved with a blind spot for the economy's third-largest employer.

In addition to its fundamental unfairness, this system serves our sector and the American people extremely poorly. The nonprofit workforce is burnt out after addressing years of crisis-level need in their communities and are increasingly leaving the sector for more profitable, and less stressful, positions in other industries. This means longer wait times for necessary services, and a slowdown in the economic recovery as potential workers remain out of the labor force while waiting for family care or training.

Wisconsin is one of the few States without a Statewide nonprofit association. There is no central organization raising up the nonprofit community. As a result, there is limited capacity to build support in gathering information about nonprofits statewide.

It is essential that nonprofit leaders and policymakers have the data necessary to address the workforce crisis in the nonprofit sector, and develop sound strategies to support the sector into the future. This will ensure that essential services are available to our communities, and ensure that the economy is able to fully recover from the consequences of the pandemic.

Therefore, we strongly urge the subcommittee to support Senator Reed and Senator Whitehouse's FY24 program requests for $4 million to enable the Bureau of Labor Statistics to include nonprofit organizations as a distinct category of employer in its Quarterly Census of Employment and Wages and related reports.

The purpose of the QCEW is to provide "a quarterly count of employment and wages reported by employers covering more than 95 percent of U.S. jobs, available at the county, MSA, state and national levels by industry." This mission is incomplete without data on the third largest workforce in the country, and we ask you to help ensure that this request is included in the final bill.

The current lack of timely, accurate wage and employment data on the nonprofit sector is untenable and inadequate for a workforce representing the third largest payroll of any industry. Nonprofits and their partners have been requesting this data for years (2021 letter to Secretary Walsh, signed by 260 leaders and researchers), and the current workforce crisis makes this expansion of the QCEW a necessity. We urge you to support this request and ensure its inclusion in the final bill.

Thank you.

[This statement was submitted by Nancy Schultz, Executive Director, Shawano Area United Way.]

PREPARED STATEMENT OF THE SLEEP RESEARCH SOCIETY

FISCAL YEAR 2024 APPROPRIATIONS RECOMMENDATION

—The sleep community joins the broader research community in requesting $50.9 billion in discretionary funding for the National Institutes of Health (NIH), an increase of $3.5 billion over FY 2023. Sleep impacts nearly every system of the body and various disease processes, please provide proportional funding increases for all NIH Institutes and Centers to further support sleep, circadian, and sleep disorders research activities.

—The sleep community joins the broader public health community in requesting $11.6 billion in overall funding for the Centers for Disease Control and Prevention (CDC) to reinvigorate meaningful professional education, public awareness, and surveillance activities.

—Please provide the emerging CDC Chronic Disease Education and Awareness (CDEA) program with $6 million, an increase of $1.5 million over FY 2023, to facilitate additional cooperative agreements to advance timely public health efforts with community stakeholders.

Chairwoman Baldwin, Ranking Member Capito, and distinguished members of the subcommittee, thank you for considering the views of the sleep, circadian, and sleep disorders advocacy community as you work on FY 2024 appropriations for medical research and public health programs. We would like to take this opportunity to thank you for providing ongoing investment in the National Institutes of

Health (NIH) and the Centers for Disease Control and Prevention (CDC) through FY 2023 appropriations, particularly for increasing funding for the new CDC Chronic Disease Education & Awareness Program, which continues to support a 3-year cooperative agreement on obstructive sleep apnea and can support additional public health projects related to healthy sleep. Please maintain and enhance the commitments to NIH, CDC, and the CDEA program as you and your colleagues work on appropriations for FY 2024.

ABOUT THE SLEEP RESEARCH SOCIETY

The Sleep Research Society (SRS) was established in 1961 by a group of scientists who shared a common goal to foster scientific investigations on all aspects of sleep, circadian rhythmicity, and sleep disorders. Since that time, SRS has grown into a professional society comprising over 1,300 researchers nationwide. From promising trainees to accomplished senior level investigators, sleep and circadian research has expanded into areas such as psychology, neuroanatomy, pharmacology, cardiology, immunology, metabolism, genomics, and healthy living. SRS recognizes the importance of educating the public about the connection between sleep, circadian rhythmicity, and health outcomes. SRS promotes training and education in sleep and circadian research, public awareness, and evidence-based policy, in addition to hosting forums for the exchange of scientific knowledge pertaining to sleep and circadian rhythms.

ABOUT PROJECT SLEEP

Project Sleep is a 501(c)(3) non-profit organization raising awareness about sleep health and sleep disorders by working with affected individuals and families across the country. Believing in the value of sleep, Project Sleep aims to improve public health by educating individuals and policymakers about the importance of sleep health and sleep disorders. Project Sleep will educate and empower individuals using events, campaigns, and programs to bring people together and talk about sleep as a pillar of health.

NIH Sleep Research Activities.—Sleep research activities at NIH and across the government are coordinated through the National Center on Sleep Disorders Research (NCSDR). NCSDR continues to implement an ambitious 5-year plan for sleep research and welcomed a dynamic new Director, Dr. Marishka Brown.

As a result of sustained investment in NIH and the scientific opportunities in the field of sleep research, the research portfolio has doubled in size from $233 million in FY 2014 to over $515 million today. This support has led to significant advancements in basic science and a number of recent high-profile awards, including a Nobel Prize. However, research gaps remain in individual sleep disorders, such as narcolepsy, restless legs syndrome, and Kleine Levin syndrome, and patients lack innovative treatments, biomarkers, and new diagnostic tools. Team-based science and translational research is now needed to build on the momentum in sleep research and secure progress that benefits patients and the healthcare system. In addition to supporting annual investment in research, please support timely committee recommendations recognizing NCSDR for recent progress in the sleep portfolio and encouraging further progress.

CDC Chronic Disease Education & Awareness Program.—Thank you for establishing the CDC CDEA program in FY 2021 by providing an initial investment of $1.5 million and then doubling that investment to $3 million for FY 2022, and enhancing that commitment with $4.5 million in funding for FY 2023. With the initial round of funding, CDC is now supporting four meritorious 3-year cooperative agreements in psoriasis, hearing loss, lymphedema, and sleep apnea. With additional funding for FY 2023, there is an expectation that CDC will fund another round of competitive cooperative agreements in critical public health areas. To ensure that progress can be sustained and new activities can be supported (including in sleep more broadly as an overlooked public health issue), please provide $6 million in funding for FY 2024. Please also provide additional funding for CDC and the National Center for Chronic Disease Prevention and Health Promotion, and encourage the usage of discretionary resources to invigorate dedicated public health activities in healthy sleep and sleep disorders.

Beverly & Noah's Story (New Hope, AL): Imagine going to bed around midnight, but you don't fall asleep until after 3 am and that causes you to have difficulty getting out of bed for school at 8 am despite several alarms. Now imagine when you do go to sleep, you spend that time in REM (the phase of sleep where dreams occur) so when you wake up you are more exhausted than you went to bed. Sometimes the dreams turn into hallucinations and you are paralyzed not being able to move. Sounds pretty scary—right? At the age of 11, my son, Noah Lang experienced all

of these symptoms and no one could tell us why. It took over a year and 5 doctors before he was properly be diagnosed with Delayed Sleep—Wake Phase Syndrome and Narcolepsy. I have spent the last 4 years advocating and raising awareness for children with these sleep disorders so that others don't have to wait so long for help. Noah has spent the last 4 years helping educate his classmates and teachers about Narcolepsy. It is imperative that we fund developments in research which is crucial to improve the lives of those living with sleep disorders and to educate the school systems on how to properly care for them while at school.

Tony's story (Trussville, AL): "That's just life."

"Everyone gets sleepy."

"Third shift is rough, that's just the way it is."

All valid comments in their own right. But sometimes, it takes getting tired of being tired to take action. That's what happened to Tony. Tony Garrison had been working the life of a nighttime third shift worker for years. He came to grips with being tired all the time. That just seemed to be the way life was. He accepted this for all time. Life changed and Tony was able to find a job working days in the same career. Hoping things would be different, he was anxious for the change. Life off of 3rd shift was great. The sleepiness and fatigue remained. He finally had enough. Tony decided to see his doctor about a sleep study. The night of the study came and went. The diagnosis came in of Obstructive Sleep Apnea (OSA) and Periodic Limb Movement Disorder (PLMD). His doctor ordered a CPAP (Continuous Positive Airway Pressure) machine for his OSA and medication for his PLMD. Good sleep was finally restored. Tony was able to get the rest he needed to be more alert and well-functioning. Today, he is a thriving husband and father, energetic coworker and living his life with Sleep Apnea under control.

Lindsay's Story (Los Angeles, CA): Imagine sitting in a room—excited, engaged, and on the edge of your seat. And then you aren't. Seemingly out of nowhere, exhaustion consumes you, leaving you heavy from your eyelids to your toes. The first time Lindsay Scola, of Los Angeles, CA, remembers this happening, she was 16. She ran out of class to sleep in the bathroom. For decades doctors continued to tell her that her extreme daytime sleepiness, vivid night terrors, sleep paralysis, and fractured sleep were normal. At 35, Lindsay was finally diagnosed with narcolepsy, a chronic neurological disorder of the sleep-wake cycle that affects one in 2000 people. Narcolepsy has no novel treatment, and 5 years into her diagnosis, she is currently on her 14th combination of medications. While her episodes of sleep attacks, sleep paralysis, and hallucinations have lessened through treatment, narcolepsy is still something she must contend with in her everyday life. Lindsay has dedicated herself to raising awareness, not just about narcolepsy but sleep disorders in general, for the medical community and the public to ensure the next person doesn't wait 20 years for answers.

[This statement was submitted by Namni Goel, PhD, President, Sleep Research Society.]

PREPARED STATEMENT OF BRIDGET SMITH

Chairwoman Baldwin, Ranking Member Capito, and distinguished members of the subcommittee, I am honored to have the opportunity to submit my testimony on behalf of more than 4,000 treatment court programs around the country, and the 150,000 people they will connect to lifesaving addiction and mental health treatment this year alone. Given the ongoing substance use crisis, I am requesting that Congress provide funding of $105 million for the Drug Treatment Court Program at the Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, for fiscal year 2024.

My name is Bridget Smith, and I am a lawyer representing law enforcement and other first responders in Wisconsin, and the founder of a non-profit serving my community. I am also a person in recovery from addiction and a proud treatment court graduate.

My life today is dedicated to service and giving back to my community. My career is dedicated to advocating for law enforcement as a labor attorney. I am grateful for the life I have today which did not seem possible years ago when I was in active addiction. My alcohol and drug use began in high school. I was able to keep the severity of my use hidden for a while, but eventually, it began to take control of my life. I was fortunate to have the support of my family who helped me seek treatment several times. For a period, I was well enough to attend college, but I found I could not stay in recovery and soon I was in crisis. When my family showed up to attend my college graduation, I was sitting in jail.

In 2012, I was accepted into drug court in Milwaukee, Wisconsin. I did well in the program, and even started a non-profit to support drug court alumni and participants before I graduated in 2013. This is where my story may differ from others you have heard. A year after graduating, I fell in with my old crowd, and my old habits crept back into my life. I started using again. But my time in drug court gave me a glimpse of the life I wanted to live-I knew I could be happy, sober and a productive member of society. During my time in drug court, I also found a community of people who cared about me. My friends from the non-profit, who were also participants or graduates of drug court, saw I was in trouble and reached out to offer support. During my first time in drug court, I had proven to myself that I could live in recovery, I just needed a little more help. And this time, thanks to the reliable friends I made while in drug court, I was able to recognize it.

They say drug court never gives up on people, and I am living proof of that. My relapse led, once again, to arrest, but I was offered a second chance at drug court, this time in Waukesha County, Wisconsin. I never looked back. My second time around, I didn't have to start from scratch. I had a foundation upon which I rebuilt my recovery. I was not going to make the same mistakes this time around. The structure, accountability, and treatment provided the perfect combination for me to begin rebuilding my life as a person in recovery.

While I was in drug court, I was inspired by the way the team supported every participant, particularly my public defender whom I credit with saving my life. I wanted to help others the way my public defender helped me, and I decided to go to law school. I began studying for the LSAT before I even graduated from drug court. With the team's help and encouragement, I applied and was accepted to Marquette University Law School.

Today, nearly 10 years later, I am an attorney representing first responders. I am reconnected with my family. I am back to being part of a recovery community that supports each other. I am back working with the non-profit I helped start. I have seen how treatment courts transform lives, and I am here because I believe everyone should have the opportunity I had. Thank you for supporting treatment courts and the millions of people like me living in recovery because of these programs.

I am just one example of how funding treatment courts, like drug courts and veterans treatment courts, not only helps individuals, but uplifts an entire community. These courts are vitally important as our Nation continues to battle the addiction crisis and its impact on communities nationwide. The multidisciplinary treatment court team, including the judge, attorneys, case managers, treatment providers, counselors, and others, collaborate to develop a unique plan for each participant according to their specific needs. From medication for addiction treatment, to counseling, to therapy and more, participants are given the treatment and support they need to get, and stay, on track in recovery. Investment in these programs helps State and local leaders increase their capacity to address the crisis, helping thousands of individuals find recovery. This treatment court funding will help strengthen communities across our Nation.

I strongly urge this committee to recommend funding of $105 million for the Drug Treatment Court Program at the Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, for fiscal year 2024, so these programs can continue to help people break cycles of addiction, find long-term recovery, and, like me, become healthy members of their communities.

PREPARED STATEMENT OF THE SOCIETY FOR INDUSTRIAL AND ORGANIZATIONAL PSYCHOLOGY

On behalf of the Society for Industrial and Organizational Psychology (SIOP), we are pleased to provide this written testimony to the Senate Appropriations subcommittee on Labor, Health and Human Services, Education, and Related Agencies for the official record. In this testimony, SIOP urges Congress to provide $35 million dollars for the Department of Education's Graduate Assistance in Areas of National Need (GAANN) program.

SUPPORT FOR GRADUATE ASSISTANCE IN AREAS OF NATIONAL NEED

SIOP requests that Congress appropriate $35 million for the Department of Education's Graduate Assistance in Areas of National Need (GAANN) program. This program is essential to ensuring that the United States has a strong workforce pipeline in areas of national need. GAANN provides funds for academic departments at institutions of higher education to provide in-need graduate students with fellowships to support their pursuit of the highest degree available in one of the programs

that the Secretary of Education has determined to be in an "area of national need." [1] GAANN is the only grant program offered by the Department of Education solely for graduate students and provides crucial financial support to students who would otherwise struggle to afford a graduate degree. The GAANN program is essential to increasing the diversity of students pursuing and obtaining graduate degrees in fields that are foundational to the United States' economic competitiveness, public health, and national security.[2] Furthermore, GAANN recipients have been shown to have a shorter average time to graduate degree completion than the Department of Education's target and the National average.

In FY 2021, Industrial-Organizational (I–O) Psychology was added to the list of areas of national need. SIOP is grateful for the addition of I–O psychology and encourages the Department of Education to continue to include the field in future competitions.[3] I–O psychology is a growing field that addresses workplace issues at the individual and organizational level. I–O psychologists apply evidence-based practices to improve the well-being and performance of employees and the organizations they work at. I–O psychologists play an important role in shaping workplace policies in important areas such as telework policy, diversity, equity, and inclusion, and policies around promotion and hiring. As the workplace continues to be transformed by emerging technologies and changes in the wake of COVID–19, I–O psychology will continue to play an essential role to supporting the American workforce and workplaces. SIOP urges Congress to provide $35 million in funding for this important program.

Thank you for the opportunity to offer SIOP's support for the Department of Education's Graduate Assistance in Areas of National Need (GAANN) program. Please do not hesitate to contact SIOP should you have any questions. Additional information is also available at www.siop.org.

[This statement was submitted by Dr. Mo Wang, President, and Tracy L. Vanneman, Executive Director, Society for Industrial and Organizational Psychology.]

PREPARED STATEMENT OF THE SOCIETY FOR NEUROSCIENCE

Chair Baldwin, Ranking Member Capito, and members of the subcommittee, on behalf of the Society for Neuroscience (SfN), I am honored to present this testimony in support of robust appropriations for biomedical research at the National Institutes of Health (NIH). SfN urges you to provide at least $50.924 billion, a $3.465 billion increase over FY23, in funding for the NIH for FY24, including the full release of funding for the NIH Innovation Account for 21st Century Cures programs and $740 million for the Brain Research through Advancing Innovative Neurotechnologies (BRAIN) Initiative. For researchers across the Nation, the ability to make life-changing advancements in the field of neuroscience is contingent upon sustained Federal funding.

One area of my lab's research at the Department of Anatomy and Neurobiology at the University of California-Irvine focuses on the biological processes that help repair the central nervous system, particularly the spinal cord. With key NIH funding, my lab discovered that modifying a critical cell growth pathway can revert neurons in adult brains to a youthful state, facilitating regeneration of the spinal cord after injury. Our research is now applying this principle to neurodegenerative disorders like Alzheimer's Disease by testing whether rejuvenated neurons will resist neurodegeneration. Basic research, like my own, provides understanding about the brain at a deep level, which paves the way for the development of novel therapeutics that will prevent and treat debilitating medical disorders. Continued progress depends on sustained Federal funding at a level that at a minimum, keeps pace with inflation.

SfN believes strongly in the research continuum—a pipeline, in which basic science leads to clinical innovations, which leads to translational uses impacting the public's health and reducing long-term medical costs. Basic science is the foundation upon which all health advances are built. To cure diseases, we need to understand them through fundamental discovery-based research. SfN is grateful to Congress for its investments in biomedical research and increases for NIH over the last 8 years, but it is critical that funding is sustained to achieve the goals of these investments.

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[1] https://www2.ed.gov/programs/gaann/index.html.

[2] https://legacy.cgsnet.org/ckfinder/userfiles/files/GAANN%20Policy%20Brief%20August%202021.pdf.

[3] https://www.siop.org/About-SIOP.

THE IMPORTANCE OF THE RESEARCH CONTINUUM

NIH funding for basic research is not only critical for facilitating groundbreaking discoveries; it is essential for building our workforce of researchers at the bench. For the United States to remain the world leader in biomedical research, Congress must continue to provide funding to fuel discoveries as well as the economy. Neuroscientists use a wide range of experimental, animal, and human models not used elsewhere in the research pipeline. These opportunities create discoveries—sometimes unexpected discoveries—expanding knowledge of biological processes, often at the molecular level. This level of discovery reveals new targets for research to treat all kinds of brain disorders affecting millions of people in the United States and beyond.

NIH basic research funding is also a key economic driver of science in the United States through funding universities and research organizations across the country. Federal investments in scientific research fuel the Nation's pharmaceutical, biotechnology, and medical device industries. The private sector utilizes basic scientific discoveries funded through NIH to improve health and foster a sustainable trajectory for America's research and development enterprise. Basic science generates the knowledge needed to uncover the mysteries behind human diseases, which leads to private sector development of new treatments and therapeutics. Industry typically does not fund research on this important first step given the long-term path of basic science and pressure for shorter-term return on investments. Congressional investment in basic science is irreplaceable for development of drugs, biologics, devices, and other treatments for brain-related diseases and disorders.

For example, in September 2022, NIH and FDA launched the Critical Path for Rare Neurodegenerative Diseases (CP–RND)—a public-private partnership aimed at advancing the understanding of neurodegenerative diseases and fostering the development of treatments for amyotrophic lateral sclerosis (ALS) and other rare neurodegenerative diseases. Bringing together experts in this area, the goal of this partnership is to generate actionable solutions that can tangibly accelerate drug development for rare neurodegenerative diseases.

The BRAIN initiative is another example of NIH's success by developing remarkable technologies for the entire research community enabling discoveries across neuroscience and related scientific disciplines that would have previously been unimaginable. By including funding in 21st Century Cures, Congress helped maintain the momentum of this endeavor, but these funds should not supplant appropriations for NIH. There is no substitute for robust, sustained, and predictable funding for NIH. SfN appreciates Congress' ongoing investment in the BRAIN Initiative and urges its full funding in FY24.

SCIENTISTS IDENTIFY MOLECULE THAT COULD HELP TREAT PARKINSON'S

NIH funded research has greatly advanced our understanding of Parkinson's disease, a movement disorder due to age-related neurodegeneration, which affects an increasing number of Americans each year. Recent work at the Vollum Institute at Oregon Health and Sciences University found that the neurotransmitter adenosine halts dopamine, which has implications for Parkinson's disease given the role of dopamine in motor control. This discovery can help develop new treatments for Parkinson's disease that's caused by the loss of dopaminergic neurons. Discoveries regarding adenosine in Zhong and Mao labs used genetically modified mice, developed through support by two BRAIN initiative and three NINDS grants.

CONGRESS & NIH MUST SUPPORT ACCESS TO MODELS NECESSARY FOR NEUROSCIENCE DISCOVERY

SfN urges the Committee to appropriate funding for biomedical research without restriction against the use of animal models. Adequate NIH funding is necessary to advance our understanding of the brain; however, full realization of this funding's promise requires appropriate access to research models, including non-human primates and other animal models. Animal research is highly regulated to ensure the ethical and responsible care and treatment of the animals. SfN and its members take their legal and ethical obligations related to this research very seriously. While SfN embraces the goal of the reduction, refinement, and eventual replacement of nonhuman primate models in biomedical research, much more research and time is needed before such a goal is attainable. Premature replacement of non-human primate and other animal models may delay or prevent the discovery of treatments and cures—not only for neurological diseases like Alzheimer's disease, addiction, and traumatic brain injury, but also for communicable diseases and countless other conditions. There are currently no viable alternatives available for studying bio-

medical systems that advance our understanding of the brain and nervous system; or when seeking treatments for diseases and disorders like depression, addiction, epilepsy, neurodevelopmental disorders like autism, neurodegenerative disorders, and post-traumatic stress disorders. SfN urges Congress to work with the NIH to ensure this important well-regulated research can continue.

