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# DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES APPROPRIATIONS FOR 2018

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WEDNESDAY, MARCH 1, 2017.

## MEMBERS' DAY

Mr. COLE [presiding]. Good morning. It is my pleasure to welcome you all to the Subcommittee on Labor, Health and Human Services, and Education for our first hearing of the year.

We are looking forward to taking testimony from members of Congress this morning. This sort of member day has not been held on this subcommittee in at least a decade. And the idea to return to this practice is one that was suggested by our new full committee chairman, Rodney Frelinghuysen, and, frankly, I think it is a good idea. And if I did not think so, I would still say I thought it was a good idea. [Laughter.]

But I actually do think it is a great idea, and he does deserve credit for it. It is an opportunity for any member of Congress to come before the panel and draw our attention to particular issues of importance in both their districts as well as across the Nation. I look forward to hearing from my colleagues about the challenges they see and how this subcommittee can help address them.

As a reminder to everyone, we really will abide by the 5-minute rule so that we are able to keep closely to the schedule we outlined for members. Before we begin, though, I would like to turn to my ranking member for any remarks that she would care to make.

Ms. DELAURO. Thank you very much, Mr. Chairman, and I concur. I think this is a wonderful opportunity to hear from our colleagues on the issues they care about in this, what I view as an extraordinary subcommittee of appropriations. And I am happy to see Mr. Thompson here. This is the second time we have gathered this morning. We were just earlier at the Submarine Industrial Base Council meeting.

I am heartened that so many of our colleagues are going to testify here this morning, and looking forward to hearing from them about how the programs that are part of the portfolio that we have jurisdiction over affects your constituents.

I have to add, though, that we have heard that the Administration wants to cut non-defense by about $54,000,000,000, and I think we would agree that this could have a very profound negative impact on the Labor, HHS, Education programs. Our bill comprises nearly one-third of the non-defense discretionary spending, so if

you take a look at what that proposed reduction would do, it would cut nearly about $18,000,000,000 from this subcommittee.

There is a very good reason that the Labor-H Committee has been called the people's bill because it does provide an opportunity for people to help meet their needs. When we do lifesaving biomedical research, we equip our Nation to deal with public health emergencies. We level the playing field for low-income children looking to learn. We help Americans get the skills that they need to find a job in a tough economy.

So, these efforts all impact the lives of our constituents and Americans all over this Nation. And, therefore, these kinds of cuts would impact each and every American, especially children, families, and seniors.

So, looking forward to listening to all of our colleagues here today and what their priorities are to ensure that we keep our promise to the American people. Thanks very much.

Mr. COLE. Thank you for your remarks. And with that, Mr. Thompson, it is good to have you here, my friend. And you are recognized for 5 minutes for whatever remarks you would care to make.

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WEDNESDAY, MARCH 1, 2017.

**WITNESS**

**HON. GLENN THOMPSON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF PENNSYLVANIA**

Mr. THOMPSON. Well, thank you. Chairman Cole and Ranking Member DeLauro, it is a privilege and an honor to be able to be before you this morning. Thanks for this opportunity. I want to thank you for your dedication to the House Appropriations Subcommittee on Labor, Health, and Human Services, Education, Related Agencies.

In our current fiscal environment, I recognize the challenges placed before the subcommittee, and I appreciate your ongoing leadership and efforts to provide quality education and health-related services to millions of Americans. It makes a difference to the folks that I serve.

As co-chair of the House Career and Technical Caucus, and a senior member of the House Committee on Education and Workforce, I would like to use my time today to highlight the importance of dedicating strong resources to programs authorized by the Carl D. Perkins Vocational and Technical Education Act, or the Perkins Act, in Fiscal Year 2018. Career and technical education provides students of all ages with the academic and technical skills necessary to become career and college ready.

According to the most recent data from the Office of Vocational and Adult Education, approximately 12 million students participated in CTE programs during the 2013–2014 school year. While quality CTE programs are available to a number of students, we have to work to make them even more accessible, and doing so will ensure that future and current members of our Nation's workforce have the opportunity to excel in high wage, high-skill, and high-de-

mand career fields, the very fields that keep our Nation competitive in the global economy.

Employers across the United States, especially those in skilled trades, are faced with difficulty as they search for qualified workers. According to a recent poll conducted by the Society for Human Resource Management, more than half of all employers reported that they are unable to recruit workers for open positions. And human resource professionals predict a lack of workforce readiness will impact employers for years to come.

Today, more than one million positions remain in trade, transportation, and the utility sector, and 315,000 manufacturing jobs go unoccupied. By training a competitive workforce to fulfill the 21st century demands, CTE programs can help employers fill those jobs and close the skills gap.