FUNDING IN REGULAR ORDER

SfN joins the biomedical research community supporting an increase in NIH funding to at least $50.924 billion for existing NIH Institutes and Centers, a $3.465 billion increase over FY23. Cuts to discretionary spending would have a devastating impact on medical research especially as the NIH caught up to its 2003 level of funding, when accounting for inflation, and would hurt the country's ability to maintain its international competitiveness in this space. Equally important as providing a reliable increase in funding for biomedical research is ensuring funding is approved before the end of the fiscal year. Continuing Resolutions have significant consequences on research, including restricting NIH's ability to fund new grants and to fully fund continuation grants. For some of our members, this means waiting for a final decision to be made on funding before knowing if their perfectly scored grant will be realized or operating a lab at a diminished capacity until appropriations are final, which can be devastating for trainees seeking to begin their careers. All the positive benefits research provides in this country are negatively impacted by these real time considerations. SfN strongly supports the appropriation of NIH funding in a timely manner, to avoid delays in approving new research grants or reductions in funding for already approved research funding.

SfN thanks the subcommittee for its continued support of biomedical research and looks forward to working with you to ensure the United States remains the global leader in neuroscience research and discovery. Collaboration among Congress, the NIH, and the scientific research community has created great benefits for not only the United States but also for people around the globe suffering from brain-related diseases and disorders. On behalf of the Society for Neuroscience, we urge you to continue your strong support of biomedical research.

[This statement was submitted by Oswald Steward, PhD, President, Society for Neuroscience.]

PREPARED STATEMENT OF THE SOCIETY OF CARDIOVASCULAR COMPUTED TOMOGRAPHY

The Society of Cardiovascular Computed Tomography (SCCT) thanks the subcommittee for the opportunity to submit outside witness testimony concerning Fiscal Year (FY) 2024 appropriations. SCCT is the international professional society devoted exclusively to cardiovascular computed tomography (CT), with members from over 85 countries. SCCT is a community of physicians, scientists, and technologists advocating for research, education, and clinical excellence in the use of cardiovascular CT.

In particular, SCCT writes to urge the subcommittee to request that the Centers for Medicare and Medicaid Services (CMS) address the flawed costing methodology that results in inadequate Medicare reimbursement rates for cardiac CT services, ultimately limiting Medicare beneficiary access to care.

Heart disease is the leading cause of death in the United States. Almost 700,000 Americans die from heart disease annually despite our many advances in treatment and diagnostic strategies for coronary artery disease (CAD). Over the past two decades, an effective test for CAD has emerged based on strong clinical science, cost-effectiveness, and the ability to positively impact patient outcomes: coronary computed tomography angiography (CCTA) or cardiac CT.

Specifically, CCTA can be used to detect blockages due to fatty or calcium deposits (plaques) in the coronary arteries that might cause symptoms or increase the risk of a heart attack. In addition, CCTA allows structures surrounding the heart to be imaged, which are frequently the cause for patient's symptoms even when CAD is not present.

Yet, despite multiple guidelines from the U.S. and Europe recommending CCTA as the preferred imaging modality for patients with chest pain and no known CAD, hospitals have not adopted this service at levels expected for the standard of care. We believe this is because CMS requires hospitals to submit CCTA claims under general CT services, resulting in reimbursement that does not accurate reflect the costs and resources required to perform the test.. Unlike general CT services, CCTA requires staff to administer vasoactive medications prior to the scan, a specially

trained technologist to acquire the scan, and special post-processing and 3D workstation software to help clinicians interpret the study. Generic CT costs do not capture the complexity of CCTA services that utilize approximately 3–4x as many resources. Thus, the low payment by Medicare is mostly due to CMS using inappropriate cost accounting, which leaves the single best validated testing strategy for CAD undervalued, and at a severe financial disadvantage compared to reimbursement for other, less accurate testing strategies for CAD. This denies people the best outcomes and costs more dollars and lives in the long run.

CMS has the tools available to provide more appropriate reimbursement for CCTA services through the exercise of the agency's equitable adjustment authority, i.e., to use a cardiac revenue code to calculate costs instead of a general CT code, thereby ensuring greater beneficiary access to guideline-driven care and eliminating health inequities in cardiac care.

Specifically, as the subcommittee begins to draft the Labor-HHS-Ed appropriations bill, SCCT urges the subcommittee to consider the report language request that SCCT submitted for the Fiscal Year 2024 appropriations process:

> *Cardiac Computed Tomography (CT).*—The Committee reiterates the concerns raised in the fiscal year 2023 Explanatory Statement and notes that unstable and low reimbursement for cardiac CT services is contributing to significant disparity in access to this vital service. Despite clinical evidence demonstrating that use of cardiac CT can improve health outcomes for beneficiaries and reduce costs for the healthcare system, beneficiaries are up to 20 times more likely to receive a stress test. The Committee strongly urges CMS to allow hospitals to bill cardiac CT procedures to a general cardiology revenue code instead of a CT revenue code.

Similar report language was included in the Fiscal Year 2023 Division H explanatory statement:

> *Cardiac Computed Tomography (CT).*—The agreement notes that unstable and low Medicare payments for cardiac CT services is contributing to significant disparity in access to services among minority populations and encourages CMS to address this inequity.

Again, SCCT appreciates the opportunity to submit this statement for the record and stands ready to assist the subcommittee and its staff with additional information and resources from our community of physicians, scientists and technologists advocating for research, education, and clinical excellence in the use of cardiovascular CT.

PREPARED STATEMENT OF DARRION SPRUEILL

It is with great pleasure and pride that I share my testimony of the impact of Federal TRIO programs on my education, career, and overall civic engagement. My journey with TRIO programs began as a fourteen-year-old rising freshman at Danbury High School in Danbury, Connecticut. I was quiet but strong-willed and highly opinionated. I had lived in a multi-generational home as an only child for much of my life. I was a happy and playful child, but I sometimes felt lonely, especially during the summer when I had to try to entertain myself.

When TRIO staff presented me with the opportunity to join Upward Bound's six-week summer program, I immediately applied, collecting all the necessary documents from my mother. While most of my peers were sleeping late, making money in summer youth employment programs, and taking vacations, I attended an annual six-week summer program for first-generation, low-income students to attend and complete post-secondary education-the program on the campus of Western Connecticut State University (WCSU).

Beyond the opportunities to prepare for college, I had the chance to engage with other programs that collaborated with my TRIO program. One of these programs, The Young Writer's Conference, allowed me to contribute poetry and short stories to a published journal. In TRIO Upward Bound, I learned to say "yes" to things that made me a better student and person overall. Seeking help was not easy for me, and as a high school freshman, my struggles with algebra were not getting any better. I avoided tutoring and had a defeatist attitude. Yet despite this, the staff of TRIO Upward Bound pushed me to attend after-school tutoring sessions and to put in the effort to finish the course.

I knew I wouldn't end the academic year well, but I continued to push through. Unfortunately, it was too late. My algebra grade was beyond recovery. And when I received my report card in the mail, I thought my time in TRIO Upward Bound was nearing its end. I remember walking up to my advisor one morning in the summer before my sophomore year and telling her, "I failed algebra." The look she gave

me let me know that she had already read my report card and was waiting for me to approach her. "We're going to make sure you recover those credits," was her response to me. I didn't have to face my director, plead my case on why I shouldn't be expelled from the program, or even hold on to the feeling of failure. I received the tools to hold myself accountable but not wallow in self-pity or regret.

Learning math through computer software was a better fit for my learning style. I recovered my credits and shared my victory with my TRIO Upward Bound advisors. Somewhere between my first year and senior year, building the blocks for my future made a lot more sense. I took advantage of community service opportunities, worked on my ability to speak Spanish, and mapped out possible majors and careers that fit my interests.

By my senior year of high school, I was a high honor roll student enrolled in advanced placement and honors-level courses. I had high-achieving friends in the TRIO Upward Bound program, and their drive influenced me to work harder. In 2013, I graduated from Danbury High School with honors and began preparing for my first semester at WCSU as a student in the Social Sciences department.

Within the first week of my first semester in college, I began to see the TRIO Upward Bound office as my "safe space" on campus. Ironically, I didn't spend much time in the office as a student in the program, but somehow as a college student at WCSU, it just made sense to take advantage of the resources (staff, computers, and relaxation space). My program director, Rob Pote, became a mentor to me. Rob is a visionary who inspires all who encounter him.

By my second month of undergraduate education, I began looking for part-time work. The TRIO Upward Bound program was a resource for every need I had, and I knew the case would be the same. One of the advisors suggested that I investigate working for the Danbury Public School's extended learning (after school) program. I have always enjoyed working with children, and the late afternoon work schedule fits perfectly with my morning class schedule. For the 4 years of my undergraduate education, I worked for the school system as a program associate. My summer work was gratifying, working as a student assistant in the TRIO Upward Bound program and the Excel program, a middle school precursor program funded by the city of Danbury. During those summers, I learned more about grants, compliance, and Federal and State funding. I was undoubtedly intrigued.

In December 2015, I lost my grandmother suddenly. It was a shock to my family, and experiencing this loss during finals week increased my stress immensely. Throughout this challenging period, I leaned on the staff and my TRIO Upward Bound office friends. Two staff members, Carmen Cornacchia and Steffanie Kruzan, attended my grandmother's funeral. Other staff members sent me condolences, and I truly felt gratitude for having these individuals in my life. TRIO is more than college completion; it is a family that uplifts you in the best and worst times of your life.

After graduating Magna Cum Laude with a bachelor's in social sciences from WCSU in May 2017, I spent many afternoons in the TRIO Upward Bound office that summer. Four years of undergraduate education felt like a walk in the park compared to the sprint of embarking on the career exploration journey. I still felt a solid connection to K–12, but I also became interested in the inner workings of higher education. I knew that somewhere in between those entities was where I wanted to begin my career.

In July 2017, during one of my regular visits to the office, Jessica Coronel, an alumna of the program and the current assistant director of TRIO Upward Bound at WCSU, told me about a large, new Upward Bound project that the U.S. Department of Education just funded at Naugatuck Valley Community College in Waterbury, Connecticut. Born and raised in Danbury, Connecticut, about 30 miles west of Waterbury, I grew up hearing about Waterbury in only one context: low-income Black and Hispanic families flock to Waterbury because it is significantly cheaper to live there. However, this scenario includes overcrowded schools, low matriculation, graduation rates, and disparaging opinions about the purpose of education.

I was hesitant to step outside of my comfort zone and build an entire program from scratch in an area that I was not wholly familiar with. However, if there was anything that I learned from my mentors and colleagues in TRIO Upward Bound, it was that stepping out of our comfort zones not only builds our character but influences those who look up to us to do the same. With this newfound motivation in mind, I spent the following weeks preparing for the possible start of my career.

I had not realized until I began to revise my resume with my TRIO Upward Bound Director, Rob Pote, that all the part-time work I had done, coupled with my knowledge of TRIO, positioned me to be a strong candidate. Although I was only twenty-two years old, I had the opportunity to engage students in a way that no other program, teacher, or administrator could. Not only was I the youngest staff

member in the building, but I am also Black, a man, and able to communicate fluently with Spanish-speaking students. To say I was an anomaly would be an understatement.

In my 1:1 mentoring sessions with students, I learned that for many of my students, I was the only Black man they knew with a college education. I then reflected on my high school years and realized that at that age, I only knew one man of color with a college degree. What does this say about our communities of color? For many moments in my twenty-seven months at John F. Kennedy High School, imposter syndrome crossed my mind. How did I make it this far with only one example of a man of color obtaining a college degree in my life? With all the effort I was utilizing to remove self-doubt from the minds of students with immense potential but low self-esteem, I was still confronting my feelings of self-doubt.

One of my fondest moments working as a program coordinator was taking a group of students to see The Lion King on Broadway. It felt like a full circle moment, as I had the opportunity to see both Sister Act and Memphis on Broadway. Being exposed to the arts contributes to a student's appreciation of it. I vividly remember sitting in the theatre watching The Lion King and reflecting on the bountiful opportunities that TRIO programs offer students who otherwise would not be able to experience them.

In March 2019, I attended my first Council for Opportunity in Education (COE) Policy Seminar in Washington, D.C. I visited Washington D.C. several times to visit friends and explore the diverse and lively city. Yet being there to advocate for first-generation, low-income students reminded me of all the fantastic life-changing work being done in D.C. every day. Following my participation in COE Policy Seminar, I began revising my resume, gaining experience in understanding Federal grant submission and reporting systems and serving as secretary for the Connecticut Association of Educational Opportunity Programs (CAEOP). CAEOP is Connecticut's state association that works directly with COE.

I also started looking at master's programs, as this would be a significant factor in deciding which universities I would apply to. With each visit back to my home base (WCSU's TRIO Upward Bound office), I was working on decreasing self-doubt and increasing my confidence.

In January 2020, I became the project manager for the National Science Foundation (NSF) ADVANCE Catalyst grant at American University in Washington, D.C. The Catalyst was an intentional, inclusive, and intersectional assessment of full-time university faculty, including the structures, policies, and procedures that affect women and underrepresented minority (URM) faculty in STEM fields. While on the Catalyst grant, I grew as a researcher and project manager. And although the pandemic had utterly altered my vision of life as a Washingtonian, my goal of receiving my master's degree was still present. And despite the sudden shift to a lockdown and remote work, I pushed myself to follow through.

In May 2020, I applied to A.U.'s Education Policy and Leadership (EPL) program within the School of Education. The program felt like a perfect match as I could combine my interests in education, government, and multicultural studies. The EPL program was everything I had hoped for despite being entirely online. And fulfilling my promise to complete my master's degree meant everything to my mother and me.

In 2021, during the final semester of my master's program, I began writing a $1,000,000 follow-up grant to continue the work on the ADVANCE Catalyst project. Again, leaning on my advisors and colleagues in the TRIO Upward Bound office felt natural, as writing grants is a significant and necessary component of their work. It took nearly a year to get funded but submitting my first grant felt like a proud moment.

In August 2022, I received a promotion and became senior project manager for my successful submission and subsequent awarding of the NSF ADVANCE Adaptation grant. In my current role, I participate in various faculty actions aimed at increasing diversity, equity, inclusion, and access for faculty in teaching, service, and learning. My work has also led to the creation of a new university-wide position for which I served as search committee co-chair: Assistant dean of faculty and inclusive excellence. Working in the office of the provost has allowed me to create change from the top down and enhance the inclusive practices that the university is developing.

From the time I became a TRIO Upward Bound student in 2009, I took every opportunity to learn and grow as a person. I reflected on these opportunities as my CAEOP colleagues presented me with the 2022 CAEOP Achiever Award in December 2022. This proud moment gave me a platform to properly thank some of the people who helped guide me along the way. From the experiences detailed in this testimony, it is evident that TRIO Upward Bound has influenced or enhanced every

milestone in my life since I was fourteen. A commitment to funding TRIO programs is to give first-generation, low-income students, such as I was, the opportunity to fulfill their purpose and improve our society.

[This statement was submitted by Darrion Sprueill, Alumnus, TRIO Upward Bound at Western Connecticut State University, Council for Opportunity in Education.]

PREPARED STATEMENT OF THE ST. BALDRICK'S FOUNDATION

My name is Hanna Jorgeson, and I was diagnosed with osteosarcoma—a bone cancer—at the age of 16. Through my cancer journey, I also was diagnosed with Li-Fraumeni Syndrome, a rare genetic mutation that greatly increases my risk of developing several types of cancer. I am pleased to have the opportunity to share my story and provide this testimony to the subcommittee in support of funding for childhood cancer research programs in Fiscal Year 2024. Specifically, I hope that Congress will once again this year provide $30 million to fully fund the programs created by the Childhood Cancer STAR Act and provide an additional $50 million once again to fund the Childhood Cancer Data Initiative.

This year, I am grateful to serve as a 2023 Ambassador with the St. Baldrick's Foundation. The St. Baldrick's Foundation is a volunteer and donor powered charity committed to supporting the most promising research to find cures for childhood cancers and give survivors long and healthy lives. St. Baldrick's is the largest charity funder of childhood cancer research grants, funding over $326 million in research grants to date.

Worldwide, a child is diagnosed with cancer every 2 minutes. Cancer is the leading disease-related cause of death in the U.S. for children and adolescents ages 1–19, and 1 in 263 children and adolescents will develop cancer before the age of 20. We have made significant advances to develop better treatments for the most common forms of childhood cancer, but for many other types, progress is limited, and for too many children there is no available cure. Unfortunately, 1 in 5 children diagnosed with cancer in the U.S. will not survive, and for the ones who do, the battle is never over. By the age of 50, more than 99% of survivors have had a chronic health problem, and 96% have experienced a severe or life-threatening condition caused by the toxicity of the treatment that initially saved their life, including brain damage, loss of hearing and sight, heart disease, secondary cancers, learning disabilities, infertility and more.

My cancer journey began in 2010 at the age of 16. At the time, I was a busy, active teen with friends, school, and soccer taking center stage in my life. I started experiencing severe pain in my right hip, which I thought was a sports injury. The pain did not improve with physical therapy, and I underwent an MRI, which revealed a grapefruit-sized tumor in my hip. The diagnosis was devastating: osteosarcoma, a bone cancer.

I immediately began a 10-round protocol of chemotherapy to shrink the tumor, but unfortunately, this was unsuccessful. Doctors said a hemipelvectomy amputation—removing my leg, hip, and half of my pelvis—was my best option for survival. After the initial 10-round chemotherapy protocol, a 23-hour surgery, 17 more rounds of chemotherapy, and months of physical therapy, I was declared cancer-free 8 months after my initial diagnosis.

I graduated from high school in 2012 and enrolled at the University of Minnesota-Duluth. Adjusting to my new normal and to college life in a wheelchair was challenging, but a chance encounter opened new doors for me to play competitive sports again. A fellow student who was also in a wheelchair introduced me to sled hockey, which is the adaptive form of able-bodied hockey. I was hooked, and I picked up the sport quickly. I played with a men's team, the Minnesota Wild, as the only woman, and most notably, I played for four seasons with Team USA Women's Para Ice Hockey team, which aspires to promote and grow the sport for disabled women.

At my 10-year cancer check-up, I was given the "all clear," but it came with an added wrinkle. It was at this time that testing revealed that I have a rare genetic disorder called Li-Fraumeni Syndrome. This gene mutation puts me at risk to develop other cancers, particularly breast cancer. I underwent a prophylactic double mastectomy and am now a breast cancer "previvor." Due to Li-Fraumeni Syndrome, I now am on a strict cancer screening protocol as well.

My cancer survivorship has been filled with challenges, but I also have been able to accomplish so much. Since my diagnosis, I married my soulmate, completed my master's degree, launched a full-time marketing career, and adopted a sweet three-legged German Shepherd named Frankie. I am so grateful to be here, and my hope

is for all kids with cancer to be able to have a full lifetime beyond their diagnosis like I have been able to do.

CHILDHOOD CANCER RESEARCH FUNDING REQUESTS FOR FISCAL YEAR 2024

Last year, Congress provided $30 million for the childhood cancer programs established in the Childhood Cancer Survivorship, Treatment, Access, and Research (STAR) Act—the most comprehensive childhood cancer bill in history. Congress also unanimously passed the Childhood Cancer STAR Reauthorization Act, which was signed into law in January 2023 (Public Law 117–350), to allow the programs and funding authorization from the original STAR Act to continue through Fiscal Year 2028. I ask that you continue to provide funding for the programs created by the Childhood Cancer STAR Act at $30 million in Fiscal Year 2024.

The STAR Act includes key research initiatives focused on some of the least studied and understood childhood cancers by expanding and enhancing biorepositories. Moreover, the STAR Act expands childhood cancer surveillance at the Centers for Disease Control and Prevention (CDC) to better identify and track incidences of child, adolescent, and young adult cancer.

Further, childhood cancer survivors like me continue to face significant health issues requiring specialized follow-up care for the rest of their lives. As such, the STAR Act allows for the development of best practices for the treatment of late effects of childhood cancers, improved collaboration among providers so that doctors are better able to care for this population as they age, and the creation of innovative models of care for childhood cancer survivors. Funding provided for the STAR Act has also supported research grants specifically aimed at childhood cancer survivorship, ensuring that survivors like me continue to receive the best possible care.

The STAR Act works hand-in-hand with the Childhood Cancer Data Initiative (CCDI), for which Congress provided $50 million last year. CCDI expands the breadth and quality of patient data and makes the data more accessible and easier for researchers to use to fast-track advances for children with cancer. CCDI is also helping newly diagnosed childhood cancer patients today. Just last year, CCDI launched the CCDI Molecular Characterization Initiative (MCI) to provide state-of-the-art molecular characterization at the time of diagnosis, which helps participants and doctors select the best and most appropriate treatment. Clinical data from nearly 1,000 MCI enrollees is now available for use by the research community. To allow this important program to continue, I ask that Congress once again fund the Childhood Cancer Data Initiative at $50 million in Fiscal Year 2024.

I, along with the St. Baldrick's Foundation, greatly appreciate the leadership and support of the subcommittee in funding childhood cancer research. We are ready to work with you in any way we can to continue to help children and their families who are fighting cancer.

PREPARED STATEMENT OF THE STATE OF WISCONSIN BOARD ON AGING AND LONG TERM CARE

Chairperson Baldwin and Ranking Member Moore Capito, I present this testimony on behalf of the 125,500 Wisconsin long-term care residents and long-term care consumers served by the Board on Aging and Long Term Care's Ombudsman Program, and in collaboration with the National Association of State Long-Term Care Ombudsman Programs (NASOP). The ombudsman program with the State of Wisconsin Board on Aging and Long Term Care (BOALTC) is tasked with advocating for the best quality of life and quality of care for individuals in long-term care who are age 60 and over. In health care jargon, we call these folks "long-term care consumers" but you know them as parents, aunts, uncles, grandparents, friends, and neighbors. With funds from the Older Americans Act, the WI ombudsman program monitors health, safety and welfare, while advocating for the rights of individuals who live in long-term care settings and who receive home and community-based services. Thank you for your past support of State Long-Term Care Ombudsman Programs (SLTCOPs) and the people these programs serve.