Last Congress, the House reached a bipartisan consensus on the importance of CTE when we voted to pass H.R. 5587, the Strengthening Career and Technical Educational for the 21st Century Act, by a vote of 405 to 5. As the individual who introduced and sponsored this legislation, you know, this bill would have reauthorized the Perkins Act, and I was encouraged by its passage, and certainly look forward to advocating for similar legislation in the 115th Congress.

In addition to taking steps to improve CTE-related policy, we must also support CTE through the appropriations process. Now, despite its importance, the Perkins Act funding has declined by 13 percent, or $170,000,000 over 10 years. Today, more than 20 States receiving a Perkins basic State allocation is at or below the level that they obtained in 1998.

Chairman and Ranking Member, this concerning trend does not reflect the needs of the students, the workers, and employers, the backbone of the American economy. We must do better by them. With this in mind, I urge the subcommittee to robustly fund Perkins Act programs for Fiscal Year 2018, and I want to thank you for your commitment to this issue and all the issues under your jurisdiction. It really is a privilege and honor to be before you this morning.

Mr. COLE. Well, it is good to have you, and you actually have a little time because whoever is next, we started early, or started on time, and the first person could not be here. So, the next witness is not up, so I will yield to my friend if she has any questions or comments she cares to——

Ms. DELAURO. Well, I would just say that I could not agree with you more just in terms of the statistics. 2015, we have States reporting that 7,300,000 high school students participated, took at least a course in CTE. The National Center for Education Sciences, 85 percent of the Nation's 3,900,000 high school kids have completed one or more occupational CTE courses. 19 percent concentrators earned at least 3 credits in that field. That is to say nothing about post-secondary.

For 2017, the House number is exactly what is funded. It is $1,100,000 as is the Senate. So, we will wait to see what happens in the movement on this bill in that direction. For now, we do not know what 2018 looks like, but I would just say continue advo-

cating anyway. It is a wonderful program, and it provides real opportunity for our youngsters.

Mr. THOMPSON. And it is a great program with a return on investment.

Ms. DELAURO. Yes.

Mr. THOMPSON. And I know we largely think of our kids, secondary education. But the fact is that Perkins serves people of all ages. It is people who just want a greater opportunity for them and their families. They want to be able to make more money, and, therefore, they will contribute more in taxes for the tax base. And so, this is for any American at any point in their life that Perkins allows him a pathway to greater opportunity, with a return on investment for employers and for the Nation.

And I do appreciate the time.

Mr. COLE. Oh, it is all right. You still have got a minute or two. [Laughter.]

But let me chime in here, too, because it is actually a very important program in my State. Oklahoma and Ohio have the two most robust career tech systems in the country, so it has been a staple for us, a big part of our education system. So, it is money well spent.

I think the fact that it has not had the increases is largely a reflection, as my friend knows, of the strains we have on the budget. And her opening comments about, look, we will obviously live within the allocation we are given by the Budget Committee. That is where the final decision rests, or the top line, and then the allocation that our chairman gives us. And I am very supportive of whatever that is.

But if we were to have cuts of the size that have been reported, then, yeah, there will be consequences to that. There is no part of this budget that can escape unscathed if we have $18 to $20,000,000,000.

Mr. THOMPSON. Yeah.

Mr. COLE. It will just change everything, and I told that to various members and probably will say it a couple more times as people come in and out. And, again, we can always disagree about different things, but actually there is a remarkable consensus on this subcommittee about these kinds of programs. They have been very bipartisan. We are all for putting young people to work. We are all for giving people whatever age the skills they need to be successful in the workplace. Not very many programs have done it as well as Carl Perkins.

Mr. THOMPSON. I think, I mean, this serves the young lady who got up this morning who did not want to get out of bed to go to school because she does not learn in a conventional way. She learns by maybe with wrenches, or a welder, or a stethoscope. But it also serves the folks who have been stuck in poverty, maybe intergenerational poverty for decades to be able to work their way away from that government dependency.

And so, certainly under the, and I do not pretend to understand how we score thing around this town, but this is one where just a little bit of an investment, and to be able to have somebody wake up and to no longer be, you know, be dependent upon the TANAF Program, or the SNAP Program, or, you know, you go down the

line of what could be tens of thousands of dollars of support. And to be able to just have that American Dream of opportunity, to wake up one day and to no longer be government dependent?

This is, well, if we could look at it from a dynamic scoring financially, this strengthens our position as a Nation.

Ms. DELAURO. Let me suggest that you take a look at something, a study that the Markle Foundation recently did along with Pew. It is Jobs in a Digital Economy, but it is about, you know, people. And you made the very good point that folks at NEH can access the program. But that there is 70 percent of folks today in this country without a college degree. That does not mean that they do not have skills or they do not need to be able to have courses, which would allow them to succeed.

It is a very, very interesting study and I think we ought to act on because you combine what we are doing with Perkins, with what you do with community colleges, with apprenticeship programs, with others in which to get people gainfully employed.

Thank you, Mr. Chairman.

Mr. COLE. You are most welcome. Got another issue you would like to bring up, G.T.?

Mr. THOMPSON. Not at this time. [Laughter.]

I had better go show up for Chairman Fowlkes' Educational Workforce hearing.

Mr. COLE. Well, thanks for coming by, and we appreciate the testimony very much. And, again, it is something the committee looks on with a great deal of interest and genuine bipartisan support. So, thanks for highlighting it.

Mr. THOMPSON. I appreciate it. Thank you.

Mr. COLE. With that, Mr. Polis, if we could have you next. We are actually moving along pretty fast here. Hey, Jared, thank you. Appreciate you being here.

[The statement of the Hon. Glenn Thompson follows:]

***Testimony of Congressman Glenn 'GT' Thompson***
***The U.S. House of Representatives Committee on Appropriations***
***Labor, Health and Human Services, Education, and Related Agencies***

Chairman Cole and Ranking Member DeLauro,

Good morning and thank you for your dedication to the House Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies. In our current fiscal environment, I recognize the challenges placed before the Subcommittee and appreciate your ongoing efforts to provide quality education and health related services to millions of Americans.

As Co-Chair of the House Career and Technical Education (CTE) Caucus and senior member of the House Committee on Education and the Workforce, I would like to use my time today to highlight the importance of dedicating strong resources to programs authorized by the Carl D. Perkins Vocational and Technical Education Act, or the Perkins Act in Fiscal Year 2018.

Career and technical education provides students of all ages with the academic and technical skills necessary to become career and college-ready. According to the most recent data from the Office of Vocational and Adult Education, approximately 12 million students participated in secondary and postsecondary CTE programs during the 2013-2014 school years.

While quality CTE programs are available to a number of students, we must work to make them even more effective and accessible. Doing so will ensure that future and current members of our nation's workforce have the opportunity to excel in high-wage, high-skill, and high-demand career fields—the very fields that keep our nation competitive in the global economy.

Employers across the United States, especially those in the skilled trades, are faced with difficulty as they search for qualified workers. According to a recent poll conducted by the Society for Human Resource Management, more than half of all employers reported they were unable to recruit workers for open positions, and human resource professionals predict that a lack of workforce readiness will impact employers for years to come. Today, more than 1 million positions remain open in the trade, transportation and utilities sector, and 315,000 manufacturing jobs go unoccupied. By training a competitive workforce to fulfill 21st Century demands, CTE programs can help employers fill these jobs and close the skills gap.

Last Congress, the House reached a bipartisan consensus on the importance of CTE when we voted to pass H.R. 5587, the Strengthening Career and Technical Education for the 21st Century Act, by 405-5. As a key sponsor of this legislation, which would have reauthorized the Perkins Act, I was encouraged by its passage and look forward to advocating for similar legislation in the 115th Congress.

In addition to taking steps to improve CTE-related policy, we must also support CTE through the appropriations process. Despite its importance, Perkins Act funding has declined by 13 percent or $170 million over ten years. Today, more than 20 states are receiving a Perkins Basic State Grant allocation that is at or below the level they obtained in 1998.

Chairman and Ranking Member, this concerning trend does not reflect the needs of students, workers and employers—the backbone of the American economy. We must do better by them. With this in mind, I urge the Subcommittee to robustly fund Perkins Act programs for Fiscal Year 2018.

***Testimony of Congressman Glenn 'GT' Thompson***
***The U.S. House of Representatives Committee on Appropriations***
***Labor, Health and Human Services, Education, and Related Agencies***

Thank you again for your commitment to the issues within the jurisdiction of your Subcommittee and the Committee as a whole.

WEDNESDAY, MARCH 1, 2017.

**WITNESS**

**HON. JARED POLIS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF COLORADO**

Mr. POLIS. Thank you very much.

Mr. COLE. You bet. The gentleman is recognized for 5 minutes to deliver whatever remarks he cares to the committee.

Mr. POLIS. Thank you, Chairman Cole, Ranking Member DeLauro. Thank you both, and particularly since this bill has not come to the floor as much as some others, it is great to have this opportunity to provide some feedback.

What could be more important than public education? I think we all value that. Our constituents value it. I am honored to serve as the ranking Democrat on the Subcommittee on Early Childhood, Elementary, and Secondary Education, so I am very involved with education here. In prior service, I was chairman of our State board of education. I have been very active in this area, providing opportunity and hope for kids.

It is impossible to highlight every education program I support in 5 minutes, so I will focus on a few that I think are important from a funding perspective.