I submit this statement and the funding recommendations for the Fiscal Year 2024 for SLTCOPs administered through the Administration for Community Living, Department of Health and Human Services, to include:

—$65 million to support our work with residents of assisted living, board and care, and similar community-based long-term care settings. These settings are significantly less regulated than nursing homes, and generally employ fewer credentialed staff, if any, often necessitating greater advocacy for supports and services;

—$70 million for our current core obligation to respond to the medical, physical, and psychosocial needs of long-term care residents, ensuring they have regular, timely and effective access to our program; and
—$52.5 million under the Elder Justice Act for training and services to address increasing complaints related to abuse, neglect, and exploitation.

Ombudsmen in WI serve approximately 125,500 persons who live in any licensed or certified long-term care setting, or who receive their home and community-based services through the Family Care/Partnership, PACE or IRIS programs. In addition to those potential clients, ombudsmen also work in consultation with and provide education to family members, service providers, managed care organizations, and the various entities that support long-term care consumers. BOALTC Coverage Map (note: map does not include 1–2 bed Adult Family Homes)

Many of the long-term care recipients in Wisconsin reside in one of the State's over 6,000 assisted living and nursing homes. These 6,000 homes are served by 17 Regional Ombudsmen who are assigned to a region of the state. The total ombudsman to potential client ratio in WI is approximately 1:6700. The Institute of Medicine recommended a client to ombudsman ratio of 1:2,000. From a client services standpoint, Wisconsin has for many years been far behind the recommended ratio. Wisconsin's current ratio is based on client data only and does not include the other stakeholders to a complaint line who call for ombudsman services, including family members, legal representatives, and providers. Many other state ombudsman programs are in similar (or sometimes worse) positions.

In the calendar year 2022, the WI ombudsman toll-free number and general e-mail inbox received 8,837 contacts, managed by 1 full-time intake specialist. Since 2016, the WI ombudsman and volunteer ombudsman programs collectively have only grown by 4 FTE positions, despite a growth in clients of more than 15,500 in that same timeframe.

State of Wisconsin Board on Aging and Long Term Care

Ombudsman Intake Contacts, 2016-2022

Calendar Year	Incoming intake calls	Intake e-mails received	TOTAL
2022	6021	2816	8,837
2021	5864	3074	8,938
2020	5471	2137	7,608
2019	5485	1752	7,237
2018*	5471	1199	6,670
2017	4926	649	5,575
2016**	4505	362	4,867

*Expansion of IRIS advocacy
**Expansion of Family Care advocacy

Current demographic projections indicate a substantial increase in the aging population of Wisconsin in coming years, particularly in some of the State's most rural and underserved counties. The State's population aged 65 and older is expected to grow by 72% between 2015 and 2040. The rate is six times higher than the overall Wisconsin population growth projection of 12% for the same period.

Ombudsmen in WI are paid professionals who complete over 520 hours of training to receive certification as Representatives of the Office of the Wisconsin Long Term Care Ombudsman. The Board on Aging and Long Term Care also houses the Volunteer Ombudsman Program (VOP), staffed by five Volunteer Coordinators who recruit and train volunteers to be placed in nursing homes in their home communities. These volunteers conduct weekly unannounced visits to their assigned nursing home(s). The residents of those homes get to know and trust their volunteer, and the volunteers become a consistent presence in that home. Unfortunately, the VOP currently only has capacity to recruit, train and manage volunteers in 32 of our State's 72 counties and is focused on nursing home coverage only.

Due to risks during the pandemic, increased complexity of the work that exceeds volunteer capacity, and noted competition across the Nation for the same pool of volunteers with other non-profit organizations, many state ombudsman programs have lost volunteers who will need to be replaced with paid staff and/or increased resources for volunteer recruitment and management. It is estimated that the numbers of volunteer ombudsmen serving long-term care ombudsman programs have

dropped from approximately 8000 pre-pandemic to fewer than 4000 currently, nationwide.

In FY22, the WI Long Term Care Ombudsman program:

—Managed 3,004 complaints with a resolution or partial resolution rate of 71%.

—Conducted 13,337 consultations to individuals and providers.

—Conducted 47 public education programs.

—Top complaints included: Discharges, Failure to follow the care plan, Medication administration, Managed care, Staffing, Failure to respond to requests for assistance, Rights related to dignity & respect, Access to information & records, Rights related to choice in health care services, Legal decision-makers

Increased and consistent funding is needed for the SLTCOPs to support consumers through the critical role ombudsmen and volunteers play in the long-term care infrastructure, specifically the long-term care and community-based care programs funded in part by Medicaid and Medicare.

When ombudsman programs were mandated through the Older Americans Act to serve residents of assisted living settings in addition to nursing homes, no new funding accompanied those mandates. Assisted living homes have fewer regulatory requirements yet serve persons of an acuity level similar to nursing homes. Assisted living has boomed, yet SLTCOP funding has not increased to meet the demand in order to effectively respond to the industry boom. In Wisconsin, there are over 5,700 assisted living homes, serving over 65,000 consumers. These options, all uniquely licensed or certified, are known as Community Based Residential Facilities (CBRFs), Residential Care Apartment Complex (RCAC) and Adult Family Homes (AFHs), all served by 17 Regional Ombudsmen in the Wisconsin Long Term Care Ombudsman program.

Table 1. Assisted Living Home and Skilled Nursing Facility Data 1990 - 2020

Provider Type	1990		2000		2010		2020	
	Number	Capacity	Number	Capacity	Number	Capacity	Number	Capacity
Assisted Living Home[1]	1,084	13,960	2,165	30,145	3,261	45,932	4,239	63,455
Skilled Nursing Facility	446	49,686	424	46,147	399	36,022	360	28,171

Source: Wisconsin Department of Health Services; Division of Quality Assurance (DQA) as viewed February 27th, 2023.

[1] Assisted Living Home data excludes Adult Family Homes that are certified to care for 1-2 residents due to lack of tabulated data available prior to April 2022 from the DQA. As of April 2022, there were 1,590 1-2 resident AFH facilities.

Home and community-based services advocacy also continues to grow in the number of persons served by the Wisconsin Long Term Care Ombudsman program, as well as in the complexity of consumer needs. In comparison to 2016, when the WI Long Term Care Ombudsman Program added its first of dedicated managed care staff, the WI Ombudsman program now serves an additional 4,544 long-term care consumers in the IRIS program and an additional 5,028 long-term care consumers in Family Care, Partnership and PACE.

The ombudsman program in WI also has a vital role in nursing home and CBRF closures, which is also an area of increasing complexity and number of closures. For example, in 2013, there were 9 nursing home and CBRF closures or conversions, whereas in 2022, there were 32 closures or conversions, affecting over 500 WI residents. Similarly, the ombudsman program has seen an increase in homes filing for bankruptcy. In 2022, an ombudsman program representative served as the Patient Care Ombudsman in Federal district court to monitor bankruptcy filings for 13 long-term care homes in the state, compared to five in 2020.

Current funding levels preclude SLTCOPs nationwide from quickly responding to complaints and monitoring long-term care facilities that may be experiencing critical shortages of staff and services, endangering resident wellbeing and safety. Without our resident-focused eyes and ears in these buildings on a consistent basis, residents are at risk of abuse, neglect, financial exploitation, and any number of life-threatening care and rights violations.

Our request for funding is directly tied to the need for recurring and predictable resources to enable all States to hire and train critically needed additional permanent staff. Increasing the number of permanent ombudsmen will enable us to meet the demand of this growing segment of our population that is aging with more significant physical and mental health needs, to serve people in the settings where they choose to live and receive their long-term services and supports, and to address the increase in complaints programs across our country are already experiencing in long-term care. Representatives of our programs have had to do significantly more with so much less, including responding to the Covid-19 pandemic and the continuing aftermath. Ombudsmen continue to respond to consequences of social isolation and increased mental health needs, while also responding to critical complaints related to the staffing crisis seen in all realms of health care. State ombudsman pro-

grams have greatly appreciated the additional COVID recovery funding, without which we couldn't have accomplished this critical work, however, in order to continue to respond effectively at this level and meet the growing demand for our advocacy, ombudsman programs need increased stable annual funding for the recruitment and training of additional paid staff (at a competitive wage) as well as for volunteer recruitment and management.

To ensure that long-term care advocacy services are both accessible and effective, our Office of the State Long Term Care Ombudsman in WI and the National Association of State Long-term Care Ombudsman Programs respectfully request the aforementioned funding levels. We look forward to all that can be accomplished together. Thank you for your ongoing support of State Long-Term Care Ombudsman Programs.

Respectfully.

[This statement was submitted by Jessica L. Trudell, JD, BOALTC, Executive Director/Wisconsin State Long Term Care Ombudsman.]

PREPARED STATEMENT OF INTERSTATE MINING COMPACT COMMISSION

I am writing in regard to the Fiscal Year 2024 Budget for the Mine Safety and Health Administration (MSHA), U.S. Department of Labor. In particular, I urge the Subcommittee to support a full appropriation of not less than $10,537,000 for state assistance grants for safety and health training of our Nation's miners pursuant to section 503(a) of the Mine Safety and Health Act of 1977 (the Act). The enacted MSHA budget for at least the last five fiscal years has included this amount, $10,537,000, for state assistance grants. This money will enable states to meet the training needs of miners and to fully and effectively carry out important state responsibilities under section 503(a) of the Act. We believe the states can more than justify the need for funding at this statutorily authorized level.

The Interstate Mining Compact Commission (IMCC) is a multi-state governmental organization that represents the natural resource, environmental protection and mine safety and health interests of its 26 member states. The states are represented by their Governors who serve as Commissioners of IMCC.

We support full funding in the amount of $10,537,000 for the state assistance grants that enable the states to provide essential safety and health training for the nation's coal miners, undiminished by use of these funds for other purposes. Section 503 of the Act was structured to be broad in scope and to stand as a separate and distinct part of the overall mine safety and health program. In the Conference Report that accompanied passage of the Federal Coal Mining Health and Safety Act of 1969, the conference committee noted that both the House and Senate bills provided for "Federal assistance to coal-producing States in developing and enforcing effective health and safety laws and regulations applicable to mines in the States and to promote Federal-State coordination and cooperation in improving health and safety conditions in the Nation's coal mines." (H. Conf. Report 91–761). The 1977 Amendments to the Mine Safety and Health Act expanded these assistance grants to both coal and metal/non-metal mines and increased the authorization for annual appropriations to $10 million. The training of miners was only one part of the obligation envisioned by Congress.

With respect to the training component of our mine safety and health programs, IMCC's member states are concerned that without full, stable funding of the State Grants Program, the federally required training program for miners employed throughout the U.S. will suffer. Our experience over the past 40 years has demonstrated that the states are often in the best position to design and offer mine safety and health training in a way that ensures that the goals and objectives of Sections 502 and 503 of the Mine Safety and Health Act are adequately met. We greatly appreciate Congress' recognition of this fact and this Subcommittee's strong support for state assistance grants, especially in past years when the Administration sought to eliminate or substantially reduce those moneys.

We also appreciate the recognition by Congress that the availability of these funds to states should not be diminished by allowing them to be used for other purposes. We urge Congress to reject any attempt to diminish the funds available to states in the budget it adopts for Fiscal Year 2024 and future years. The budget that is adopted should include the full amount of $10,537,000 for state assistance grants, without any provisos or other qualifications that could reduce the amount of money states receive.

Thank you for the opportunity to present our views on the proposed FY 2024 budget for MSHA.

[This statement was submitted by Thomas L. Clarke, Executive Director, Interstate Mining Compact Commission.]

PREPARED STATEMENT OF TITLE IV–A COALITION

Dear Chairwoman Baldwin and Ranking Member Collins,

On behalf of the 130+ undersigned national, State, and local organizations, we urge Congress to increase the Student Support and Academic Enrichment (SSAE) grant program, authorized by Title IV Part A of The Every Student Succeeds Act (ESSA), program by $100 million to $1.48 billion in FY24.

This bipartisan flexible block grant supports investments in safe and healthy students, well-rounded education programs, and the effective use of technology in education. Robust and steady funding for Title IV–A helps ensure districts are able to provide a full array of services and learning opportunities that support the whole child, and improve academic success for all students. As a formula-based program focused on the flexible, locally-determined use of funds, the grant is well suited to ensuring that a large number of geographically and socioeconomically diverse districts have resources they can direct in a manner that best addresses their particular needs. Title IV–A has continuously maintained bipartisan support in part because of the flexibility it affords States and districts to implement programming based on specific needs of their school community.

Like Congress, district leaders also favor the program's flexibility: In our 2023 survey of over 600 districts across the Nation, the preliminary data continuously shows that district leaders appreciate the program's flexibility above all else. To that point, when asked about how districts invested in the many allowable uses across the three buckets, districts selected a wide-range of activities including, but not limited to: funding STEM and computer science, music and the arts, environmental education, International Baccalaureate and Advanced Placement courses (IB and AP), physical education, health and wellness, professional development for use of educational technology, violence prevention, behavioral and mental health supports and much more. Survey data also reveals that without these funds, the expansion of existing programs and creation of new programs would not be possible, making the amount of funding second to flexibility in terms of importance for districts.

This Federal investment is absolutely critical to supporting comprehensive student needs, ensuring a safe and healthy school environment, and increasing access to a well-rounded education necessary for students to thrive in a modern society and workforce.

For these reasons, we must continue to invest in our Nation's schools, educators, and most importantly, our students and we urge Congress to fund the SSAE flexible grant program at $1.48 billion in FY24.

Thank you for your consideration of this request. We look forward to working with you to ensure these investments continue to support districts, educators, and students in a manner tailored to their unique needs.

Sincerely.

NATIONAL ORGANIZATIONS

Communities In Schools
International Society for Technology in Education (ISTE)
Advance CTE
AASA, The School Superintendents Association
Committee for Children
Afterschool Alliance
All4Ed
American Federation of School Administrators
American Heart Association
American Library Association
American Occupational Therapy Association
American Psychological Association
American School Counselor Association
American School Counselor Association
AnitaB.org
Association of School Business Officials International (ASBO)
City Year, Inc
Coalition for Community Schools
Code.org
Collaborative for Academic, Social, and Emotional Learning
Council of Administrators of Special Education
EDGE Consulting Partners
Educational Theatre Association
Futures Without Violence
GLSEN
Institute for Educational Leadership
International Baccalaureate
Joint National Committee for Languages
League of American Orchestras
Learning Disabilities Association of America
Learning Forward

MENTOR
North American Association for Environmental Education
National Association for College Admission Counseling
National Association for Music Education
National Association of Elementary School Principals
National Association of School Nurses
National Association of School Psychologists
National Association of Secondary School Principals (NASSP)
National Association of Secondary School Principals (NASSP)
National Center for Learning Disabilities
National Coalition for Technology in Education and Training
National Council for Languages and International Studies
National Council for the Social Studies
National Council of Teachers of Mathematics
National PTA
National Science Teaching Association
School-Based Health Alliance
SETDA
SHAPE America—Society of Health and Physical Educators
Society of Women Engineers
The Education Trust
Young Audiences Arts for Learning

STATE AND LOCAL ORGANIZATIONS

SHAPE Alaska	Alaska
Pacific Northwest Association for College Admission Counseling	Alaska, Idaho, Montana, Oregon & Washington
SHAPE Arkansas	Arkansas
Association of California School Administrators	California
California Association of School Counselors	California
Colorado School Counselor Association	Colorado
Society for Health and Physical Education Colorado	Colorado
Connecticut Council for the Social Studies	Connecticut
CTAHPERD	Connecticut
New England ISTE	CT, MA, ME, NH, & VT
Florida Association of School Psychologists	Florida
Florida School Counselor Association	Florida
Georgia Council for the Social Studies	Georgia
Great Plains Association for College Admissions Counseling	Great Plains (Kansas, Nebraska, and Oklahoma)
Hawaii Association for Health, Physical Education, Recreation and Dance.	Hawaii
SHAPE Idaho	Idaho
Illinois AHPERD	Illinois
Illinois Association for College Admission Counseling	Illinois
Indiana Association of School Psychologists	Indiana
Indiana School Counselor Association	Indiana
Iowa Association for College Admission Counseling	Iowa
KAHPERD Kansas Association for Health Physical Education Recreation and Dance.	Kansas
Kentucky Society for Technology in Education (KySTE)	Kentucky
Kentucky SHAPE	Kentucky
Louisiana School Psychological Association	Louisiana
Louisiana Association of Computer Using Educators	Louisiana
Maine Association for Health, Physical Education, Recreation, and Dance.	Maine
Maine School Counselor Association	Maine
Maryland Society for Educational Technology	Maryland
SHAPE Maryland	Maryland
Maryland School Counselor Association	Maryland
Michigan Association for College Admission Counseling (MACAC)	Michigan
SHAPE Michigan	Michigan
Minnesota School Counselor Association	Minnesota
MNSHAPE	Minnesota
Magnolia State School Counselor Association	Mississippi
Missouri Association of Secondary School Principals	Missouri
Missouri School Counselor Association	Missouri
Missouri Society of Health and Physical Educators	Missouri
SHAPE Montana	Montana
NSCSS	Nebraska
Society of Health and Physical Educators of Nebraska	Nebraska
NH Association for Health, Physical Education, Recreation & Dance (NHAHPERD).	New Hampshire

New Jersey School Counselor Association	New Jersey
NJ Principals and Supervisors Association	New Jersey
New Mexico School Counselor Association	New Mexico
SHAPE New Mexico	New Mexico
New York State School Counselor Association	New York
NYS Association for Health, Physical Education, Recreation and Dance	New York
North Carolina School Counselor Association	North Carolina
ND SHAPE	North Dakota
NWOET	Ohio
Ohio AHPERD	Ohio
Ohio School Counselor Association	Ohio
Oklahoma Association for Health, Physical Education, Recreation, and Dance.	Oklahoma
Oregon School Psychologists Association	Oregon
Association of School Psychologists of Pennsylvania	Pennsylvania
PACAC	Pennsylvania
Pennsylvania School Counselors Association	Pennsylvania
Palmetto State School Counselor Association	South Carolina
South Carolina Alliance for Health, Physical Education, Recreation and Dance.	South Carolina
South Carolina Council for the Social Studies	South Carolina
Tennessee Association of School Psychologists	Tennessee
Texas Association for College Admission Counseling	Texas
Texas Computer Education Association	Texas
Texas Association for College Admissions Counselors	Texas
Lone Star State School Counselor Association	Texas
Society of Health and Physical Educators- Vermont	Vermont
Vermont Principals' Association	Vermont
Virginia School Counselor Association	Virginia
Virginia AHPERD Association of Health, Physical Education, Recreation, and Dance.	Virginia
SHAPE Washington	Washington
SHAPE WV	West Virginia
West Virginia School Counselor Association	West Virginia
Wisconsin Health and Physical Education	Wisconsin
Wisconsin Council for the Social Studies	Wisconsin
Rocky Mountain Association for College Counseling	Wyoming
Natrona County High School	Wyoming

PREPARED STATEMENT OF THE TOURETTE ASSOCIATION OF AMERICA

Dear Chairwoman Baldwin, Ranking Member Capito, and Members of the subcommittee:

The Tourette Association of America (TAA) would like to take this opportunity to thank the members of the subcommittee for the opportunity to submit written testimony and for considering our request for funding for Fiscal Year 2024 (FY24). The Centers for Disease Control and Prevention (CDC) play a pivotal role in educating the public. To that end, the Tourette Syndrome Public Health Education and Research Program at the CDC are critically important to the TS and Tic Disorder community. We respectfully request that you appropriate the enacted level of $2.5 million for the program in FY24 Labor, Health, and Human Services (LHHS), Education, and Related Agencies Appropriations. The program on Tourette Syndrome is administered within the National Center on Birth Defects and Developmental Disabilities (NCBDDD) at the CDC, in partnership with the TAA. This program was established by Congress in the Children's Health Act of 2000 (PL. 106–310 Title 23) and is the only such program that receives Federal funding for Tourette Syndrome (TS) public health education. With your support at the enacted level of $2.5 million, CDC can ensure critically necessary progress continues in the areas of public education, research, and diagnosis for TS and Tic Disorders.

The TAA is the only national non-profit organization working to make life better for all people affected by TS and Tic Disorders. We have served in this capacity for 51 years. Tics are involuntary, repetitive movements and vocalizations. They are the defining feature of a group of childhood-onset, neurodevelopmental conditions known collectively as Tic Disorders and individually as Tourette Syndrome, Chronic Tic Disorder (Motor or Vocal Type), and Provisional Tic Disorder. People with TS and Tic Disorders often have substantial healthcare costs across their lifespan for healthcare visits, special educational services, medication, and psychological and be-

havioral counseling. In a recent survey conducted by the TAA (2022 TAA Impact Survey: https://tourette.org/research-medical/impact-survey/), 28% of parents struggle to cover the high costs of services for their child such as counseling, appointments, and tutoring; 15% of parents report they lost their job or they are not able to work as often due to the increased caregiver duties of having a child living with TS; and, 6% of parents are not able to afford medications and/or desired medical care for their child. A Coronavirus impact survey, conducted by TAA (https://tourette.org/coronavirus-and-tourette-syndrome/), found that 82% of respondents said their tics or other symptoms worsened during the pandemic.