The first one I want to mention is the Federal Charter School Program. In the 2015–2016 school year, public charter schools educated more than 2,900,000 students in 6,800 schools. 43 States and the District of Columbia have enacted charter school laws. Over half the students served by public charter schools are free and reduced lunch students. Over half are minorities, 17 percent limited English proficient.

Public charter schools continue to grow and deliver outstanding educational outcomes for students nationwide, and particularly the Federal support piece is so important because it focuses on quality. Separate studies by the Center of Reinventing Public Education and Mathematics, a policy researcher found that charter school students are more likely to graduate from high school, go on to college, stay in college, and have higher earnings in early adulthood.

Charter school program funds are critical to continue this success. Nearly every public charter school that is successful got off the ground because of this Federal Charter School Program.

I strongly encourage the committee to continue that investment in the next Fiscal Year by investing a minimum of $350,000,000, which would fund Federal charter school expansion programs. And, again, this ties into quality, but is, of course, like any public school, not all charter schools are good. It is certainly not a silver bullet. But with a lot of the equality indicators authorized for practices, this is very important.

The next item I want to hit upon in the Education Innovation and Research, or EIR, Grant Program, which is the successor to the Investing in Education, which we used to call the I3 Grant Program. Very, very important program. It was modeled after the successful Small Business Innovation Research, or SBIR, Program, which has been around for several decades. And it has been funded in over $2,000,000,000 across 11 Federal agencies.

EIR would apply the successful SBIR approach in the field of social spending and would really shift to evidence-based outcomes for experimental, innovative policies. On June 7th, 2016, the House Republican Task Force on Poverty, Opportunity, and Upward Mobility introduced a Better Way blueprint, released by Speaker Ryan, which included support for EIR type programs, which is a tiered evidence program.

Early research has shown evidence that the I3 program, the successor to EIR, is working. A report by Patrick Lester at the Social Innovation Center released in January found that many programs demonstrated positive impacts in reading and literacy. Evidence-based programs truly should have the highest intention and investment with our limited Federal resources.

And I would be remiss if I did not reiterate my strong support for the core programs within our public education system that are Federal; that is, Title I and ESE, ESEA. Title I funding, absolutely critical in addressing some of the disparities in funding and in poverty in our country. ESEA, I would remind the committee that the Federal government has never lived up to its commitment to fully fund special education, and we are appreciative of any progress that can be made in that regard.

In addition to education, I want to mention my strong support for other programs under the jurisdiction of this subcommittee, notably, programs that provide adequate healthcare for individuals living with HIV and AIDS, mostly notably the Ryan White HIV/AIDS Programs and the AIDS Drug Assistance Program, both housed in HHS. These programs help ensure that people with HIV and AIDS receive the services they need, so it is an important contribution to the overall piece, which is very important for this committee so it does not make solving problems elsewhere even more complicated and costly.

Finally, on the labor side, I wanted to highlight the importance of employee-owned companies in providing major economic benefits to communities and addressing some of the income and equity disparities in our country. A lot of data around employee-owned companies, higher rates of employee retention, better able to weather turbulent markets.

Many great employee-owned companies, including some in my district, like New Belgium Brewery, many in other areas of the country as well, like Cliff Dansko, King Arthur, Flower. These are very important companies where the workers can share in the value that is created for the shareholders.

And the Department of Labor shares regulatory oversight of ESOPs with the IRS, but could do more to help businesses try to convert to employee ownership structures. Labor could and should be doing more to support employee-owned businesses, and I am asking this committee to include report language that would require the Department of Labor to work with the IRS and the SBA to develop guidance and tools available to those interested in employee ownership structures.

And, again, since we will not have the opportunity to do that on the floor, maybe we will, but if we do I would encourage you to include that in the committee mark. I do not think it is terribly con-

troversial, but it would be a very good thing for the Department of Labor to take on.

I look forward to working with each of you on these programs. Happy to answer any questions.

Mr. COLE. Well, we will not have much time for questions, so we are moving along. But I do want to make a couple of comments and reassure you on a couple of things. And very much agree with very many parts of your testimony.

On charter schools, actually we made last year a very substantial increase, and, again, very bipartisan. Particularly congratulate my friend, Senator Blunt, who was a big pusher on that on the other side of the Rotunda. And obviously, you know, while we may have different views about the Secretary of Education, we do have somebody that cares a lot about charter schools there.

So, it would be interesting to see what the Administration wants to do, but there is bipartisan commitment.

Also, you know, this committee frankly for 2 years in a row had proposed more for IDEA than the Administration has requested, and we proposed $500,000,000 in the 2016 budget, and the Administration proposed $170,000,000. That an increase in a $11 to $12,000,000,000 program. We settled at $410,000,000, so I thought that was a pretty reasonable compromise. And they were flat last year, but we, again, included an increase.