The CDC Tourette Syndrome Website (https://www.cdc.gov/ncbddd/tourette/data.html) on data and statistics States that data suggest roughly 50% of children and teens with TS are not diagnosed. Studies including children with both diagnosed and undiagnosed TS have estimated that 1 out of every 162 children (0.6%) have TS. However, these numbers do not include children with Chronic or Provisional Tic Disorders. The estimated combined total of all school-aged children with TS or another persistent Tic Disorder is approximately 1-in-50 (https://www.sciencedirect.com/science/article/abs/pii/S0165178122002840?via=ihub). Factoring in lifelong prevalence, CDC estimates that 1.4 million adults and children are living with Tourette Syndrome or another persistent Tic Disorder in the United States today. These statistics outline the need for additional research on prevalence. Diagnosis is often complicated. Among children diagnosed with TS, 83% have been diagnosed with at least one additional mental, behavioral, or developmental condition according to the CDC website. These co-occurring conditions include Attention Deficit-Hyperactivity Disorder (ADHD), Obsessive Compulsive Disorder (OCD), Autism, Oppositional Defiance Disorder, anxiety, depression, learning difficulties among others and can significantly impact the lives of those affected by TS. In TAA's 2022 Impact Survey, 23% of children and 48% of adults have considered suicide in their lifetime and 10% of children and 27% of adults have attempted suicide at least once in the last 12 months. Physical pain from tics has been experienced by 72% of children and 87% of adults. This underscores the need to increase the diagnosis rate so physicians, teachers and parents can ensure that adequate support services are in place. The CDC TS Program works to ensure primary care, family doctors or pediatricians are equipped with the additional knowledge necessary either to diagnose or to refer a patient for optimal treatment.

Education professionals often do not receive detailed instruction on how to assess and accommodate students who may have TS and Tic Disorders. A study published in the Journal of Developmental & Behavioral Pediatrics and written in partnership between the CDC and the Tourette Association of America, "Impact of Tourette Syndrome on School Measures in a Nationally Representative Sample", found children with Tourette were more likely to have an individualized IEP, have a parent contacted about school problems and have incomplete homework as compared to children without Tourette or a Tic Disorder. Additionally, most children with Tourette Syndrome had other mental, behavioral, or emotional disorders or learning and language disorders. In TAA's 2022 Impact Survey, 80% of children felt that TS negatively impacted their school experience and education and 76% of parents noted their child having an individualized education plan (IEP) or 504 plan in place at their school. Additionally, 66% were forced to miss school or have extended absences. Educators spend a significant amount of time with their students providing more opportunities to assess symptoms and behavior over a longer period of time. By increasing their knowledge base and understanding of Tourette Syndrome, Tic Disorders and associated co-morbidities, educators can refer students for medical assessment and can also better serve the needs of this population whose challenges are unique to the disorder. Educators can then begin to work more closely with medical providers to develop effective, individualized education plans.

TS and Tic Disorders are greatly misunderstood and often suffer from misinformation and stigma. For example, coprolalia, the involuntary utterance of obscene and socially unacceptable words and phrases, is an extreme and rare symptom often sensationalized by the media. Less than 10% of those diagnosed have this symptom, it is not required for diagnosis, and does not persist in many cases. The CDC TS Public Health, Education and Research Program provides important information on symptoms/diagnostic criteria on their website and through the outreach program educating the public and parents on Tourette Syndrome and Tic Disorders to ensure a better understanding which can lead to better diagnosis, earlier treatment and a better understanding.

Delayed diagnosis or the lack of diagnosis can increase health care costs, increase education costs and delay important treatment and therapy for the patient. Comprehensive Behavior Intervention for Tics (CBIT) is a non-medicated treatment consisting of three important components: training the patient to be more aware of his

or her tics and the urge to tic; training patients to do competing behavior when they feel the urge to tic; and, making changes to day-to-day activities in ways that can be helpful in reducing tics. CBIT is now recognized as a first line treatment by the American Academy of Neurology: https://www.aan.com/Guidelines/Home/GuidelineDetail/958. The CDC Tourette Syndrome Public Health, Education and Research Program strives to increase the understanding and awareness among these critically important medical and education professionals to increase the percentage of school aged children with TS who are diagnosed, improve the timeframe from symptoms to diagnosis and educate them about treatment options like CBIT.

We appreciate the opportunity to submit testimony and appreciate your thoughtful consideration of our request. TAA urges you to provide continued funding for Fiscal Year 2024 for the Tourette Syndrome Public Health Education and Research Program at CDC's National Center for Birth Defects and Developmental Disabilities at the enacted level of $2.5 million.

PREPARED STATEMENT OF TRUST FOR AMERICA'S HEALTH

Trust for America's Health (TFAH) is pleased to submit testimony on the fiscal year (FY) 2024 Labor, Health and Human Services, Education, and Related Agencies (LHHS) appropriations bill. TFAH is a non-profit, non-partisan public health policy, research, and advocacy organization that promotes optimal health for every person and community. Troubling rates of chronic disease, rising deaths from overdose and suicide, and increasing threats from natural disasters and infectious disease outbreaks all underscore the urgent need to strengthen prevention and public health. While Congress allocated short-term funding to address COVID–19, this funding cannot build ongoing capacity, promote overall health, or strengthen the underlying infrastructure and workforce. Now is the time to ensure every community has the chance for health and well-being. TFAH urges Congress to fund the Centers for Disease Control and Prevention (CDC) at $11.581 billion for FY2024, including these effective programs:

Emergency Preparedness: The COVID–19 response was hindered in part because the CDC's emergency preparedness funding had been repeatedly cut, reducing essential training and expert personnel. The Public Health Emergency Preparedness (PHEP) cooperative agreement has enabled great strides in our Nation's all-hazards preparedness, but PHEP has been cut significantly from $918 million in FY2002 to $735 million in FY2023, or about half when accounting for inflation. The cooperative agreement supports 62 State, local, and territorial recipients to develop and strengthen core preparedness capabilities and is the main Federal program that supports the work of health departments in preparing for and responding to all types of disasters, including bioterrorism, natural disasters, and infectious disease outbreaks. TFAH recommends at least $1 billion for PHEP to rebuild capacity to respond to an escalating number of emergencies.

The pandemic has also demonstrated the impact of failing to invest in comprehensive readiness of the healthcare delivery system. The Healthcare Readiness and Recovery Portfolio, including the Hospital Preparedness Program (HPP), administered by the Administration for Strategic Preparedness and Response at HHS, provides critical funding and technical assistance to health care coalitions (HCCs) across the country to meet the disaster healthcare needs of communities. HPP builds resilience in the healthcare delivery system by increasing its ability to operate and provide care during a disaster, saving lives and ensuring the earliest possible recovery of the system. Unfortunately, funding has been cut drastically from $515 million in FY2003 to $305 million in FY2023, over 60 percent when accounting for inflation. Although HPP has saved lives during disasters, these cuts have limited medical surge capacity and healthcare situational awareness in all States. TFAH recommends at least $500 million for HPP to help the healthcare system to save lives during disasters.

Healthy Outcomes in Schools: CDC's Division of Adolescent and School Health (DASH) provides evidence-based health promotion and disease prevention education for less than $10 per student. DASH collaborates with State and local education agencies to increase health services, promote protective factors, and reduce risky behaviors. Examples of these strategies include mentoring programs, service-learning opportunities, and student-led groups. DASH also operates two school-based data collection systems that provide educators with information they can translate into programs, policies, and practices to improve student health and well-being. A 2022 study found that these programs resulted in significant decreases in sexual risk behaviors, violent experiences, and substance use, as well as improvements in mental

health and reductions in suicidal thoughts and attempts.[1] Findings CDC released in February 2023, showing increasing levels of suicidal thoughts and behaviors for nearly all groups of youth, also underscore the importance of this work.[2] TFAH recommends at least $100 million for DASH to expand its work to 75 of the largest local education agencies, 50 States, and 7 territories to reach approximately 25 percent of all U.S. students.

Suicide Prevention: According to CDC data, the number of suicides increased in 2021 to nearly historic peak levels after slight declines in 2019 and 2020, and suicide rates increased significantly, overall, for non-Hispanic Black, American Indian/Alaska Native (AI/AN), and Hispanic persons in 2021.[3] Findings CDC released in February 2023 also show worsening trends in suicidal thoughts and behaviors among teen girls, specifically, through 2021.[4] More broadly, deaths from suicide increased each year from 2012 through 2018, and more than 450,000 Americans died from suicide between 2012 and 2021. CDC's work helps identify and disseminate effective strategies for preventing suicide by supporting multi-sector partnerships, using data to identify populations of focus and risk and protective factors, conducting rigorous evaluation efforts, and filling gaps through complementary strategies and communications. Fourteen current recipients use CDC funding to support data collection of nonfatal suicide related outcomes through emergency department syndromic surveillance. These data can identify upticks and spikes in nonfatal suicide-related outcomes in near-real time to inform local responses. TFAH recommends at least $80 million to expand prevention activities to all 50 States, Washington, D.C., and 18 Tribal and territorial communities and support State health departments as they expand comprehensive suicide prevention and surveillance.

Adverse Childhood Experiences: Adverse childhood experiences (ACEs) are potentially traumatic events-in connection with abuse, neglect, and high community rates of violence and crime-that occur in childhood and can have long-lasting effects on an individual's lifelong health and opportunity. CDC has recognized the association between ACEs, suicides, and substance use disorders, and that the prevention of ACEs could reduce cases of depression in adults by an estimated 44 percent.[5] To help address these issues, CDC has worked to build the evidence base by funding innovative research and evaluation, supporting surveillance and data innovation, and identifying strategies and building capacity and awareness to prevent ACEs. CDC currently supports six State-level offices, institutes, or departments that are implementing ACEs prevention strategies, including economic assistance to families, efforts to connect youth to care, and short-term and long-term interventions to reduce harms.[6] Recipients of CDC funding also build or enhance awareness, analysis, and application of ACEs-related data, which directly informs and tailors ACEs prevention activities in communities. TFAH recommends at least $15 million to expand surveillance and ACEs prevention activities to additional States.

Obesity and Chronic Disease Prevention: In 2020, 41.9 percent of adults had obesity and 19.7 percent of youth ages 2–19 had obesity.[7] Even though obesity accounts for nearly 21 percent of U.S. healthcare spending, funding for CDC's Division of Nutrition, Physical Activity, and Obesity (DNPAO) is only equal to about 31 cents per person.[8] This Division's current funding level can only support 16 States through

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[1] Robin L, Timpe Z, Suarez NA, et al. "Local Education Agency Impact on School Environments to Reduce Health Risk Behaviors and Experiences Among High School Students." Journal of Adolescent Health, February 2022. https://www.sciencedirect.com/science/article/abs/pii/S1054139X21004006.

[2] Youth Risk Behavior Survey Data Summary & Trends Report: 2011–2021. Atlanta: CDC Division of Adolescent and School Health, February 13, 2023. https://www.cdc.gov/healthyyouth/data/yrbs/pdf/YRBS__Data-Summary-Trends__Report2023__508.pdf (accessed February 13, 2023).

[3] Stone D, Mack K, Qualters J, "Notes from the Field: Recent Changes in Suicide Rates, by Race and Ethnicity and Age Group—United States, 2021." Morbidity and Mortality Weekly Report, 72(6):160–162, February 10, 2023. https://www.cdc.gov/mmwr/volumes/72/wr/mm7206a4.htm.

[4] Youth Risk Behavior Survey Data Summary & Trends Report: 2011–2021. Atlanta: CDC Division of Adolescent and School Health, February 13, 2023. https://www.cdc.gov/healthyyouth/data/yrbs/pdf/YRBS__Data-Summary-Trends__Report2023__508.pdf .

[5] Justification of Estimates for Appropriations Committees. Centers for Disease Control and Prevention, FY2024. https://www.cdc.gov/budget/documents/fy2024/FY-2024-CDC-congressional-justification.pdf.

[6] Preventing Adverse Childhood Experiences: Data to Action. In Centers for Disease Control and Prevention, updated September 22, 2022. https://www.cdc.gov/violenceprevention/aces/preventingace-datatoaction.html.

[7] State of Obesity 2022. Trust for America's Health. Sept 2022. https://www.tfah.org/report-details/state-of-obesity-2022/.

[8] J. Cawley and C. Meyerhoefer, "The Medical Care Costs of Obesity: An Instrumental Variables Approach," Journal of Health Economics 31, no. 1 (2012): 219–30.

the State Physical Activity and Nutrition (SPAN) program and 15 land grant universities through the High Obesity Program to promote healthy eating, active living, and obesity prevention in schools, worksites, and neighborhoods; build obesity-prevention capacity of State health departments and national organizations; and conduct research and evaluation. TFAH recommends at least $130.42 million for DNPAO to expand this work to 50 States and the territories.

Additionally, community-driven approaches are needed to address persistent health gaps facing populations of color and Tribal Nations. Among the programs that are effective in reducing racial and ethnic health disparities are the Racial and Ethnic Approaches to Community Health (REACH) program and Healthy Tribes. CDC's REACH program, within DNPAO, works in 40 communities across the country to support innovative, evidence-based programs that reduce health disparities. The REACH program is undergoing a re-compete this year, and increased funding is needed to meet the overwhelming need for the program, which has 260 approved but unfunded applications. The Healthy Tribes program coordinates three programs that support AI/AN health: Good Health and Wellness in Indian Country, Tribal Epidemiology Centers for Public Health Infrastructure, and Tribal Practices for Wellness in Indian Country. Healthy Tribes supports chronic disease prevention while allowing Tribal leaders to direct interventions that are most effective for their communities. TFAH recommends at least $102.5 million for the total REACH funding line (CDC), with $75.5 million directed to REACH and $27 million for Healthy Tribes.

Social Determinants of Health: Social determinants of health (SDOH) such as housing, employment, food security, education, and transportation have a major influence on individual and community health,[9] contributing to an estimated 80–90 percent of a person's health outcomes.[10] CDC's program aims to support collaborations across sectors and promote cost-saving interventions that prevent chronic health conditions. In a review of similar multisector partnerships addressing SDOH, 29 organizations projected these efforts would result in a savings of $644 million over 20 years from saved medical costs and increased productivity levels.[11] TFAH recommends at least $100 million to further develop CDC's SDOH Program.

Environmental Health: Many emergencies occur due to environmental hazards. Since CDC's National Environmental Public Health Tracking Network began in 2002, grantees have taken over 400 data-driven actions to eliminate risks to the public. Data cover asthma, drinking water quality, lead poisoning, and flood vulnerability, and States use this information to conduct targeted interventions in affected communities. Currently, only 33 States, local, and city health departments are funded to participate in the Tracking Network. With a $1.44 return in health care savings for every dollar invested, [12] the Tracking Network is a cost-effective program that examines and combats harmful risk factors. As of FY2023, CDC is still only able to fund 31 States, in addition to one city and one county to participate in the Tracking Network. TFAH recommends at least $65 million for the National Environmental Public Health Tracking Network to fund all 50 States.

Age-Friendly Public Health: The disproportionate impact of the COVID–19 pandemic on older adults has shown that collaboration between the public health and aging sectors is vital. Public health interventions play a valuable role in optimizing the health and well-being of older adults by prolonging their independence, reducing health care costs, coordinating existing multi-sector efforts, and disseminating and implementing evidence-based policies. Yet as of now, there is no comprehensive health promotion program for older adults. TFAH recommends funding for a CDC Healthy Aging unit to promote the health and well-being of older adults, advance health equity and reduce healthcare costs by developing Age-Friendly Public Health Systems (AFPHS) at State, local, territorial, and Tribal health departments. AFPHS interventions can optimize the health and well-being of adults 65 and over, prolong their independence, help reduce disparities and advance equity, and help reduce the Nation's healthcare spending. Elevating healthy aging as a core function of public health departments is necessary to foster multi-sector collaboration and develop effective solutions to improve the lives of older Americans. We recommend the Com-

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[9] Taylor, L et.al, "Leveraging the Social Determinants of Health: What Works?" PLoS One. 2016 Aug 17;11(8):e0160217. doi: 10.1371/journal.pone.0160217. PMID: 27532336; PMCID: PMC4988629.

[10] S. Magnan. Social Determinants of Health 101 for Health Care: Five Plus Five. National Academy of Medicine, Oct 9, 2017. https://nam.edu/social-determinants-of-health-101-for-health-care-five-plus-five/.

[11] CDC, SDOH Evaluation. https://www.cdc.gov/chronicdisease/programs-impact/sdoh/pdf/GFF-eval-brief-508.pdf.

[12] Return on Investment of Nationwide Health Tracking, Washington, DC: Public Health Foundation, 2001.

mittee provide CDC at least $50 million for an Age Friendly Public Health program to address the health needs of older adults.

[This statement was submitted by J. Nadine Gracia, M.D., MSCE, President and CEO, Trust for America's Health.]

PREPARED STATEMENT OF THE TUSKEGEE UNIVERSITY COLLEGE OF VETERINARY MEDICINE

SUMMARY OF FISCAL YEAR 2024 RECOMMENDATIONS

Health Resources and Services Administration:

—$1.51 billion for the Health Resources and Services Administration (HRSA) Title VII health professions and Title VIII nursing workforce development programs.
—$47.42 million for HRSA's Minority Centers of Excellence.
—$47.95 million for HRSA's Health Careers Opportunity Program.
—At least $2.31 million (FY 2023 level) for HRSA's Minority Faculty Loan Repayment Program.
—$67 million for HRSA's Scholarships for Disadvantaged Students (SDS).

Centers for Disease Control and Prevention:

—$74 million for the Racial and Ethnic Approaches to Community Health (REACH) Program.

National Institutes of Health:

—$50.92 billion for the National Institutes of Health.
—$1 billion for the National Institute on Minority Health and Health Disparities (NIMHD).
—$300 million for the Research Centers at Minority Institutions (RCMI).
—$200 million in new, annual research funding dedicated specifically targeted at enabling historically black health professions schools to support research that reverses health status disparities among minority Americans.
—$50 million for the NIMHD's Research Endowment Program (REP).
—$100 million for NIH's Extramural Research Facilities program.

Office of the Secretary:

—At least $74.84 million (FY 2023 level) for the Office of Minority Health at the Department of Health and Human Services.
—$5 billion in new funding designated for Historically Black Health Professions Institutions for the improvement and development of health care infrastructure.

Department of Education:

—At least $100.78 million (FY 2023 level) for the Strengthening Historically Black Graduate Institutions (HBGI) Program.

Community Project Funding/Congressional Directed Spending Request (HRSA):

—$1 million for the Development of a Center for Food Animal Health, Food Safety, and Food Defense in TUCVM.

Chairwoman Baldwin, Ranking Member Capito, and distinguished members of the subcommittee, thank you for the opportunity to submit testimony and thank you for your leadership in addressing challenges facing the health workforce, health disparities, and medically underserved communities. I am Dr. Ruby Perry, Dean and Professor of Veterinary Radiology at the College of Veterinary Medicine at Tuskegee University. Since its inception in 1945, Tuskegee University College of Veterinary Medicine (TUCVM) has educated more than 70 percent of the Nation's African American veterinarians, and is recognized as the most diverse of all veterinary schools and colleges in the U.S. The College is the only veterinary medical professional program located on the campus of a historically black college or university (HBCU) in the U.S.

The pandemic has pulled back the curtain on what TUCVM and other Historically Black Graduate Institutions (HBGIs) and HBCUs know and work on everyday: the pitfalls and shortcomings of minority health, as well as health professional shortages throughout the Nation. Given the recent deluge of media coverage surrounding these disheartening topics, the country is primed and ready to act in a meaningful way. Our funding recommendations are robust, and we realize ambitious, however

there have rightfully been discussion concerning the devastating effect of the pandemic on people of color and the need to address this effect for any future pandemic. To be as clear as we can be, there must be more robust investment on minority health and disparities. To achieve this, we know that it will require the steadfast leadership of health equity champions. We stand ready to work with you and your colleagues to facilitate these efforts.

The benefits of increasing diversity in the health professions to reduce such disparities have been studied at length, are based on empirical data, and are well understood by the medical community. Examples of these benefits include:

—Minority physicians are more likely to practice in medically underserved areas and care for patients regardless of their ability to pay.

—There is evidence that the intellectual, cultural sensitivity, competency, and civic development of students is enhanced by learning in a diverse educational environment.

—A diverse health workforce encourages a greater number of minorities to enroll in clinical trials designed to alleviate health disparities.

There is little left to discover or dispute with respect to the benefits of achieving greater racial and ethnic diversity of the Nation's health professionals—the attention has once again shifted to identifying the most effective and sustainable methods to do so. While there are many national campaigns underway to increase diversity in all medical and health professions schools particularly during this period of enrollment growth, it is imperative that we further recognize and leverage the public value of Historically Black Health Professions Schools.

Ironically, because of their mission focus, the financial models of historically black health professions schools are uniquely disadvantaged compared to most of their peer institutions. Unlike subspecialty-oriented, research-intensive institutions—with higher margin clinical services, an integrated hospital system, substantial research enterprises, sizeable endowments, and a critical mass of wealthy donors—these institutions are faced with an unprecedented set of adverse factors that challenge their financial viability. Consequently, they are disproportionately dependent on the various Federal programs that support their core purpose.

Specifically, these programs include: the Title VII Health Professions Training Programs administered by the Health Resources and Services Administration (HRSA) of the Department of Health and Human Services (HHS); the Research Centers at Minority Institutions (RCMI), the Extramural Research Facilities; the Research Endowment; and Centers of Excellence programs administered the National Institutes of Health's National Institute on Minority Health and Health Disparities; and the Historically Black Graduate Institution (HBGI) program administered by the Office of Postsecondary Education of the U.S. Department of Education (DOE).

President Biden signed the John Lewis NIMHD Research Endowment Revitalization Act last year to revitalize this important initiative, and Congress designated $12.00 million for the Research Endowment Program in FY 2023. This reinvigoration will allow minority-serving institutions to participate in this competitive opportunity to build their research endowments in a manner consistent with the statutory goal of assisting them in achieving a research endowment that is comparable to the endowments of other schools in their health professions discipline. The NIMHD Research Endowment Program (REP) allows academic institutions to build research infrastructure and recruit, train, and maintain a diverse faculty and student body. Additional robust funding in FY 2024 would allow active and former NIMHD Centers of Excellence to continue their historic focus on research to close the gap between the burden of illness and premature mortality experienced more commonly by communities of color, as well as other medically underserved populations. It would also help improve access to grants to fund research projects, as well as hire staff and provide scholarships for students who come from underserved communities. To ensure successful implementation, we are asking for the Committee to allocate robust funding to NIMHD for this program, building on the $12 million that was allocated in FY 2023.

Chairwoman Baldwin, unfortunately, over the past several years funding for diversity-focused programs has deteriorated in varying degrees. Absent a monumental overall investment, the financial position and academic viability of historically black health professions schools will deteriorate rapidly. Thank you all again for the opportunity to share the priorities of the College of Veterinary Medicine at Tuskegee University.

[This statement was submitted by Ruby L. Perry, DVM, PhD, Diplomate-ACVR, Dean & Professor of Veterinary Radiology, College of Veterinary Medicine, Tuskegee University.]

PREPARED STATEMENT OF THE U.S. HEREDITARY ANGIOEDEMA ASSOCIATION

SUMMARY OF FISCAL YEAR 2024 RECOMMENDATIONS

—Provide the National Institutes of Health (NIH) with at least a $3.5 billion increase in discretionary funding for FY 2024 to bring overall agency funding up to a minimum of $50.9 billion annually.
—Continue to support committee recommendations that encourage advancement and expansion of the hereditary angioedema research portfolio at NIH, as well as research efforts focused on rare conditions more broadly.
—Provide the Centers for Disease Control and Prevention (CDC) with at least a $2.4 billion increase in discretionary funding for FY 2024 to bring overall agency funding up to a minimum of $11.6 billion annually (consistent with the budget request).
—Continue to resist the utilization of quality adjusted life years (QALYs) and discriminatory value frameworks and otherwise encourage the Centers for Medicare and Medicaid Services (CMS) to further ensure rare disease patients do not face arbitrary restrictions when comprehensive coverage, proper access, and appropriate out of pocket costs.

Chairwoman Baldwin, Ranking Member Capito, and distinguished members of the subcommittee, thank you for the opportunity to present the views of the U.S. Hereditary Angioedema Association (U.S. HAEA) on funding and related policy items for NIH, CDC, and CMS during consideration of appropriations for FY 2024. First and foremost, thank you for supporting these programs with proper funding in FY 2023, and for including report language resisting the utilization of QALYs and discriminatory value frameworks. It is our hope that this investment will continue for FY 2024 along with further guidance to protect patients from discriminatory coverage practices.

ABOUT U.S. HAEA

U.S. HAEA is a patient organization dedicated to improving the health and wellbeing of people with Hereditary Angioedema (HAE). We would like to recognize this subcommittee for its leadership and commitment to providing medical research and public health programs with notable funding increases for FY 2022. This investment will have a tangible positive impact for patients by significantly improving scientific inquiry and public health activities.

The U.S. HAEA is a non-profit patient advocacy organization dedicated to serving the estimated 6,500 HAE sufferers in the U.S. We provide a support network and a wide range of personalized services for patients and their families. We are also committed to advancing clinical research designed to improve the lives of HAE patients and ultimately find a cure.

ABOUT HEREDITARY ANGIOEDEMA

Hereditary angioedema (HAE) is a painful, disfiguring, debilitating, and potentially fatal genetic disease that occurs in about 1 in 50,000 people. Symptoms include episodes of swelling in various body parts including the hands, feet, face and airway. Patients often have bouts of excruciating abdominal pain, nausea and vomiting that is caused by swelling in the intestinal wall. Approximately one-third of undiagnosed HAE patients are subject to unnecessary exploratory abdominal surgery. About 50% of patients with HAE will experience laryngeal edema at some point in their life. This swelling is exceedingly dangerous because it can lead to death by asphyxiation. The historical mortality rate due to laryngeal swelling is 30 percent.

A RESEARCH SUCCESS STORY

After decades of fierce patient advocacy and sustained efforts by compassionate physicians, medical science has produced innovative therapies that, when accessible, can improve the quality of life for most people living with HAE. Nevertheless, there remains a compelling need for research aimed at developing preventive therapies that completely eliminate HAE's devastating symptoms.

NIH has a modest, but meaningful HAE research portfolio. Recent annual investments will facilitate growth in this portfolio and have led to important new scientific projects. The ongoing research at NIH will lead to a time when HAE patients can move beyond their disease. However, a key question that remains is how much of this investment is going to rare and ultra-rare disease research programs, particu-

larly in-light of the "big ticket" items that are often now the focus of annual research appropriations.

As scientific understanding creates more innovative treatment options, FDA and CMS policy makers must ensure fair and proper access to physician-directed care with reasonable out of pocket costs. US HAEA welcomes the opportunity to serve as a resource for you and your authorizing colleagues in this important funding and policymaking area.

[This statement was submitted by Anthony J. Castaldo, President and CEO, U.S. Hereditary Angioedema Association.]

PREPARED STATEMENT OF UNITED WAY OF DANE COUNTY

Nonprofits play a critical role in enriching our civil society and strengthening communities across the Nation. They are also an economic engine—nonprofits are the third-largest employer in the U.S., accounting for more than 12.5 million workers and 10% of the private workforce.

They not only provide essential services and programs for Wisconsin residents; they also provide the foundation for economic growth by offering child and senior care, educational supports, career development and adult education, and workforce development. For-profit businesses cannot find the skilled workers they need without a thriving nonprofit sector.

Although it plays a critical role in economic growth, the nonprofit sector is not able to access the timely wage and employment data available to every other industry. The Bureau of Labor Statistics provides nonprofit sector data only every 5 years, meaning that nonprofits are still extrapolating from 2017 data, without any comprehensive research that factors in the COVID–19 pandemic, inflation, technology advances or other factors affecting the current employment landscape.

According to the National Council of Nonprofits, "The labor market is active: more than 11 million jobs were posted in May 2020 and roughly 4.3 million workers quit or changed jobs that month, according to the Bureau of Labor Statistics. That agency does not specify nonprofit jobs, so nonprofits are forced to rely on anecdotal evidence to determine whether job applicants are taking work in the for-profit or governmental sectors, and which subsectors, if any, are close to their pre-pandemic employment levels."

By contrast, for-profit companies have access to quarterly wage and employment data that enables them to track real time employment totals and wage information, and benchmark their outcomes against larger trends, while helping policymakers understand challenges and craft responsive policy.

According to its mission statement in the 2020–2025 strategic plan, the BLS "measures labor market activity in the U.S. economy to support public and private decision making." This mission simply cannot be achieved with a blind spot for the economy's third-largest employer.

In addition to its fundamental unfairness, this system serves our sector and the American people extremely poorly. The nonprofit workforce is burned out after addressing years of crisis-level need in their communities and are increasingly leaving the sector for more profitable, and less stressful, positions in other industries. This means longer wait times for necessary services, and a slowdown in the economic recovery as potential workers remain out of the labor force while waiting for family care or training.

Wisconsin is one of the few States without a Statewide nonprofit association. There is no central organization raising up the nonprofit community. As a result, there is limited capacity to build support in gathering information about nonprofits statewide.

It is essential that nonprofit leaders and policymakers have the data necessary to address the workforce crisis in the nonprofit sector, and develop sound strategies to support the sector into the future. This will ensure that essential services are available to our communities, and ensure that the economy is able to fully recover from the consequences of the pandemic.

Therefore, we strongly urge the subcommittee to support Senator Reed and Senator Whitehouse's FY24 program requests for $4 million to enable the Bureau of Labor Statistics to include nonprofit organizations as a distinct category of employer in its Quarterly Census of Employment and Wages and related reports.

The purpose of the QCEW is to provide "a quarterly count of employment and wages reported by employers covering more than 95 percent of U.S. jobs, available at the county, MSA, state and national levels by industry." This mission is incomplete without data on the third largest workforce in the country, and we ask you to help ensure that this request is included in the final bill.

The current lack of timely, accurate wage and employment data on the nonprofit sector is untenable and inadequate for a workforce representing the third largest payroll of any industry. Nonprofits and their partners have been requesting this data for years (2021 letter to Secretary Walsh, signed by 260 leaders and researchers), and the current workforce crisis makes this expansion of the QCEW a necessity. We urge you to support this request and ensure its inclusion in the final bill.

Thank you.

[This statement was submitted by Jody Bartnick, Vice President, Community Impact, United Way of Dane County.]

PREPARED STATEMENT OF UNITED WAY OF RHODE ISLAND

Nonprofits play a critical role in enriching our civil society and strengthening communities across the Nation. They are also an economic engine—nonprofits are the third-largest employer in the U.S., accounting for more than 12.5 million workers and 10% of the private workforce.

They not only provide essential services and programs for Rhode Island residents; they also provide the foundation for economic growth by offering child and senior care, educational supports, career development and adult education, and workforce development. For-profit businesses cannot find the skilled workers they need without a thriving nonprofit sector.

While many of our families lived on the edge of a financial crisis before COVID–19, the pandemic further demonstrated just how critical the nonprofit sector is in Rhode Island. As manager of one of the State's largest call centers, 211, we know the vital role nonprofits play in addressing our needs. As Rhode Islanders adjust to a post-COVID–19 life too many of our neighbors and community members are still struggling financially to make ends meet. In 2022, across the country, United Way 211 answered:

—211's responded to 18 million requests in 2022
—4.8m housing (4.4m 2021)
—2.6m utilities
—2.5m food
—1.6m healthcare (7m 2021)
—95% of unmet needs we're related to housing. Most had already been evicted and were in need of emergency housing (motel voucher) or shelter.

Our financial crisis crosses income and generational lines. Rhode Islanders are sacrificing medicine or being forced out their homes, young professionals are being pushed out of the state as it is becoming more difficult to anchor down here. The nonprofits sector is addressing those needs and more on a daily basis.

Although it plays a critical role in economic growth, the nonprofit sector is not able to access the timely wage and employment data available to every other industry. The Bureau of Labor Statistics provides nonprofit sector data only every 5 years, meaning that nonprofits are still extrapolating from 2017 data, without any comprehensive research that factor in the COVID–19 pandemic, inflation, technology advances or other factors affecting the current employment landscape.

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By contrast, for-profit companies have access to quarterly wage and employment data that enables them to track real time employment totals and wage information, and benchmark their outcomes against larger trends, while helping policymakers understand challenges and create responsive policy.

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In addition to its fundamental unfairness, this system serves our sector and the American people extremely poorly. The nonprofit workforce is burnt out after addressing years of crisis-level need in their communities and are increasingly leaving the sector for more profitable, and less stressful, positions in other industries. This means longer wait times for necessary services, and a slowdown in the economic recovery as potential workers remain out of the labor force while waiting for family care or training.

Rhode Island nonprofits and their staff have been heroes over the last 2 years, but without long-term investment in these organizations and their talented, effective workers, the current situation is unsustainable. Rhode Islanders appreciate what nonprofits bring to their community. The fact that they continue to serve as needs grow demonstrates their resilience and outsized impact. Nonprofits need support throughout the entire year. Nearly 17 percent of the State's workforce—one in six workers—are employed by a nonprofit, making it a sector larger than manufacturing in the Ocean State.

It is essential that nonprofit leaders and policymakers have the data necessary to address the workforce crisis in the nonprofit sector, and develop sound strategies to support the sector into the future. This will ensure that essential services are available to our communities, and ensure that the economy is able to fully recover from the consequences of the pandemic.

Therefore, we strongly urge the subcommittee to support Senator Reed and Senator Whitehouse's FY24 program requests for $4 million to enable the Bureau of Labor Statistics to include nonprofit organizations as a distinct category of employer in its Quarterly Census of Employment and Wages and related reports.

The purpose of the QCEW is to provide "a quarterly count of employment and wages reported by employers covering more than 95 percent of U.S. jobs, available at the county, MSA, state and national levels by industry." This mission is incomplete without data on the third largest workforce in the country, and we ask you to help ensure that this request is included in the final bill.

We need to treat nonprofits like the small businesses and economic drivers that they are. We are missing a huge opportunity as we recover and rebuild our economy. It would be unfair to assume nonprofits will continue to be here to meet the needs of our communities without systemically addressing their capacity. To better support Rhode Island's nonprofit community, advocates point to the need for more long-term planning and actionable investments aimed at sustaining the organizations that are pillars in their communities.

The current lack of timely, accurate wage and employment data on the nonprofit sector is untenable and inadequate for a workforce representing the third largest payroll of any industry. Nonprofits and their partners have been requesting this data for years (2021 letter to Secretary Walsh, signed by 260 leaders and researchers), and the current workforce crisis makes this expansion of the QCEW a necessity. We urge you to support this request and ensure its inclusion in the final bill.

Thank you for your time and consideration,

[This statement was submitted by Cortney Nicolato, President and CEO, United Way of Rhode Island.]

PREPARED STATEMENT OF UNITED WAY OF WISCONSIN

Nonprofits play a critical role in enriching our civil society and strengthening communities across the Nation. They are also an economic engine—nonprofits are the third-largest employer in the U.S., accounting for more than 12.5 million workers and 10% of the private workforce.

They not only provide essential services and programs for Wisconsin residents; they also provide the foundation for economic growth by offering child and senior care, educational supports, career development and adult education, and workforce development. For-profit businesses cannot find the skilled workers they need without a thriving nonprofit sector.

Although it plays a critical role in economic growth, the nonprofit sector is not able to access the timely wage and employment data available to every other industry. The Bureau of Labor Statistics provides nonprofit sector data only every 5 years, meaning that nonprofits are still extrapolating from 2017 data, without any comprehensive research that factors in the COVID–19 pandemic, inflation, technology advances or other factors affecting the current employment landscape.

According to the National Council of Nonprofits, "The labor market is active: more than 11 million jobs were posted in May 2020 and roughly 4.3 million workers quit or changed jobs that month, according to the Bureau of Labor Statistics. That agency does not specify nonprofit jobs, so nonprofits are forced to rely on anecdotal evidence to determine whether job applicants are taking work in the for-profit or governmental sectors, and which subsectors, if any, are close to their pre-pandemic employment levels."

By contrast, for-profit companies have access to quarterly wage and employment data that enables them to track real time employment totals and wage information, and benchmark their outcomes against larger trends, while helping policymakers understand challenges and craft responsive policy.

According to its mission statement in the 2020–2025 strategic plan, the BLS "measures labor market activity in the U.S. economy to support public and private decision making." This mission simply cannot be achieved with a blind spot for the economy's third-largest employer.

In addition to its fundamental unfairness, this system serves our sector and the American people extremely poorly. The nonprofit workforce is burnt out after addressing years of crisis-level need in their communities and are increasingly leaving the sector for more profitable, and less stressful, positions in other industries. This means longer wait times for necessary services, and a slowdown in the economic recovery as potential workers remain out of the labor force while waiting for family care or training.

Wisconsin is one of the few States without a Statewide nonprofit association. There is no central organization raising up the nonprofit community. As a result, there is limited capacity to build support in gathering information about nonprofits statewide.

It is essential that nonprofit leaders and policymakers have the data necessary to address the workforce crisis in the nonprofit sector, and develop sound strategies to support the sector into the future. This will ensure that essential services are available to our communities, and ensure that the economy is able to fully recover from the consequences of the pandemic.

Therefore, we strongly urge the subcommittee to support Senator Reed and Senator Whitehouse's FY24 program requests for $4 million to enable the Bureau of Labor Statistics to include nonprofit organizations as a distinct category of employer in its Quarterly Census of Employment and Wages and related reports.

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The current lack of timely, accurate wage and employment data on the nonprofit sector is untenable and inadequate for a workforce representing the third largest payroll of any industry. Nonprofits and their partners have been requesting this data for years (2021 letter to Secretary Walsh, signed by 260 leaders and researchers), and the current workforce crisis makes this expansion of the QCEW a necessity. We urge you to support this request and ensure its inclusion in the final bill.

Thank you.

[This statement was submitted by Charlene Mouille, President and CEO, United Way of Wisconsin.]

PREPARED STATEMENT OF UPSTREAM USA

Dear Chairwoman Baldwin and Ranking Member Moore Capito:

The undersigned organizations, representing primary care providers, physicians, and health care advocates, believe that patients should have access to basic preventive services, including contraception, through their primary care provider. We urge you to support the request of $50 million for initiatives that expand access to high-quality contraceptive care in primary care settings under the Health Resources and Services Administration in the Fiscal Year 2024 Labor, Health and Human Services, Education, and Related Agencies Appropriations bill.

While the provision of contraceptives is often associated with specialists, nearly half of all counties in the U.S. do not have a single obstetrician-gynecologist. Primary care providers could help address gaps in those areas, but data show that only 40% of primary care providers offer contraception. Many primary care providers do not feel equipped to offer patient-centered contraceptive counseling or to administer all contraceptive methods. Studies indicate, however, that both patients and providers support the broader inclusion of family planning in primary care settings. When asked what might pose a barrier, both patients and providers reported that additional training is needed for primary care providers to meaningfully integrate contraceptive care into their practices. In particular, many providers are not trained to insert and remove intrauterine devices and implants, creating additional barriers to those methods. Addressing these gaps is critical, as more than 19 million women of reproductive age currently reside in a contraceptive desert.

Funding training and technical assistance for primary care providers would ensure that patients can access the family planning services they need and deserve at any provider of their choice, including as a routine part of primary care.

We appreciate your consideration of the request to provide $50 million in funding for contraceptive access initiatives in FY 2024. Please contact Rebekah Fries, Federal Policy & Advocacy Specialist from Upstream USA, at rfries@upstream.org for more information or with any questions.

Sincerely,

American Academy of Family Physicians (AAFP)
American College of Obstetricians and Gynecologists (ACOG)
American College of Physicians (ACP)
Families USA
Family Planning Elevated
National Rural Health Association (NRHA)
Primary Care Development Corporation (PCDC)
Upstream USA

PREPARED STATEMENT OF URBAN INSTITUTE

I am writing to share my professional views on the potential benefits that would accrue from the Bureau for Labor Statistics (BLS) Office of Employment and Unemployment Statistics adding the nonprofit dimension to the Quarterly Census of Employment and Wages (QCEW) and the value this addition could provide for policymakers.

I hold a PhD in public policy and have spent the past 20 years researching the nonprofit sector. I currently work as an associate professor at Arizona State University and as director of the National Center for Charitable Statistics at the nonpartisan Urban Institute, where I help turn administrative data on nonprofits into resources that support insights into and oversight of the sector. In this role I have a unique vantage point on the value of public data, and from these perspectives I can speak to the importance of BLS data. The views expressed in this testimony are my own and should not be attributed to the Urban Institute, its trustees, or its funders.

The QCEW data series is a comprehensive and reliable information source that offers insights into the dynamics of the U.S. labor market. It is derived from quarterly reports submitted by nearly all employers subject to unemployment insurance laws. The data encompass a wide range of industries, including private-sector businesses, State and local government entities, and Federal Government agencies. Currently, once every 5 years the Bureau of Labor Statistics generates a sectoral report that segments the QCEW data by nonprofit, for-profit, and government sectors.

The vast coverage and meticulousness of the QCEW data make it a highly valuable resource for policymakers in several ways.

1. *Employment dynamics analysis:* The QCEW data provide a detailed snapshot of employment trends, including changes in total employment, industry-specific employment, and regional variations. Policymakers can use this information to understand the overall health of the labor market, identify emerging trends, and make informed decisions regarding economic development strategies, workforce planning, and job creation initiatives.

2. *Industry and occupational analysis:* The QCEW data offer a granular view of employment by industry and occupation, enabling policymakers to identify sectors experiencing growth or decline. This information is crucial for developing targeted policies and programs to anticipate job training and reskilling opportunities that align with emerging labor market demands.

3. *Regional economic analysis:* The QCEW data provide employment information at the State, county, and metropolitan statistical area levels, allowing policymakers to assess regional economic performance. By understanding employment dynamics across different regions, policymakers can tailor regional development plans, allocate resources effectively, and implement targeted policies to address specific regional challenges, such as unemployment, wage disparities, or skill gaps.

4. *Wage analysis and labor market conditions:* The QCEW data include wage information, facilitating analysis of wage trends across industries, regions, and occupations. Policymakers use wage growth to measure labor market competitiveness, helping them design policies that promote fair wages, identify structural inequalities, and ensure economic opportunities for workers.

5. *Evaluation of policy interventions:* The QCEW data are a valuable tool for policymakers to evaluate the effectiveness of policy interventions. The comprehensive nature of the data supports robust counterfactual analysis by looking at pre- and post-policy intervention measures across geographies. In this way, policymakers can

gauge the impact of their initiatives, identify areas of success or improvement, and refine their policies accordingly.

These points speak to the general virtues of the QCEW data series, but these data have been especially valuable to the nonprofit sector because of the distinctive way labor operates within charitable and human service organizations. Many of these insights were impossible before the BLS began producing the intersectoral series.

As one example, nonprofit sector workers often accept a trade-off between high pay and work more aligned with their values and vision of the world. Nonprofits also leverage volunteers as alternatives to paid labor to operate programs at lower cost. Consequently, it was long assumed that nonprofit wages were lower than their for-profit counterparts. It was not until QCEW intersectoral data were available that we learned that nonprofits in fact pay higher wages, when comparisons are made across similar-sized firms in the same industries, owing to their commitment to clients and mission-informed management.[1]

Markets with higher proportions of nonprofit providers tend to have more diverse service offerings and higher-quality services. Nonprofits are also the first to fill gaps in service deserts. For these reasons, it is especially important to understand policies that have differential benefits for nonprofits and for-profit firms. Although the National Center for Charitable Statistics provides an expansive amount of data on our country's 1.5 million nonprofits, public data on for-profit firms other than large publicly traded companies are comparatively sparse. Thus, rigorous intersectoral analysis was all but impossible before the advent of the QCEW intersectoral series, a significant blind spot given some of the most important human services like education, health care, public safety, housing, economic development, and athletics all operate as mixed markets.