If we can get our 2017 bill to the floor ever, you know, in one form or another, I think we would like to do more, but you will see that the House on a bipartisan basis actually led in doing IDEA. That is actually one of the most efficient programs we have. Every school district in America needs it. So, I really thank you for highlighting those and, frankly, the rest of your remarks as well.

My friend has a comment. I will yield to her.

Ms. DELAURO. Just quickly, I would associate myself with the Chairman's remarks, but I would also talk about Title I where this committee on a bipartisan basis has increased the funding for Title I, understanding its need. And that was, quite frankly, in opposition to what was proposed by the prior Administration.

I am excited about your EIR Program, knowing something about how SBIR has been so critically important. And I know in my own district, the research, the innovation, everything that has come out of that has been very, very successful. So, we will try to reiterate that here as well.

And with regard to Ryan White, our budget in the House is the same as it was in 2016. Well, it is less in the Senate, but we will see if the House can prevail if we ever get the document. Thanks.

Thank you very much.

Mr. COLE. Does my friend from California care to make any remarks quickly? Okay. We can. Thank you very much. Appreciate you being here, Representative Polis.

And, Jim, you are next up, so we have the distinguished gentleman from Rhode Island. It is good to have you here, my friend, and you are recognized for 5 minutes for whatever remarks you care to make to the committee.

[The statement of the Hon. Jared Polis follows:]

**Congressman Jared Polis, CO-02**
**Testimony before the House Committee on Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies**
**March 1, 2017 10:00am**

Chairman Cole, Ranking Member DeLauro, and members of the subcommittee, thank you for the opportunity to testify this morning.

In Congress, one of my top priorities is supporting public education. That support is rooted in my own experience as chair of the Colorado State Board of Education and as the founder of two charter schools in Colorado. This Congress, I'm honored to serve as ranking member of the subcommittee on Early Childhood, Elementary, and Secondary Education on the Education and Workforce Committee.

Education programs can't be successful without adequate funding. It would be impossible for me to highlight every education program and its impact in the time that I have today, so I'd like to highlight a few programs that are priorities for me and my district in Colorado.

I first want to speak in support of the federal **Charter School Program**. In the 2015-16 school year, public charter schools educated more than 2.9 million students in over 6,800 schools. Forty-three states and the District of Columbia have enacted charter school laws. Over half of the students served by public charter schools are eligible for free or reduced-priced lunch, over half are students of color, and 17 percent are Limited English Proficient—all higher percentages than those served in traditional public schools.

Public charter schools continue to grow and deliver outstanding educational options to students nationwide and, in particular, to low-income children. Since 2010, many research studies have found that students in charter schools do better in school than their traditional school peers. A 2015 report from the Center for Research on Education Outcomes (CREDO) at Stanford University found that charter schools located in our nation's largest urban districts are

showing significant positive performance impacts for the most disadvantaged students. Overall, students enrolled in urban charter schools gained 40 additional days of learning in math and 28 additional days in reading compared to their traditional public school peers. Separate studies by the Center on Reinventing Public Education and Mathematica Policy Research have found that charter school students are more likely to graduate from high school, go on to college, stay in college and have higher earnings in early adulthood.

Charter School Program funds are critical to continuing this success. CSP supports the launching of new charter schools, sharing successful innovations with other traditional public schools, and providing incentives to state governments and other stakeholders to provide school facilities. This committee has historically supported the Charter School Program through consistent annual increases. I encourage the committee to continue that investment in the next fiscal year by investing a minimum of $350 million and up to $700 million, which would fund charter school expansion plans and account for the more than one million students nationwide on charter school waiting lists.

The **Education Innovation and Research (EIR)** grant program, the successor to the Investing in Innovation (i3) grant program, was introduced during the Senate markup of the Every Student Succeeds Act (ESSA) as a bipartisan amendment by Senators Hatch and Bennett, and it was adopted by voice vote. The EIR provision was modeled after the successful Small Business Innovation Research (SBIR) program that was created by Congress in 1982, reauthorized and expanded with overwhelming bipartisan support in 1992, 2000, and 2011, and is now funded at over $2 billion per year across 11 federal agencies. EIR would apply the successful SBIR approach in the field of social spending.

Shifts towards the evidence-based use of federal funds hold great promise to both improve student outcomes and increase the return on federal education investments as more resources are spent on programs and practices known to make a positive impact rather than on those with no or unknown effects on student success. On June 7, 2016, the House Republicans' Task Force on Poverty, Opportunity, & Upward Mobility introduced "A Better Way" blueprint for reforming social programs, released by Speaker Ryan, which included support for tiered evidence programs, of which EIR is an example.