Thousands of policies enacted at the federal, State, and local level can either help sustain the balance of service providers operating in mixed markets or shift toward markets dominated by for-profit firms. This shift can be especially problematic when firms providing high-quality services exit a thin market since it can result in a drop in service quality across all providers. Some examples of policies with differential impact include features of the Affordable Care Act that disadvantaged nonprofit nursing home networks and caused many nonprofit providers to merge or shut down while for-profit providers expanded,[2] changes to local government contracting practices that make nonprofits more or less competitive in the selection process, or changes in the financing of housing and economic development that could disproportionately impact nonprofit providers, which are disallowed from using private equity.

People who believe nonprofits serve a unique and important role in our society will understand the value of timely and high-quality data to support enlightened policymaking. The Quarterly Census of Employment and Wages data produced by the Bureau of Labor Statistics play a vital role in informing policymakers about the dynamics of the U.S. labor market Scholarly insights on important intersectoral dynamics have been unlocked through the pilot phases of QCEW intersectoral data.[3] These data have seeded a nascent body of scholarly work that seeks to understand the myriad ways in which policies can have an intended or unintended impact on nonprofits operating in mixed markets. The work would become immensely more useful if the data were available annually, and the economic benefits could far outweigh the modest investments in data infrastructure.

[This statement was submitted by Jesse Lecy, PhD, Director, National Center for Charitable Statistics, Urban Institute*.]

*The views expressed are my own and should not be attributed to the Urban Institute, its trustees, or its funders.

PREPARED STATEMENT OF VACCINATE YOUR FAMILY

On behalf of Vaccinate Your Family, thank you for the opportunity to provide written testimony to the House Labor, Health and Human Services, and Education Appropriations subcommittee. To continue the fight against vaccine-preventable dis-

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[1] See Lester M. Salamon and S. Wojciech Sokolowski, "Nonprofit Organizations: New Insights from QCEW Data," Monthly Labor Review 128 (2005), 19–26; and John L. Bishow and Kristen Monaco, "Nonprofit Pay and Benefits: Estimates from the National Compensation Survey," Monthly Labor Review (2016), https://doi.org/10.21916/mlr.2016.4.

[2] See Lester M. Salamon, The Resilient Sector Revisited: The New Challenge to Nonprofit America (Washington, DC: Brookings Institution Press, 2015).

[3] See Erik Friesenhahn, "Nonprofits in America: New Research Data on Employment, Wages, and Establishments," Monthly Labor Review (2016), https://doi.org/10.21916/mlr.2016.9.

eases, including COVID–19, and to prevent future pandemics, we respectfully ask the subcommittee to include $1.13 billion for the Section 317 immunization programs at the Centers for Disease Control and Prevention (CDC).

Vaccinate Your Family builds on the important legacy of our cofounders Former First Lady Rosalynn Carter and Former First Lady of Arkansas Betty Bumpers. Together, these pioneers worked to advance a national focus on protecting all people in the United States from vaccine-preventable diseases. Their work began in the 1970s as First Ladies of Georgia and Arkansas, respectively, and continued during the Carter Administration and every subsequent administration. VYF's work has resulted in Federal support for vaccine programs nationwide and drastic increases in the number of children and adults protected against deadly diseases.

Today, thanks to our founders' enduring legacy, our organization's impact is beyond measure as vaccinations have saved millions of lives and significant costs. We are led by a committed Board of Directors, Scientific and Medical Advisory Board, and staff comprised of renowned medical, public health, communications, and policy experts.

SECTION 317 IMMUNIZATION PROGRAMS

The vast majority of immunization funding comes from the Section 317 program at the Centers for Disease Control and Prevention (CDC). Named for its Section of the Public Health Service Act, the 317 program awards grants to 64 State, local, and territorial public health agencies. Grantees can use these funds for a variety of purposes, including purchasing vaccines for uninsured adults, staffing vaccination clinics, and carrying out community-specific education campaigns.

We are grateful for the recent increases in funding for the 317 Program, however, those increases have been insufficient to meet the needs of our Nation. Like many public health programs, Section 317 has been chronically underfunded. In the 10 years prior to fiscal year 2022 funding for the program only increased by $25 million, an average of $2.5 million per year. In contrast, the U.S. spends $26.5 billion treating adults for just four vaccine-preventable diseases: flu, pneumococcal disease, shingles, and pertussis (whooping cough). Outbreaks of diseases have also required reallocations of 317 funds, further diminishing the amounts available for routine vaccination initiatives.

Public health officials need these funds more than ever. As you know, the Public Health Emergency (PHE) declaration for COVID–19 ended on May 11, ending the Federal Government's purchase of COVID–19 vaccines. Public health departments will now have to cover this cost for uninsured adults, straining already tight budgets. While the White House recently proposed a plan to provide COVID–19 immunizations to uninsured individuals, details about this plan and the timelines remain unclear. It is also unclear to what extent this plan would alleviate the financial strain on health departments. Even before the end of the PHE, health departments had to address mpox (monkeypox), measles, and polio outbreaks, and provide millions of catch-up doses of routine vaccinations missed during the pandemic, while contending with increased vaccine hesitancy and access challenges.

Underfunding Section 317 will result in decreased vaccination rates, increased risk of disease outbreaks, as well as hospitalizations and premature deaths of thousands of Americans from vaccine-preventable diseases. To sustain the investment made in emergency supplemental funding bills earlier in the pandemic, the CDC's Immunization Program should be funded at $1.13 billion to fully implement Section 317 programs.

The bottom line is that investing in 317 will result in enormous cost savings by preventing diseases. Vaccinate Your Family appreciates the opportunity to offer our testimony. We look forward to working with you to protect ourselves, our families, and our communities from vaccine-preventable diseases. For more information, please contact Jaimie Vickery, Government Affairs Lead, at jaimie@vaccinateyourfamily.org.

Sincerely.

[This statement was submitted by Amy Pisani, MS, CEO, Vaccinate Your Family.]

PREPARED STATEMENT OF VIVENT HEALTH

Chair Baldwin, Ranking Member Moore Capito, and members of the subcommittee, thank you for allowing me to submit written testimony. My name is Bill Keeton, and I serve as the Vice President and Chief Advocacy Officer for Vivent Health, headquartered in Milwaukee, Wisconsin. Vivent Health provides HIV prevention, care, and treatment services to more than 14,000 people impacted by HIV,

including more than 900 who are using preexposure prophylaxis, or PrEP, a medication that prevents HIV. Vivent Health provides services through 15 sites that offer integrated health care and social services supported by the Ryan White HIV/AIDS Program, including 10 locations throughout Wisconsin and 5 locations in Austin, TX; Chicago, IL; Denver, CO; Kansas City, MO; and St. Louis, MO. I want to thank the subcommittee for its past funding of the Ending the HIV Epidemic and other HIV prevention and treatment programs. Today, I am pleased to submit testimony on behalf of Vivent Health and as a member of a large coalition of public health, HIV, viral hepatitis, and harm reduction organizations to urge Congress to appropriate $200 million for a National PrEP Program as part of a $275 million increase for the Ending the HIV Epidemic program at the Centers for Disease Control and Prevention (CDC).

The bipartisan Federal Ending the HIV Epidemic initiative started under President Trump's administration calls for 50% of the approximately 1.2 million people in the U.S. who are at risk for HIV to have access to PrEP by 2030. This strategy was conceptualized to help prevent a portion of the approximately 35,000 new case of HIV per year. Currently, 75% of individuals who could take PrEP do not have access to it. Lack of access harms people in communities who are disproportionately at risk for HIV and slows progress toward the bipartisan goal of ending the domestic HIV epidemic. A national PrEP program would decrease disparities in medication access, improve health, and reduce health care and other costs.

Approximately 35,000 new HIV cases each year impact individual and public health and generate significant costs. The total number of new cases of HIV each year will generate approximately $17.5 billion in HIV care costs (in today's dollars) over the lifetime of these individuals. HIV also can shorten a person's lifespan if untreated and can exacerbate other health issues, which can reduce quality of life and increase costs.

I urge the committee to ensure that a PrEP program is national in scope, as it is critical to ensure that communities nationwide have access to this vital, effective, and cost-efficient HIV prevention tool regardless of whether people live in the largest cities or most rural areas. Robustly expanding access to PrEP is paramount and will help end HIV in our Nation.

Wisconsin Struggles to Provide PrEP to Populations in Need, Resulting in More Cases of HIV

Vivent Health began offering PrEP as a part of its HIV prevention programs soon after it was approved by the FDA in 2012. Initially, skepticism, lack of awareness, and patient cost were the most common barriers to people taking PrEP. While skepticism of PrEP has subsided and awareness of PrEP has improved, the cost of PrEP and its associated clinical and laboratory costs remain significant barriers preventing vulnerable people from accessing PrEP, especially people who are low income, uninsured or underinsured.

Perhaps most instructive, and also most disheartening, about the need for increased access and utilization of PrEP is the following situation, which occurs all too frequently. When an HIV-vulnerable individual has committed to taking PrEP as part of their HIV prevention strategy, HIV prevention staff will connect them with a physician and health services team to complete an assessment and begin to enroll the individual in care. Unfortunately, when patients are notified of what their PrEP co-pays and out-of-pocket costs will be—even when they are insured—many individuals will decline PrEP citing an inability to pay. By the time people in this situation decide to pursue taking PrEP at a later date, it is sometimes too late, as HIV screening prior to initiating PrEP often indicates that some of the individuals seeking PrEP have contracted HIV during the interim time period.

The CDC's August 2022 HIV Surveillance supplemental report estimated that 1.2 million persons in the U.S. were eligible for PrEP, but only 24.7% were prescribed PrEP in 2020, resulting in a 75% gap in access to this effective HIV prevention medication. In the state of Wisconsin where I reside, the CDC's September 2022 National HIV Surveillance System also reported that during the first half of 2022, there were approximately 13,000 people who would be eligible for PrEP in the state, but of these people, only 2,400 or 18.6% were prescribed PrEP—significantly worse than the National average. (See https://www.cdc.gov/hiv/library/reports/surveillance-data-tables/vol-3-no-4/index.html Table 3b).

The Bipartisan Ending the HIV Epidemic Initiative calls for Access to PrEP to Prevent HIV

The bipartisan Ending the HIV Epidemic initiative calls for 50% of the approximately 1.2 million people who could benefit from PrEP (HIV prevention medication) nationwide to have access by 2030. Currently, only 1 in 4 individuals who need

PrEP receive it, with significant racial, geographic, and other disparities in who has access. In 2020, only 10.4% of women, 9% of Black individuals, and 16% of Hispanic individuals assessed to be in need of PrEP had a prescription. The updated National HIV/AIDS Strategy for 2022–2025 named PrEP as a highly effective and cost-efficient intervention that the Nation should scale up to end HIV in the U.S. A national PrEP program would help to ensure equitable access to PrEP nationwide.

PrEP is Cost-Effective

Currently there are approximately 35,000 new HIV cases each year, and for each case there is a lifetime healthcare cost of approximately $500,000. Annual new cases of HIV result in $17.5 billion in lifetime health care costs. Expanding access to PrEP, a highly effective medication that can prevent HIV, would avert new HIV infections and help drive down these costs.

A recent paper from Johns Hopkins published in the Journal of Law, Medicine and Ethics noted that the lower-cost generic form of PrEP could cost as little as $26/month for a 30-day supply (less than $1/day). The authors estimated that every 1,000 monthly PrEP prescriptions would cost $80,000. 6,000 monthly PrEP prescriptions would cost less than $500,000 in lifetime care costs for just 1 prevented HIV infection. (Killelea, A., Johnson, J., Dangerfield, D., Beyrer, C., McGough, M., McIntyre, J., Sharfstein, J. (2022). Financing and Delivering Pre-Exposure Prophylaxis (PrEP) to End the HIV Epidemic. Journal of Law, Medicine & Ethics, 50(S1), 8–23. doi:10.1017/jme.2022.30). A national PrEP program that expands ready access to PrEP nationwide and among populations at risk for HIV would improve health outcomes, help stop the spread of HIV, and dramatically reduce costs. Increasing access to PrEP is necessary to eliminate the HIV epidemic in the U.S.

A recent NIH study showed that a variety of approaches are needed to increase PrEP uptake. This fact very much applies to the rural areas which Vivent serves, and a national PrEP program is crucial to help implement these strategies. Additionally, a national PrEP program also would make access to PrEP and required medical and support services more easily accessible, regardless of the State or jurisdiction in which a person resides.

CONCLUSION

As a father of three wonderful children, like any parent, I want my kids to grow up in a world that is better than the one I grew up in. I grew up in the 1980–90s when HIV was an untreatable condition that was killing countless Americans, and creating fear, panic, and sorrow. In college in the late 90s, I worked in a biochemistry lab trying to isolate ways to inhibit the HIV integrase enzyme and stop HIV from continuing to spread. At that time, it seemed almost unthinkable to imagine medications being so powerful as the ones available today—literally able to help stop new HIV infections and end HIV as an epidemic. Today, because of barriers to PrEP access, we still see patients receiving new HIV diagnoses daily. However, the tools to end HIV and create a better world for our children and future generations are available, and a national PrEP program would help end HIV faster and more effectively while reducing costs.

I urge Congress to pass a $275 million increase for CDC's Ending the HIV Epidemic Program, of which $200 million should support a National PrEP Program in the Fiscal Year 2024 Labor, Health and Human Services, Education, and Related Agencies Appropriations bill. Thank you also for your time and consideration of my testimony, and please do not hesitate to contact me at Bill.Keeton@viventhealth.org, Jenny Collier at jcollier@colliercollective.org, or William McColl at bmccoll@colliercollective.org if you have questions or need additional information.

[This statement was submitted by Bill Keeton, Vice President and Chief Advocacy Officer, Vivent Health Milwaukee. WI.]

PREPARED STATEMENT OF THE WAIHA WARRIORS

SUMMARY OF FISCAL YEAR 2024 RECOMMENDATIONS

—Please provide the National Institutes of Health (NIH) with $50.9 billion to facilitate continued growth in rare disease research activities.

—Please provide proportional increases for the National Institute of Allergy and Infectious Diseases (NIAID), the National Heart, Lung, and Blood Institute (NHLBI), and the National Center for Advancing Translational Sciences

(NCATS) to facilitate establishment and advancement of a wAIHA research portfolio.

—Please provide a separate, meaningful increase to advance and adequately support the emerging Advanced Research Projects Agency for Health (ARPA–H).

—Please provide the Centers for Disease Control and Prevention (CDC) with $11.6 billion to support public health efforts for the rare disease community.

—Please continue to systematically provide meaningful funding increases for the Chronic Disease Center at CDC, and please support $6 million in funding (a $1.5 million increase) for the line-item CDC Chronic Disease Education and Awareness (CDEA) program to ensure additional cooperative agreements are available for stakeholders.

Chairwoman Baldwin, Ranking Member Capito, and distinguished members of the subcommittee, thank you for the opportunity to present the views of the wAIHA Warriors and the community of individuals impacted by Warm Autoimmune Hemolytic Anemia (wAIHA). First and foremost, thank you for the meaningful investment in medical research and public health programs through the FY 2023 omnibus appropriations package. For FY 2024, we join other rare disease organizations and the broader patient community in asking for a sustained and meaningful investment in NIIH, CDC, and related Federal programs. We also deeply appreciate this opportunity to raise awareness of wAIHA and share the patient experience. Please consider us a resource moving forward. Thank you again.

ABOUT WARM AUTOIMMUNE HEMOLYTIC ANEMIA

wAIHA is a rare autoimmune disorder in which the immune system creates antibodies that destroy healthy red blood cells. The condition is progressive, potentially fatal, and difficult to address at later stages. It can be idiopathic or occur secondary to another condition. wAIHA can impact anyone and affects men and women equally, though it most commonly affects individuals over 50. Research has led to scientific advancements and potential therapies, but at this time treatment options are extremely limited and consist of 1) steroids and transfusions, 2) immunosuppression and chimeric anti CD20 antibodies, and 3) removal of the spleen. The condition is associated with significant morbidity and mortality, and less than 50% of patients remain in remission following front-line treatment.

ABOUT THE WAIHA WARRIORS

The wAIHA Warriors are a patient-driven grassroots organization focused on supporting the community of individuals impacted by wAIHA. Collectively, we use our stories and experiences to raise awareness, advance research, and improve healthcare. We also promote fellowship and engagement among community members to overcome the isolation of wAIHA and work to educate and mobilize healthcare providers to better address this rare disease experience.

PATIENT EXPERIENCE; ERIC, NEW YORK

In February 2011 I had a bad flu just before Super Bowl weekend. I was well enough to attend a Super Bowl party but remember not feeling myself. A few weeks later I had my regular annual physical with my internist. We were away celebrating a friend's 50th birthday, sitting at the pool, when my internist called and told me that my blood work was totally out of kilter (he used the term "pancytopenia"). My wife, Liz, who is a pediatrician, was nervous and just like when our kids were little, I only got nervous when she got nervous. I was very lucky that one of my closest friends is a Hematologist/Oncologist. The next day I went to see him, he set me up for all sorts of scans and bone marrow biopsies and we were off trying to figure out what it was and was not.

Over the next few months, he became confident that I did not have any sort of acute blood cancer. I still did not feel myself (I was tired, not hungry, not sleeping well, and not in a good mood). Most the blood tests became normal except for the hemoglobin/hematocrit. My spleen was very large. My friend thought I had AIHA (but my Coombs tests, which are typically what seal the AIHA diagnosis) were negative. Over the summer, I had one Coombs that was barely positive. In August 2011, my hemoglobin was going down and I had a blood transfusion.

In September 2011, my friend/hematologist wanted me to get another opinion, so he referred me to another hematologist who is more of a "benign hematologist" as they are known—don't typically treat blood cancers. She confirmed the diagnosis of AIHA. She began me on prednisone and I felt a little better.

My friend/hematologist thought that if I had a splenectomy (which was thought to be the primary treatment option back then) I might be "cured" and I would not have to be on chronic prednisone the rest of my life. I had the surgery In February 2012. It was a very difficult few days in the hospital followed by about 3 weeks of recovery at home. But after that, I felt pretty good. I was on very very low dose of prednisone (less than 5mg per day) and that lasted for a few years.

In June 2015, I got sick again (tired, peeing a lot, not sleeping, could feel my pulse in my temples). The goal then became to find something that was not as harmful as prednisone that could control the hemolysis and my hemoglobin levels. Over the next couple of years, I had a couple of courses of Rituximab, and also tried courses of Azathioprine and Danazol. When I was hemolyzing and my hemoglobin was dropping, I needed to increase the prednisone. I made an appointment to see a leading physician, Dr. Kuter, in December 2017. He gave me (and my hematologist) the "state of the art" on the treatments available. The next time I had a deep crash of my hemoglobin, in June 2018, we tried one. Shots of Procrit. Those worked quickly and my hemoglobin went as high as it had been since all this started in 2011. By the middle of 2019, I had another crash and it was time to see what else was out there. I connected with Dr. Irina Murackhovskaya at Einstein/Montefiore who was doing some clinical trials for AIHA drugs. I had to get my hemoglobin below 10 to participate and I needed a positive Coombs test, and we managed that closely. In October 2019 I started the trial and I chose this trial because it was open and I would definitely get the drug (not a placebo). In early December 2020, I did not feel well. My legs felt like lead weights. Over the next few weeks my prednisone started dropping pretty quickly. By Christmas week, I was feeling as sick as I had felt in a long time. My Hgb dropped below 8, I had a blood transfusion and I increased my prednisone to 60mg per day (the same as the highest I ever had in the past).

During 2021, I felt well. Still working at home. Things started opening up. We started to get out more. That helped a lot. I continued to wean down the prednisone and by the late Fall was on about 7.5 mg per day. My Hgb was pretty stable. My other hemolysis markers were better and stable too.

In early March, my Hgb was 14.2 (highest I can remember and "normal" range on some ranges). All my other hemolysis markers were as good as they had ever been. Had to have another round of primary Evusheld as the CDC changed the recommendation on how much to get for primary round.

I feel good now. Started back to work 3 days a week towards end of March. Did a quick 3 weeks of Breakthrough M2 diet program and went from about 193 lbs. to about 178 lbs. (15 lbs.) in 3 weeks. Things are starting to get back to (post COVID) normal. In April, my Hgb went back down to low 13s but still holding strong as are the other hemolysis markers. Fingers crossed that they will stay good. With Passover, gained back about 5 lbs. but still feeling pretty good.

Thank you again for your time and for your consideration of this testimony. As you work with your colleagues on FY 2024 Appropriations, please also consider timely committee recommendations encouraging NIH research in wAIHA.

[This statement was submitted by Karen Jones, Executive Director, wAIHA Warriors.]

PREPARED STATEMENT OF ALEX WASHBURN

To Chairman Murray, Ranking Member Collins, and Members of the subcommittee:

As an alumnus of the TRIO Talent Search program, I write on behalf of the more than 880,000 students currently served by TRIO programs as well as my fellow six million alumni to request a $106.8 million funding increase for TRIO in Fiscal Year 2024, for a total appropriation of $1.298 billion.

Low-income community residents and students from underdeveloped high schools face limited opportunities and few chances to pursue their dreams on the challenging road to higher education. Unfortunately, this was the reality that I grew up in during my formative years in Blountsville, Alabama. I am part of a family of five that relies mainly on the income from our farm. While it may seem like a lucrative business from the outside, the reality is that it comes with its fair share of costs, stress, injuries, payments, surgeries, bills, and the inability to take a day off. As a result, I quickly realized that my only shot at attending college was to either excel in a sport or perform exceptionally well on the ACT or SAT.

Being born with a speech impediment, I had to take speech classes to help improve my speech. Despite facing challenges, I overcame them through school and community activities, which helped me become a top academic student. Although I

had a high GPA, I struggled with the ACT and SAT. I knew that to get into college without the stress of obtaining a large amount of debt, I would need to score well on these standardized tests. I also participated in many sports and was hoping for a chance to continue that in college. However, I failed to meet the ACT and SAT requirements that would help pay for most of my college, and I had dislocated my shoulder during a baseball game, so my dream of going to college seemed out of reach. I was struggling with the reality of knowing I would have to take out loans and possibly not have the chance to attend the college that I felt I was led to. But I stumbled upon a chance of hope to go to college, and it appeared in the form of TRIO Talent Search, a program that would change the course of my life forever.

The Talent Search program opened doors that I never knew existed. Through the program, I learned about external scholarships, learned what a FASFA was, and was given opportunities that I did not think were available to me. One of the greatest opportunities led me to an organization called the Youth Leadership Development Program, or YLDP. Being selected to join this organization through the TRIO Talent Search program as a junior at J.B. Pennington High School changed my life forever. During my junior and senior years, I attended meetings, created service projects, heard guest speakers, and learned about leadership. I learned that the best type of leadership to encompass is that of a servant leader like Jesus Christ. Because of the TRIO Talent Search program, I was able to learn many enduring life lessons, and as I go through life, I try my best and live my life like that of a servant leader. Not only did I learn these valuable lessons, but I was also able to discover my purpose in life-a purpose I believe all should strive for, and that is to help others who cannot help themselves. And I believe that this is the fundamental belief that TRIO stands for.

In addition to providing me with the opportunity to learn about YLDP, the TRIO Talent Search program also helped me with the Free Application for Federal Student Aid (FAFSA). I was able to understand the importance of completing the FASFA form and the benefits that it could provide for college. This was a daunting task for my family and me, but with the help of the guidance from the program, I was able to complete the application accurately and on time. This allowed me to receive financial aid that I otherwise would not have received and helped me get one step closer to obtaining the money I needed to go to Auburn University.

With the TRIO Talent Search program's exceptional leadership and support, I had also applied for a YLDP scholarship to Auburn. As the announcement day approached, I was filled with nervous anticipation, and I sat watching as they called out the names of the scholarship recipients and the amounts they would receive. When it was time for the Auburn representative to speak, I heard my name called out. I was awarded the exact sum I needed to pursue my academic dreams. The moment was indescribable, but I knew that this was a turning point in my life.

Talent Search program is one of the seven TRIO programs that serve nearly a million low-income and first-generation students and students with disabilities throughout the United States and the territories. The TRIO programs help students like me enter and succeed in college at every stage of the education pipeline, from middle school through adult education. The Talent Search program provides financial aid and college admissions information to 6th through 12th graders. The results speak for themselves. Eighty percent (80%) of college-ready seniors who have participated in Talent Search enroll immediately in college following high school graduation as compared against only 60% of high school seniors from the lowest-income quartile.[1]

Because of TRIO, I have been able to attend college and pursue my dream of a higher education. I have been blessed with the knowledge of how to apply for scholarships; a better understanding of what leadership really is; and a commitment to others who need help. Without the program's support, I might not have had the opportunity to attend college without a financial burden hanging over my head—or even go to college at all. The TRIO Talent Search program provided me with the resources I needed to overcome financial and academic obstacles and set me on a path toward a brighter future. Now I'm a junior at Auburn University studying Industrial and Systems Engineering with a minor in Business Engineering Technology. I have been able to participate in undergraduate research and will finish

[1] U.S. Department of Education, Office of Postsecondary Education, Student Service, Fast Facts Report for the Talent Search Program, Washington, D.C., 2016; Cahalan, M., Addison, M., Brunt, N., Patel, P., Vaughan III, T., Genoa, A. & Perna, L. (2022). Indicators of Higher Education Equity in the United States: 2022 Historical Trend Report. Washington, DC: The Pell Institute for the Study of Opportunity in Higher Education, Council for Opportunity in Education (COE), and Alliance for Higher Education and Democracy of the University of Pennsylvania (PennAHEAD).

a three-term co-op this summer. I have been able to secure more scholarships based on what I learned in high school through TRIO, and now I don't have to worry about finances and can focus on my studies. I could never have imagined such a bright future for myself, but the TRIO staff's constant support and their commitment to helping young students excel and receive a college education provided that for me.

Therefore, I hope the subcommittee will increase TRIO funding by $106.7 million in Fiscal Year 2024 and allow more students to benefit from the programs that so enriched my life.

PREPARED STATEMENT OF THE WESTERN GOVERNORS' ASSOCIATION

Chair Baldwin, Ranking Member Capito, and Members of the subcommittee, the Western Governors' Association (WGA) appreciates the opportunity to provide written testimony on the appropriations and activities of the Federal agencies under the subcommittee's jurisdiction, including the Departments of Labor (DOL), Health and Human Services (HHS), and Education (ED). WGA is an independent organization representing the Governors of the 22 westernmost States and territories. The Association is an instrument of the Governors for bipartisan policy development, information sharing and collective action on issues of critical importance to the western United States.

DOL funding for workforce development through the Workforce Innovation and Opportunity Act (WIOA) supports economic growth and job creation in the States. More flexibility under current WIOA funding streams is needed to better anticipate coming labor market disruptions. Additional flexibility would also help workers who are not traditionally eligible for assistance and at-risk incumbent workers as they prepare for displacement. Flexibility should include allowing Governors to fund outreach and the marketing of services to reach more people in need. Short term and competitive funding for innovative programs is inefficient and creates unintended obstacles for small States with limited grant writing resources. Western Governors appreciate the subcommittee's concern about shortages of water and wastewater system operators and recommendation to DOL to make funding available to this sector through WIOA in FY2023 and encourage similar considerations in FY2024.

Western Governors support the expansion of registered apprenticeship programs and encourage Congress to support and incentivize state, territorial, local, and industry-led partnerships to create and scale apprenticeship programs through increased appropriations. New Federal investments in apprenticeships should be provided through line-item formula funding and aligned with existing efforts to foster a coherent system with minimal duplication at the Federal, state, territorial, and local levels.

Western Governors call for full funding for high-quality career and technical education (CTE) programs through the Career and Technical Education for the 21st Century Act (Perkins). Adequate funding of Perkins State Grants is essential to ensure that CTE programs align with statewide visions for education and workforce development. Further, better linkages between K–12, higher education and the workforce system are needed. Western Governors call for a carveout of Perkins funding directed to the workforce system to support stronger linkages to K–12 and higher education.

Western Governors urge an expanded WIOA funding stream for youth, targeted toward youth who are disconnected from school and work, as well as the establishment of a Youth Employment task force to make further recommendations on effective workforce strategies to address the crisis in youth employment. Finally, to ensure that workforce development programs are inclusive of people with disabilities, Congress should provide additional funding and training for States to conduct outreach and education on equal opportunity and nondiscrimination and to link workforce programs with K–12 special education services.

Improvements in state data infrastructure are needed to better support State education and workforce development, including responding to changing labor market demand, improving the effectiveness of policies and programs, and improving the delivery of services. The subcommittee should provide adequate funding to support state Labor Market Information centers and the U.S. Bureau of Labor Statistics. States should receive a greater share of funds under the state-Federal cooperative statistics programs. Western Governors also call for significantly greater ongoing funding through the Workforce Information Grants to States to enhance state capacity, evidence-based decision making, and the production of locally relevant labor market intelligence. Finally, Western Governors recommend that Congress invest long-term in multi-State data collaboratives and in more voluntary state participation in collaboratives to enable a truly national data infrastructure to emerge.

Building a sufficient cybersecurity workforce is especially important to Western Governors. A skilled cyber workforce is imperative to the protection of critical infrastructure, which includes a vast array of potential targets. These include: the Nation's electric grid; energy resource supply and delivery chains; finance, communications, and election systems; and a panoply of public, private, military and industrial systems. Western Governors request sufficient appropriations for high-quality cybersecurity education and workforce development programs to grow and sustain the cybersecurity workforce, including those that target underrepresented populations, those that include rotational components to retain personnel, and work-based learning opportunities such as apprenticeships.

Despite efforts by Western Governors to address the shortage of qualified health care workers in our States, significant challenges remain. Governors urge the Federal Government to examine and implement programs to ensure States have an adequate health care workforce—including positions in primary care, behavioral and oral health, as well as other in-demand specialties—prepared to serve diverse populations in urban, suburban, and rural communities. Understanding that significant disparities remain in access and treatment for many populations, Governors support efforts to increase diversity and representation in the health care workforce to improve health outcomes for all. Western Governors encourage the subcommittee to fund new types of personnel, such as community health workers or promotores, in order to further extend the health care team and ensure that patients are connected to resources, and innovation within the behavioral health care workforce to address gaps in the continuum of care professionals.

Americans are facing record levels of adverse mental health conditions, suicidal ideation, and substance misuse, trends that have been exacerbated by the COVID–19 pandemic. Western Governors appreciate the substantial investment in mental and behavioral health services by the subcommittee in FY2023 and support continued efforts to improve the quality and quantity of these services. They are essential to reducing suicide rates and treating a range of behavioral health conditions, including substance use disorder, which disproportionately affect the West. Western Governors recognize and support efforts at the Federal, state, territorial and local levels to promote the integration of physical and behavioral health services. The Governors encourage Congress and the Administration to support States' and territories' integration efforts and encourage health care providers to better incorporate behavioral and physical medicine into their practice of care. The expansion of early intervention, diversion, and community reentry programs aid in such efforts.

COVID–19 has laid bare the importance of investing in our Nation's public health system. Western Governors appreciate the subcommittee's focus on public health preparedness and response in FY2023 and request further investments in public health infrastructure and health surveillance mechanisms to effectively confront future public health challenges.

In addition, Western Governors are committed to identifying risks facing high utilizers of health care services and addressing social determinants of health. They encourage the continued support of services and programs that empower States, territories and local governments to solve persistent economic and social conditions that often hinder health outcomes.

As we continue to recover from the widespread effects of the COVID–19 pandemic on the labor market and the health care system in the United States, it is critical to align policies, performance metrics, regulations and reporting requirements across Federal workforce, human services, housing and education agencies in order to achieve the best program outcomes. Given the numerous Federal agency programs, policies, and regulations directly affecting the collective States, agency coordination with States and the integration of state data into Federal programs for policymaking is paramount to their success. Western Governors support full and consistent Federal funding for agencies to carry out the requirements of the Foundations for Evidence-Based Policymaking Act of 2018 (Pub. L. 115–435) and encourage the subcommittee to direct Federal agencies to improve their internal processes and coordinate with States on Federal data policies and procedures, as required in the act.

Western Governors recognize that it is an enormous challenge to judiciously balance competing funding needs throughout the Federal Government, appreciate the difficulty of the decisions you must make, and stand ready to work with you on these important matters.

[This statement was submitted by Jack Waldorf, Executive Director, Western Governors' Association.]

PREPARED STATEMENT OF THE WISCONSIN ASSOCIATION FOR HOMELESS AND RUNAWAY SERVICES

The Wisconsin Association for Homeless and Runaway Services (WAHRS) is a Statewide, Wisconsin non-profit organization working to prevent and end youth homelessness in Wisconsin. We represent a membership of over 20 Wisconsin community-based organizations, and work in partnership with schools, state and national organizations, and committed individuals, and youth with lived expertise of homelessness. With our network, we advance commonsense solutions that prevent and end youth homelessness. This testimony supports a request of $300 million in Fiscal Year (FY) 2024 funding for the Runaway and Homeless Youth Act (RHYA) program, administered by the U.S. Department of Health and Human Services. This request includes two separate programs in the appropriations table, as follows:

First Line Item: Consolidated Runaway and Homeless Youth (RHY) Programs
Description of Program: The Consolidated Runaway and Homeless Youth Act (RHYA) programs prevent trafficking, identify survivors, and provide services to runaway, homeless, and disconnected youth. The grants provided through the RHY program includes:

Basic Center Programs: provides temporary shelter and counseling services to youth who have left home without permission of their parents or guardians, have been forced to leave home, or are experiencing homelessness or housing instability, who might otherwise end up in the law enforcement, child welfare, mental health, or juvenile justice systems.

Transitional Living Programs and Maternity Group Homes: provides longer-term housing with supportive services, including Maternity Group Homes for pregnant and parenting youth

National Communications System: 24/7 national phone, text, and online communications system which connects youth and families in crisis with prevention services and reunifies families

National Technical Assistance Center: provides training and technical assistance to all RHYA grantees

Second Line Item: Service Connection for Youth on the Streets
Description of Program: The Service Connection for Youth on the Streets program is commonly called the Street Outreach Program and is funded by the Runaway and Homeless Youth Act. These funds are granted to community-based organizations to provide education, prevention, treatment, counseling, connection, and referrals to vital services to prevent sexual abuse and human trafficking for youth at-risk of and experiencing trafficking and homelessness.

This request is vital because only 25% of applicants receive a grant due to the lack of Federal funding. In Wisconsin, current state allocations for competitive Basic Center Project funding do not provide sufficient resources for two current grantees to continue their much needed work in the Fox Valley/Brown County and Dane County Communities. This will force these grantees to compete at a National level for whatever funds remain after each State's resources have been allocated to viable projects. This demonstrates the desire of communities to serve our young people and their families who are in crisis and the severe underallocation of resources to address this need. This is especially devastating, considering that 4.2 million youth and young adults experience homelessness every year in America (Chapin Hall). In Wisconsin, over 17,000 youth are reported by DPI as experiencing homelessness each year, including nearly 2000 youth who are identified as unaccompanied, without an active legal guardian to provide for their needs. Further, Loyola University found that 1 in 5 youth experiencing homelessness are trafficked for sex, labor or both. Community-based housing options and supportive services through the Runaway and Homeless Youth Act program prevents human trafficking and serves survivors.

Runaway and Homeless Youth Act grantees are community-based organizations. They adapt and deliver services based on local needs, including rural and suburban settings (where homelessness looks different). Increased funding to RHYA is needed to help more youth and families access safety and avoid chronic homelessness as an adult.

Like other forms of social disadvantage, homelessness is not equally distributed among youth. The Chapin Hall data demonstrates that Black and Indigenous youth are the most at risk of homelessness, with Black youth 83% more likely than white youth to become homeless, and American Indian and Alaska Native youth have more than double the risk of homelessness as other youth. LGBTQ+ youth are 120% more likely to experience homelessness than non-LGBTQ+youth. Additionally, youth who are Black or multiracial and LGBTQ+ experience the highest rates

of homelessness and housing instability. There is also a disproportionate risk for homelessness among specific subpopulations, including pregnant and parenting, young people without a high school diploma, and young people involved in the child welfare or court legal system. These demographics are mirrored in the Wisconsin communities who are competitively applying for the limited resources available this year.

Youth experiencing homelessness face a particularly steep climb to adulthood. They are not plugged into networks of support needed for healthy development. RHYA programs provide the support and connection youth need to successfully transition to adulthood. These services and support are also more cost-effective than other systems (child welfare, juvenile and adult court systems) youth experiencing homelessness come into contact with.

Last reauthorized in 2018 (Public Law 115–385), Runaway and Homeless Youth Act programs provide appropriate, relevant, and readily accessible services critical to addressing episodic or longer-term homelessness among youth, including family reunification when safe and appropriate. The origin of RHYA was in 1974 as Title III of the Juvenile Justice and Delinquency Prevention Act to provide youth-specific community-based services as an alternative to involvement in the policing and incarceration systems for youth status offenders.

$300 million for the Runaway and Homeless Youth Act Program would:

—Support approximately 1,400 RHYA projects in communities across the United States that meet our young people where they are. These youth are not eligible for HUD homeless assistance due to HUD's narrow definition of homelessness and the hidden nature of homelessness among youth.

—Allow approximately 49,034 young people access to housing and connect with 70,000 youth via street outreach and drop-in centers. This is far from meeting the need, but would significantly increase our country's capacity to end youth homelessness by doubling the number of young people served. It would also provide a cost savings of more than $12 billion in fiscal costs and over $30 billion in costs to society.

—Ensure that our young people are not left out of national efforts to end homelessness. Successfully addressing youth homelessness will save money and dramatically reduce future chronic adult homelessness.

—Increase the percentage of applicants who receive funding from 25% to 50%.

[This statement was submitted by Joli Guenther, Executive Director, Wisconsin Association for Homeless and Runaway Services.]

PREPARED STATEMENT OF THE WISCONSIN GERIATRIC EDUCATION CENTER

My name is Dr. Stacy Barnes, and I am a Social Gerontologist with 30 years of professional experience working to improve quality of life for older adults and family caregivers. I hold a master's degree in Gerontological Studies from Miami University in Oxford, OH, and an interdisciplinary doctorate in Social Gerontology from Marquette University. I have also completed a fellowship with the U.S. Department of Health and Human Services as part of its Primary Health Care Policy Fellowship program. As Director of the Wisconsin Geriatric Education Center, Associate Professor of Practice for Marquette University's College of Nursing, and former President of the National Association for Geriatric Education, I am pleased to submit this statement for the record recommending appropriations of at least $82 million in Fiscal Year 2024 to support geriatrics workforce training under the Geriatrics Workforce Enhancement Program (GWEP) and the Geriatrics Academic Career Award (GACA) program administered by the Health Resources and Services Administration.

It is important to recognize that our physical, mental, emotional, and medical issues are a result of a lifetime of individual choices and experiences that combine to make our bodies and minds unique in many ways. Couple with that normal age-related changes and it is easy to understand why older adults are more likely to suffer from chronic illnesses (e.g., cancer, heart disease, diabetes), consume far more prescription medications, and sustain more fall-related injuries than younger people. Older adults also consume more ambulatory care, hospital services, nursing home services and home health care services. Our nation urgently needs more health care workers to support this population and, moreover, a greater number of health professionals who are trained to meet the complex health needs of older patients. Most health care professionals, however, receive little or no training in geriatrics or gerontology, which leaves us ill-prepared to care for older Americans as their health needs evolve.

How can the health care sector meet the challenge of serving the ever-growing numbers of older people who need care? Fortunately, we have two successful Federal initiatives that utilize innovation, collaboration, and efficiency to develop and train the health care workforce that we need: the Geriatrics Workforce Enhancement Program (GWEP) and the Geriatrics Academic Career Award (GACA) program. If we could support the creations of more GWEPs and GACAs, we would be able to replicate the proven successes of these programs across the country. GWEP sites train thousands of current and future health care professionals each year; they promote team care, enhance clinical skills, increase medication reviews, and improve coordination of care. The GWEP is currently the only Federal program designed to increase the number of providers in a variety of health disciplines with the skills and training to care for older adults. The GWEP awardees also educate and engage the broader frontline workforce, including the caregiving workforce and family caregivers, and focus on opportunities to improve the quality of care delivered to older adults, particularly in underserved and rural areas. Due to GWEPs' partnerships with primary care and community-based organizations, GWEPs are uniquely positioned to rapidly address the health needs of older adults and their caregivers. The Geriatric Academic Career Award (GACA) program is an essential complement to the GWEP. GACAs empower early-career clinician educators to become leaders in geriatrics education and research. It is the only Federal program designed to increase the number of faculty with geriatrics expertise in a variety of health disciplines.

In 1 year alone (academic year 2020–2021), GWEP grantees provided training for 69,518 students and fellows participating in a variety of geriatrics-focused degree programs, field placements, and fellowships. GWEP grantees partnered with 262 health care delivery sites to provide clinical training experiences to trainees, with 52 percent of these sites located in medically underserved communities. GWEP grantees produced webinars, courses, and workshops that were used by 142,022 individuals. These efforts lead to improved geriatric care as indicated by fewer falls, better drug prescribing, less confusion/delirium, fewer restraints, shorter lengths of hospital stays, more advanced care planning, greater alignment of health care with patient priorities, and decreased costs.

Wisconsin, like the rest of the Nation, is experiencing unprecedented growth in the number and proportion of older adults. The population aged 65+ will grow by 758,000 or 98% between now and 2040. The fastest growing segment of Wisconsin's population is the 85+ group, which is projected to increase by 139% during this same period. By 2030, every county in Wisconsin will have more than 20% of their population comprised of older adults. As Wisconsin's population ages, demand for health care is outpacing the number of new geriatric providers entering the workforce, particularly in rural areas.

Wisconsin was fortunate to have a GWEP award from 2015—2020 that allowed us to strengthen the eldercare workforce and improve older adults' access to quality health care and services. The WGEC directly contributed to the number of health care workers with geriatric certification through its bi-annual board review course in geriatric medicine, three maintenance of certification online modules, and other continuing education programs. Health professionals and students improved their geriatric knowledge and clinical skills, and, in some cases, experienced significant attitudinal shifts pertaining to older patients and team-based care. Assessment results indicate that most trainees experienced statistically significant gains in the assessed competency domains. Immediately following training, trainees were strongly motivated to apply the information they had learned in the workplace. Overwhelmingly, learners reported utilizing the training content to improve the quality of care they provided to patients and to train other health professionals in their workplace. The WGEC also had a direct impact on patients and caregivers through its large-scale community events (e.g., Breaking the Silence about Alzheimer's Disease in Communities of Color, and the Solomon Carter Fuller Memory Screening Day) and smaller, educational workshop series (e.g., The Savvy Caregiver, and Living Well with Chronic Conditions). Patients and caregivers underwent health screenings and significantly improved their understanding of health topics and chronic disease management. They reported greater self-efficacy in recognizing early warning signs and/or symptoms and improved access to community support services.