Early research has shown evidence that the i3 program, the successor to EIR, is working. A report by Patrick Lester, Director of the Social Innovation Research Center, released in January, found that many programs demonstrated positive effects in reading and literacy, kindergarten readiness, STEM (science, technology, engineering, and math), the arts, charter schools, distance learning in rural communities, college preparation, and teacher professional development.

Evidence-based programs should receive the highest attention and investment from the federal government, and I strongly encourage the committee to support adequate funding for EIR.

Finally, I would be remiss if I didn't reiterate my strong support for the programs that really are the crux of our country's education system. Those include Title I of ESEA and the Pell Grant Program, which support education for our nation's neediest students. I also want to reinforce my support for funding Title IV of the Every Student Succeeds Act, and specifically programs that support education technology, STEM, and computer science.

**HIV/AIDS**

In addition to education, I want to mention my strong support for programs that help provide adequate healthcare for individuals living with HIV/AIDS. Most notably, the Ryan White HIV/AIDS Program and the AIDS Drug Assistance Program, both housed at HHS, help ensure that individuals with HIV/AIDS receive the service they need. Importantly, both programs are critical towards a national effort to end the HIV/AIDS epidemic. I encourage the committee to continue to fund and strengthen these programs.

**Labor**

Employee-owned companies provide major economic benefits to communities, employees and the businesses themselves. Companies that are structured in this manner, whether an ESOP or a cooperative, have higher rates of employee-retention, are able to weather market turbulence better than a traditionally structured company and have higher rates of job growth than other small businesses. Employee-owned companies include businesses like New Belgium Brewery in my district, Clif, Dansko and King Arthur Flour. These are anchor companies in their communities, providing well-paying jobs and benefits while giving employees an ability to actively engage in the management of the business to ensure profitability and corporate responsibility.

The Department of Labor shares regulatory oversight of ESOPs with the IRS, but does little to help businesses seeking to convert to employee-ownership structures. Labor could and should be doing more to support employee-owned businesses, which is why I am asking this Committee to include report language that would require the Department of Labor to work with IRS and the SBA to develop guidance and tools available to those interested in employee-ownership structures. Further, I ask the Committee to set-aside a portion of technical training money aimed at replicating effective strategies to states through the WIOA general technical

assistance program and support training centers that will aid in the creation of employee-ownership businesses.

Again, thank you for the opportunity to testify today. I look forward to working with each of you to ensure that each of these programs receive adequate funding in Fiscal Year 2018.

WEDNESDAY, MARCH 1, 2017.

**WITNESS**

**HON. JAMES LANGEVIN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF RHODE ISLAND**

Mr. LANGEVIN. Thank you, Chairman Cole, and Ranking Member DeLauro, and distinguished members of the committee. I appreciate your time today, and thank you for holding the hearing and inviting members of Congress to testify.

So, I appreciate the opportunity to highlight three initiatives that would not only positive impact my State of Rhode Island, but to also help to improve the lives of people across the Nation.

Number one is the funding of the Lifespan Respite Care Act; two is investing in the Carl D. Perkins Career and Technical Act; and three is supporting the Adoption Opportunities Program.

First, I respectfully request $5,000,000 for the Lifespan Respite Care Act Programs. When I first championed the enactment of this law back in 2006, it was a bipartisan effort with then Congressman Mike Ferguson from New Jersey. He and I partnered up, and it is an important bill that became law. And for me, it was with the firsthand knowledge of the tremendous difference that a dedicated caregiver can make in the life of a person with a disability or chronic condition.

The Lifespan Respite Program is the only Federal initiative that exclusively concentrates on respite and does not restrict program eligibility based on the age or veteran status. So, basically respite is when someone is a family caregiver and is caring for a sick child, someone with a disability, or an elderly parent. The caregiver themselves often need some backup and support.

If you have someone coming in for an hour a day or a couple of hours a week just so that the person can go and do the other things they need to do for the family, whether it is going to the doctors themselves, or going grocery shopping, or taking the kids to the ball game, or what have you. These are important things that make a family work, but the caregiver can get burned out very easily. So, this helps to coordinate a patchwork system that different States have so that we are most effectively using resources to have the most effective system for respite.

So, more than 35 States and the District of Columbia have received grants under this program, bolstering a coordinated community systems that are often the only resource for struggling families caring for a loved one. Caregivers need and deserve relief from the physical and emotional responsibility of caring for a person with a chronic illness or disability.

Lifespan Respite Programs often help caregivers manage stress, thereby mitigating the development of physical and mental health issues associated with the strain of their roles. Respite care programs also help to delay or, in some instances, avoid nursing home entry, which strengthens families and improves the wellbeing of all parties.

Reducing the strain on institutionalized care facilities also alleviates pressure on our healthcare system. For example, caregivers provided an estimated $470,000,000,000 in uncompensated care—uncompensated care—if you had to put a dollar figure on it that

family caregivers provided in 2013, more than the total Federal and State Medicaid spending for that year.

Respite is about more than providing caregivers a chance to recharge. The Lifespan Respite Program reinforces the healthcare infrastructure that allows people with a disability or illness to remain at home and supports families who are willing to provide quality care.

I also respectfully request strong support for the Carl D. Perkins Career and Technical Education Act. Career and technical education ensures students are career and college ready, and Perkins provides the largest Federal investment in CTE across the country.

In the 2013–2014 school year, more than 12 million students participated in CTE programs. According to the Bureau of Labor Statistics, many of the fastest-growing jobs through 2022 will be CTE fields, including STEM, skilled trades, and IT. However, half of employers report that they unable to recruit workers for open positions.

Perkins grants ensure students learn the skills needed for these jobs. They development strong educational pathways for students in careers and strengthen career counseling, provide professional development for educators, and purchase vital equipment for classrooms. This bipartisan deserves strong support for 2018.

Lastly, I respectfully request $50,000,000 for programs under the Adoption Opportunities Act. Every day, over 427,000 children are living in foster care across the country. Unfortunately, children who enter the child welfare system after age 14 are much more likely to age out of foster care than be adopted. Already at a disadvantage, these children end up without a network of support, especially in times of crisis.

More than half of children who age out of foster care experience episodes of homelessness, and 25 percent do not receive a high school diploma or GED. Only 6 percent complete a 2- or 4-year college degree.

Adoption Opportunities grants support permanent solutions for foster children. They encourage the adoption of older children, minorities, and children with special needs, and provide post-adoption support. So, I urge you to support the Adoption Opportunities because, quite simply, every child deserves a family.

So, thank you for listening to my testimony and taking my requests into consideration for the Fiscal Year 2018 Labor, Health and Human Services, and Education bill. Each program I highlighted provides American families with crucial tools to achieve success in today's society.

From finding loving homes for foster children to providing crucial career, and education service, to ensuring caregivers who serve those in need receive care themselves, these programs matter. They strengthen our communities, and they uphold our Nation's promise of compassion, equality, and opportunity.

Mr. COLE. I want to thank my friend for his testimony, one of my fellow former secretary of state. We served together at the same time.

Mr. LANGEVIN. Yes, sir.

Mr. COLE. And always thoughtful as usual. You will be happy to know that your good friend, Mr. Thompson from Pennsylvania, was

in here also pushing for Carl Perkins money earlier, so bipartisan on that.

Just so the members know because we have got several that have arrived. We are not going to normally do questions, but at the end of each person, if there is a comment or question that you want to make, I am just going to throw that open to the committee. But we will try to move on schedule, but, again, I——

Mr. LANGEVIN. Mr. Chairman——

Mr. COLE [continuing]. Everybody is free to make a comment or ask a question.

Mr. LANGEVIN. I was remiss in not acknowledging G.T. and his great work, G.T. Thompson from Pennsylvania. We have been great bipartisan partners in career and technical education programs, and I thank him for his leadership. Thank you.

Mr. COLE. Well, we thank the gentleman for his testimony. I see my friend—oh, I am sorry.

Ms. DELAURO. No, no, I just want him to just keep fighting.

Mr. COLE. My friend, the gentlelady from Kansas is here, and she is next up on our agenda. As she is working her way, I am going to take personal privilege as chairman to chastise her for announcing that she is not going to be running again next time. This is one of our most thoughtful and best leaders on our side of the aisle and, I think, in Congress. And there is nobody I am going to miss more around this place than my good friend from the neighboring State, so.

[The statement of the Hon. James Langevin follows:]

House Committee on Appropriations

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

**Congressman James R. Langevin (RI-02)**

*Testimony -- March 1, 2017*

Thank you, Chairman Frelinghuysen and Ranking Member Lowey, for holding this hearing and inviting Members of Congress to testify today. I appreciate the opportunity to highlight three initiatives that would not only positively impact my home state of Rhode Island, but help to improve the lives of people across the nation. These initiatives include: (1) funding the *Lifespan Respite Care Act* to safeguard the health of family caregivers while protecting the continuum of quality care for people with a disability or chronic illness; (2) investing in the *Carl D. Perkins Career and Technical Education Act* to prepare students for the demands of the 21st century economy; and (3) supporting the *Adoption Opportunities* program to help find permanent families for youth in foster care.

First, I respectfully request $5 million for *Lifespan Respite Care Act* programs, which have been funded at approximately $2.5 million per year since FY 2009. When I championed the enactment of this law back in 2006, it was with first-hand knowledge of the tremendous difference a dedicated caregiver can make in the life of a person with a disability or chronic condition.