Unfortunately, a software glitch disqualified the Wisconsin Geriatric Education Center's application in 2019 and, consequently, we do not currently have a GWEP in our state. For the past 4 years, Wisconsin has struggled to secure funding for workforce development, and it is now lagging other States in implementing age-friendly care. Wisconsin is not alone in its struggle to fund geriatric education because the current cohort of 43 GWEP grantees covers only 35 States and 2 territories (Guam and Puerto Rico). It is critical to the older adults living in Wisconsin

and in the other unfunded States that Federal funding be continued and expanded, so that our parents, relatives, friends, and neighbors receive optimal care from age-friendly health systems and from health care practitioners skilled in geriatric care. Appropriations of at least $82 million for GWEPs and GACAs in FY 2024 will help ensure that our States and Territories have sustainable funding and resources necessary to build and retain the health care workforce.

In summary, GWEP sites and GACA recipients have improved the supply, distribution, capabilities, and quality of the eldercare workforce who care for our Nation's growing older adult population, including the underserved and minority groups. On behalf of the Wisconsin Geriatric Education Center and all families who have benefited across the country, thank you for your previous support and for your thoughtful consideration of this request for FY 2024 funding.

Sincerely.

[This statement was submitted by Stacy L Barnes, PhD, Director, Wisconsin Geriatric Education Center, Associate Professor of Practice, College of Nursing, Marquette University.]

PREPARED STATEMENT OF THE WOMEN FIRST RESEARCH COALITION

The Women First Research Coalition (WFRC) appreciates the opportunity to provide this outside witness testimony to the Senate Committee on Appropriations subcommittee on Labor, Health and Human Services, Education, and Related Agencies (Labor-HHS) for the Fiscal Year (FY) 2024 Labor-HHS appropriations bill. As you begin work on FY 2024 appropriations, we respectfully request that you provide at least $50.9 billion for the National Institutes of Health (NIH). We also request that you consider including our report language on the "Building Interdisciplinary Research Careers in Women's Health (BIRCWH) scholars program," the "Women's Reproductive Health Research (WRHR) program", and the "Reproductive Medicine Network" in the report that accompanies the final FY 2024 Labor-HHS appropriations bill.

WFRC is a coalition comprised of the Nation's leading professional medical and research organizations specializing in women's health. Our coalition was formed to address pressing challenges in women's health research and to raise awareness among Federal policymakers, Executive Branch officials and the public about the need for sustained and strengthened investment in women's health research, the prioritization of research in conditions that are specific to women or those conditions that may present differently in women than men, advance an equitable and appropriate investment in women's health research that improves the health outcomes of women, and ensure an adequate women's research workforce.

FUNDING FOR NIH

Robust, sustained and predictable funding is important for all biomedical research, particularly research on conditions that are unique to or predominately occur in women, including polycystic ovary syndrome (which affects up to 20 percent of women), endometriosis (which affects up to 12 percent of women), uterine fibroids (which affect up to 40 percent of women), menopause (which affects all women) and cancers of the cervix, uterus and ovary. As Congress appropriates funding for FY 2024, the WFRC is requesting that Congress provide at least $50.9 billion, an increase of $3.5 billion, to the NIH, which would allow for meaningful growth above inflation that would expand NIH's capacity to support promising science in all disciplines. Almost all of NIH's institutes and centers fund research on women's health; therefore, any funding increases should be allocated proportionately to all NIH institutes and centers to ensure that meritorious research in women's health is supported across the NIH. This would build on Congress' recent investments in NIH that have allowed for advances in discoveries toward promising therapies and diagnostics, supported current and new scientists nationwide and advanced the potential of medical research. It will also allow NIH to support meritorious research in women's health.

SUPPORT FOR THE BIRCWH FELLOWS PROGRAM

Administered by the NIH Office of Research of Women's Health (ORWH), the Building Interdisciplinary Research Careers in Women's Health (BIRCWH) program is a mentored career-development program designed to connect junior faculty, known as BIRCWH Scholars, to senior faculty with shared interest in women's health and sex differences research. There are currently 20 active BIRCWH programs across the country—each one is a 2-year program, and costs approximately

$170,000 per fellow per year. Since its creation in 2000, the BIRCWH program has trained over 700 fellows.

Approximately 70 percent of BIRCWH fellows supported during 2000–2018 received at least one successful R-level grant from the NIH and many received private grants as well. To continue this important work, more funding is necessary to support additional BIRCWH fellows at all existing sites. Therefore, the WFRC respectfully requests that you include the following report language in the report that accompanies the FY 2024 Labor-HHS appropriations bill under the NIH Office of the Director:

BIRCWH Scholars Program.—The Committee allocates $6 million to the Office of Research on Women's Health (ORWH) Building Interdisciplinary Research Careers in Women's Health (BIRCWH) program with the goal of strengthening the workforce pipeline. These funds would support additional researchers focused on women's health and sex differences, including research focused on cancer and maternal health. The Committee continues to recognize the effectiveness of the BIRCWH program, which is a two-to-3-year mentored career development program that connects junior and senior faculty with shared interests.

SUPPORT FOR THE WOMEN'S REPRODUCTIVE HEALTH RESEARCH (WRHR) PROGRAM

The Women Reproductive Health Research (WRHR) Career Development program is funded through the Eunice Kennedy Shriver National Institute of Child Health and Development (NICHD) and co-sponsored by the ORWH. The WRHR program emphasizes research relevant to OB/GYN and related subspecialties, including maternal-fetal medicine, gynecologic oncology, reproductive endocrinology, infertility, adolescent gynecology, and urogynecology. Grants are available to OB/GYNs who have recently completed postgraduate clinical training and will soon start basic, translational, and/or clinical research relevant to women's reproductive health. There are 17 active WRHR centers in OB/GYN departments across the country.

To continue this important work, more funding is necessary to support additional WRHR fellows at all existing sites with a goal of increasing the diversity of the scholars, sites, research areas supported by the program, and ultimately the diversity of the biomedical research workforce. Therefore, the WFRC respectfully requests that you include the following report language in the report that accompanies the FY 2024 Labor-HHS appropriations bill under the NICHD:

Women's Reproductive Health Research Program.—The Committee allocates $3 million to the National Institute of Child Health and Human Development (NICHD) Women's Reproductive Health Research (WRHR) career development program to fund one additional scholar at all existing sites, with the goal of increasing the diversity of the scholars, sites, and research supported by the program. The Committee recognizes the effectiveness of the WRHR program, which provides an opportunity for obstetrician/gynecologists (OB/GYNs) who recently completed postgraduate clinical training to further their training in basic, translational and clinical research.

SUPPORT FOR THE REPRODUCTIVE MEDICINE NETWORK

NICHD runs several networks that support women's health research, including the Reproductive Medicine Network (RMN). The RMN had a proven track record of supporting infertility research, which affects an estimated 19 percent of reproductive aged couples. In recent years, NICHD replaced the RMN with the Consortia for Infertility and Reproductive Medicine (ConFIRM) Clinical Trial Program of linked R01s. The RMN had a proven track record of success by providing a single hub that supported multiple substudies and secondary analyses, and there are concerns that changes made to the RMN network are imperiling research supported by the network. As structured, the ConFIRM Clinical Trial Program is forcing awardees to duplicate efforts, which increases NIH's costs and limits sites' ability to share foundational information.

It is critical that NICHD continue to support research in reproductive medicine through a mechanism that is more similar to the RMN network than the revised ConFIRM Clinical Trial program. Therefore, the WFRC respectfully requests that you include the following report language in the report that accompanies the FY 2024 Labor-HHS appropriations bill under the NICHD:

Reproductive Medicine Network.—Infertility, defined as the inability to conceive within 1 year of unprotected intercourse, affects an estimated 19% of reproductive aged couples. Beyond this definition, bout 26% of women have difficulty getting pregnant (but not for 1 year or longer) or carrying a pregnancy to term. The Reproductive Medicine Network (RMN), which has since been replaced by the Consortia for Infertility and Reproductive Medicine (ConFIRM) Clinical Trial Program of

linked R01s, had a proven track record of supporting infertility research by providing a single hub that supported multiple substudies and secondary analyses. Most importantly, it informed major changes to clinical practice and supported the training of young investigators in the field. While the Committee understands that the NICHD has moved away from the U01/U10 mechanism the RMN utilized, we are concerned that the ConFIRM Clinical Trial Program is not supporting coordination or a pipeline of young investigators in this field in the same manner as the RMN. The Committee urges NICHD to report on its plans to support clinical trials on infertility and a potential reversion to a multisite clinical trial model that leverages network infrastructure, similar to the other existing networks, within 180 days after the publication of this report.

CONCLUSION

Thank you again for the opportunity to submit testimony to the Committee as you begin your work on the FY 2024 appropriations bills. We look forward to working with you to ensure that there is appropriate funding for women's health research at the NIH, to continue to support the physician-scientist workforce pipeline, and to strengthen research networks.

PREPARED STATEMENT OF WOMEN'S FUND OF RHODE ISLAND

Dear Chair Baldwin and Senate Appropriations subcommittee Members on Labor, Health and Human Services, Education and Related Agencies,

I am writing in support of Senator Reed and Senator Whitehouse's program requests for $4M for BLS to include nonprofit organizations as a distinct category of employer in its Quarterly Census of Employment and Wages and related reports. The nonprofit sector is the country's third largest industry in terms of jobs and plays a central role in many aspects of American life. From healthcare to housing, houses of worship to human services, education to environmental protection and more, the U.S. government at all levels relies on the sector to generate innovation solutions and provide critical services. The nonprofit sector is both a major creator and component of local economies.

Because employment data for the sector is not tracked as regularly as other job sectors (only every 5 years as opposed to quarterly), its impact is undervalued. As a result, opportunities to invest in and leverage the sector are wasted. As an example, during the COVID pandemic, decisions were made to support small businesses and keep employees working but many nonprofit organizations were not able to participate. ARPA funding often went through nonprofit organizations to their clients, but there was nothing to support the organization itself to make sure its infrastructure remained stable.

As a nonprofit whose focus is gender equity through systemic change, it is not lost on us that many who work in the nonprofit sector are women and people of color, often working for low salaries and meager benefits. Hiding the value of the sector by only publishing employment data every 5 years allows inequities to continue and prevents our communities from addressing employment issues in a timelier fashion. How can problems be addressed if we don't know they exist? The latest BLS data for the sector is from 2017... well before COVID hit and changed employment figures in all sectors.

We urge you to support this appropriation request.

Sincerely.

[This statement was submitted by Kelly Nevins, Chief Executive Officer, Women's Fund of Rhode Island.]

PREPARED STATEMENT OF YOUTHBUILD, USA

Chair Tammy Baldwin and Ranking Member Shelley Moore Capito, thank you for the opportunity to testify on YouthBuild's Fiscal Year (FY) 2024 appropriations and policy priorities. YouthBuild strongly supports the Department of Labor's (DOL's) YouthBuild program and respectfully requests that you provide $193 million for this critical program in the FY2024 Labor, Health and Human Services, Education, and Related Agencies (LHHS) Appropriations bill. This increase would allow the YouthBuild program to further meet the continuing needs of opportunity youth amidst increased demand. This year, 46 Senate members signed onto a bipartisan Dear Colleague letter led by Senators Kirsten Gillibrand and John Cornyn urging Congress to appropriate this amount for YouthBuild. We also urge support of the

Administration's proposed increases to the Reentry Employment Opportunities program and for AmeriCorp State and National programs as well as urge the Committee to include additional language to address three implementation challenges facing YouthBuild grantees and their participants.

The opportunity youth population—young adults between the ages of 16 and 24 who are neither in school nor employed—are our greatest source of untapped potential. YouthBuild's evidence-based model helps participants earn their high school diploma or equivalent while developing job skills by building affordable housing for homeless and low-income individuals in their communities. In addition to construction, young people can gain experience and train for careers in other high-need sectors, such as healthcare, information technology, and logistics. While workforce education is at the core of what we do, YouthBuild also recognizes the need to provide participants with a supportive community. Our evidence-based model, by combining professional training with wraparound services, permits YouthBuild to play a unique role in serving opportunity youth at the nexus of workforce and education.

Our ability to reconnect opportunity youth is essential to investing in the American workforce, supporting our education system, and rebuilding our communities. In a reversal of a decade-long trend of falling rates, the Nation unfortunately experienced an increase in the number of opportunity youth in 2020 with an estimated 4.8 million youth not in school or employed. An investment in YouthBuild will help decrease these numbers and represents an investment in equity, with participants coming from some of the most underserved populations, including 83 percent of participants who identify as people of color and 85 percent who are economically disadvantaged.

Critically, YouthBuild works. A rigorous randomized control study found that, compared with their peers, students who attended YouthBuild saw significant increases in the receipt of high school equivalency credentials and in college and vocational school enrollment. At YouthBuild, justice-involved youth are also less likely to recidivate; 19 percent of our participants have been involved in the juvenile justice system but, within 1 year of enrollment in YouthBuild programs, the recidivism rate plummets to only six percent. Pandemic-related challenges have only increased the importance of wraparound supports, such as case management, mentoring, and counseling services, that YouthBuild programs provide to participants.

To date more than 200,000 YouthBuild students worldwide have participated in the program, building more than 36,000 units of affordable housing and performing nearly 51 million hours of community service. YouthBuild programs are currently operating in 45 States, the District of Columbia, and Puerto Rico. Local programs also leverage private funds to maximize YouthBuild's impact by raising a 25 percent non-federal match. Increased Federal support for this effective and strategic investment would allow the DOL to sustain current grantees and fund new programs to meet growing demand.

Each year, there are more communities applying to host YouthBuild sites than the Department has the funding to support. According to DOL, the applicant pool grew annually from FY16–FY18 despite only 39 percent of applications being funded in FY18. Many strong sponsors across the country apply to launch or renew YouthBuild programs, but there continues to be insufficient funding to support these local efforts. Our funding request would help more young people become skilled, educated, and community-focused members of our society and help them reach their full potential. If there is an issue that all policymakers can agree upon, it is providing our most vulnerable populations of young people with opportunities to succeed.

In addition to our request for increased appropriations, we would like to express our strong support for the Administration's proposed $55 million increase for the Reentry Employment Opportunities program and the $93 million increase for AmeriCorp State and National programs. We believe these increased investments will ensure that the most underserved populations, including the economically disadvantaged, people of color and justice-involved youth, can find opportunities to improve their lives and pursue a meaningful career.

In addition to our funding requests, we urge the Committee to include three provisions to address implementation challenges for YouthBuild grantees and their participants in the LHHS bill. First, as shown by the chart below, the timing of when the Funding Opportunity Announcement (FOA) for YouthBuild varies greatly from year to year. The unpredictability of timing for the FOA makes it difficult for YouthBuild programs to develop a financial plan and prepare for their programs.

Without a standardized timeframe for issuance, grantees can face gaps in service opportunities or, even worse, are forced to cease operations altogether.

FY	Solicitation for Grant Applications/Funding Opportunity announcement released	Due	Announced/ Awarded	Time from Release to Award
FY17	3/9/17	5/9/17	8/8/17	5 months
FY18	5/18/18	9/18/18	2/1/19	9 months
FY19	6/5/19	8/6/19	12/16/19	6 months
FY20	12/11/2020	2/9/2021	6/10/2021	6 months
FY21	11/22/2021	1/21/2022	4/26/2022	5 months

In order to give potential and existing YouthBuild grantees more predictability as to when program funds will be announced and awarded, we respectfully request that the Committee include the following report language:

"The committee is aware that there has not been a consistent schedule for the issuance of Funding Opportunity Notices (FOAs), and the subsequent award of funds, for the YouthBuild program. The FOAs have been announced during different time periods during each of the last few years with seemingly little connection to when appropriations are finalized for a given fiscal year. This unpredictability imposes unnecessary burdens on those seeking YouthBuild grants to serve YouthBuild participants in an ongoing and seamless manner. To address this situation, the Committee directs the Secretary to make every effort to announce new YouthBuild FOAs, and make subsequent award announcements, during the same time period each year."

Second, YouthBuild urges the Committee to streamline the process required to certify whether an individual can be classified as an out-of-school youth. Youth that exit YouthBuild and are identified as out-of-school youth currently must wait 90 days to be eligible for services under the WIOA Youth Formula Program under DOL guidance. We find that this three-month period can have extremely detrimental effects on a youth's progress and believe that eliminating the waiting period will help ensure that Federal services are accessible to some of the Nation's most vulnerable populations. To eliminate the current waiting period, we respectfully request that the Committee include the following report language:

"In order to ensure that all out-of-school youth receive WIOA services promptly, the Committee directs the Secretary to modify guidance issued pursuant to the WIOA Youth Formula Program to reduce the period of time before providing services to a YouthBuild participant that has exited YouthBuild and has subsequently been identified as an out-of-school youth for the purpose of receiving services under such program to the minimum amount possible."

Lastly, we ask that you fulfill the Administration's request for a legislative proposal to allow YouthBuild grant funds to be applied to matching requirements for AmeriCorps programs, particularly because YouthBuild grantees are already required to raise a 25 percent non-federal match. AmeriCorps programs are a critical pathway to continuing higher education and career advancement for YouthBuild students and alumni, but unfortunately the extremely tight budgets endemic to operating a YouthBuild program make it challenging enough to find the already required non-federal match. The additional match requirement for AmeriCorps is unreachable for the majority of YouthBuild programs. As such, we believe this proposal would help diversify the kinds of individuals who participate in AmeriCorps and help solve this issue.

Thank you for considering our requests, if you have any questions, comments or concerns please contact Jeremy Hanson-Gutiérrez at jhansongutierrez@youthbuild.org.

Prepared Statement of Rebeca Zapata

I grew up in the small rural town of Elkins, Arkansas, with 3,743 residents. It is a town where everyone knows everyone, and you must drive half an hour to get to the closest Walmart. While I had a joyous childhood, I could not help but feel different as one of the few Mexican Americans within such a small town. My parents moved to northwest Arkansas due to the opportunities and quiet life that Arkansas had to offer. My father made a living as an industrial maintenance technician, and my mother served as a home-based preschool instructor. As a second-generation Mexican American, I had large higher education aspirations but needed to figure out how to achieve them. And while my parents were supportive, their knowl-

edge of higher education was limited as both only had high school diplomas. It was through my 8th-grade science teacher that I learned about the TRIO Upward Bound Math-Science program. This program would make one of the most positive and lasting impacts on my life trajectory.

My high school career as a TRIO Upward Bound Math-Science student exposed me to many firsts, educational opportunities, and valuable mentorship. Through this amazing program, I could make life-long friends, present scientific posters to university professors, connect with my future university, and gain exposure to life outside my rural town. Through the program's one-on-one mentorship, I could identify potential universities, give feedback on applications, and receive information on scholarship opportunities. The TRIO Upward Bound programs gave me access to all the opportunities and resources they provided me. I wholeheartedly credit my educational trajectory to the support provided to me by the TRIO Upward Bound programs. It was also through the TRIO Upward Bound programs that I gained exposure to the University of Arkansas campus. As a student, each summer, we would stay on campus for six weeks, attending classes and activities facilitated to acclimate us to life in higher education. I came from a small school with only 89 total students in my graduating class, and the TRIO Upward Bound programs prepared me for life in a more prominent university. My decision was evident when it came time to decide where to attend university. I would attend a place that felt like a second home due to the assistance of the TRIO Upward Bound programs; I would attend the University of Arkansas.

As a first-generation and low-income student, attending a massive campus like the University of Arkansas, with a student population of over 27,000, should have been daunting. But because of my time with TRIO Upward Bound programs, I was prepared. I knew where to find my classes, as I had visited the campus every summer for 4 years with TRIO Upward Bound. The mentorship and advice I received through TRIO Upward Bound also prepared me for other challenges while in university, such as talking with professors, finding student organizations to become involved, and, most importantly, how to handle university life as a commuter student. Research shows that commuter students are typically disadvantaged, facing lower grades and higher dropout rates. But TRIO Upward Bound programs prepare students by inviting alumni to speak to aspiring students about their struggles and how they overcame them so that we could learn how to succeed. Through those conversations, I found ways to become involved on campus as a commuter student and successfully navigate university life. Eventually, I graduated with a bachelor's degree in psychology and a bachelor's degree in sociology from the University of Arkansas within 4 years and with no debt due to the scholarship I had applied for and received during my time as an undergraduate. As a first-generation student, this was a proud moment for me, my family, my community, and my TRIO Upward Bound programs family. Even after being 4 years out of the TRIO Upward Bound program, I was still regularly involved with and communicated with the staff, providing me with encouragement and support.

My experiences with the TRIO Upward Bound program inspired my current career path. I am in my third year of a doctoral program at the University of Texas Rio Grande Valley, pursuing my Ph.D. in clinical psychology. I aspire to return to Arkansas after obtaining my degree and working towards licensure to provide services for adolescents and families facing mental health issues. I also want to continue to be involved with supporting the TRIO Upward Bound programs, as it is through this program that I have been able to get to this point. I have been involved in the TRIO Upward Bound program in several forms, as a psychology tutor for students, as a residential mentor during the summer, as an assistant residential coordinator, as an office worker during my time in undergraduate, and most recently as a summer instructor of introduction to and careers within psychology. I am passionate about giving back to TRIO Upward Bound programs because it has given me so much. It has been wonderful to be on the other side of the program, no longer as a student but as a mentor and instructor. I have witnessed the growth, determination, and drive that TRIO Upward Bound programs continue to foster in current students.

I hope lawmakers continue to support and expand funding for TRIO as these programs have made lasting and positive impacts on youth. First-generation and low-income youth should have access to these programs just as I did because it was through TRIO Upward Bound programs that I could find my passion and have the support to pursue it. Without TRIO programs, I would not have made it to a university, nonetheless, be the first in my family to graduate. These programs provide opportunities and guidance toward a better life for students. Thank you for allowing me to advocate for this beautiful program, TRIO, and for your time and consideration.

[This statement was submitted by Rebeca Zapata, Alumna, Upward Bound Math-Science at the University of Arkansas.]

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