The Lifespan Respite program is the only federal initiative that exclusively concentrates on respite, and does not restrict program eligibility based on the age or veteran status of the individual receiving care. More than 35 states and the District of Columbia have received grants under this program, bolstering coordinated community systems that are often the only avenue for our nation's families struggling to care for a loved one in need.

Continued federal support for the development and coordination of these respite care programs across the country is crucial to improving the life of family caregivers, maintaining options for care settings, and saving Americans money.

Caregivers need, and deserve, relief from the physical and emotional responsibility of caring for a person with a chronic illness or disability. Lifespan Respite programs help caregivers manage stress, thereby mitigating the development of physical and mental health issues associated with the strain of their role.

Respite care programs also help to delay, or in some instances avoid, nursing home entry, which strengthens families and improves the well-being of all parties. The reduction of hospitalization alleviates pressure on the health care system and the costs associated with providing medical care. Nationally, caregivers provided an estimated $470 billion in uncompensated family caregiving in 2013, more than total federal and state Medicaid spending for that year. Shifting those costs to our hospitals, medical centers, and nursing homes in an already fragile environment is unnecessary and can be prevented if we continue to invest in respite services.

Respite is about more than providing caregivers a chance to recharge. The Lifespan Respite Program is about creating, and continuing to support, an infrastructure that serves our communities and alleviates preventable institutionalized health care—especially when there are people with a disability or illness who want to remain at home, and there are families who are willing to provide that quality care for their loved ones.

I also respectfully request strong support for the *Carl D. Perkins Career and Technical Education Act* (Perkins).

Career and Technical Education (CTE) ensures students of all ages are career and college-ready, and Perkins provides the largest federal CTE investment in high schools and community and technical colleges across the country. During the 2013-2014 school years, more than 12 million students participated in secondary and postsecondary CTE programs in the United States. However, many CTE programs are experiencing reductions in funding.

According to the Bureau of Labor Statistics, many of the fastest-growing jobs through 2022 will be in CTE fields, including STEM, health care, skilled trades, IT, and marketing. Many employers already report that they are unable to recruit workers for open positions. In fact, the skilled trades are the hardest jobs to fill in the United States, with recent data citing 1,019,000 jobs open in the trade, transportation and utilities sector, and 315,000 jobs open in manufacturing.

Perkins grants help close this skills gap. They allow institutions to develop strong educational pathways for students, strengthen career guidance and counseling, provide professional development for educators, purchase equipment for classrooms, ensure access for underserved populations, and promote strong school accountability systems. Investment in Perkins ensures our students are learning relevant technical and employability skills, and it has strong bipartisan support.

Last Congress, the House overwhelmingly passed H.R. 5587, the Strengthening Career and Technical Education for the 21st Century Act, by a vote of 405-5. While we continue to work on the reauthorization of Perkins in the new Congress, I urge you to continue supporting strong funding for CTE so we may invest in our students and our economy.

Lastly, I respectfully request $50 million for the *Adoption Opportunities* program. In FY2016, it was funded at $39.1 million, with $4 million dedicated to state grants for testing child-focused parent recruitment.

On any given day, over 427,000 children are living in foster care across the country, awaiting adoption by a loving, caring family. Unfortunately, children who enter the child welfare system after age 14 are much more likely to age out of foster care than be adopted. In 2015, 20,789 children aged out of the foster care system. Already at a disadvantage, these children end up without a network of support, especially in times of crisis.

More than half of children who have aged out of foster care experience episodes of homelessness and 25 percent do not receive a high school diploma or GED. Only six percent of children finish a two or four year degree after aging out. They are more likely to be unemployed, receive public assistance, and become involved in the criminal justice system. It is our moral responsibility to care for these children as we would our own.

The *Adoption Opportunities* program supports permanent solutions for youth in foster care. It encourages the adoption of older children, as well as minorities and children with special needs, and provides postadoption support to families. Investing in these services not only improves the quality of life for children, it results in long-term government and societal savings. A Department of Health and Human Services Children's Bureau study found that, "approximately $65,422 to $126,825 is saved for every child who is adopted rather than placed in long-term foster care."

We must commit to funding *Adoption Opportunities*, because, simply put, every child deserves to have a family.

I want to once again thank you for receiving my testimony and taking my requests into consideration for the Fiscal Year 2018 Labor, Health and Human Services, and Education bill. The programs and initiatives I have highlighted today help shape the lives of Americans at various stages of life. From finding loving homes for children in foster care, to offering crucial career services and technical learning opportunities, to ensuring caregivers who provide a much needed service to those in need receive care themselves. These programs matter, they strengthen our communities, and they uphold our nation's promise of compassion, equality, and opportunity.

WEDNESDAY, MARCH 1, 2017.

**WITNESS**

**HON. LYNN JENKINS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF KANSAS**

Ms. JENKINS. Well, thank you, Mr. Chairman. Thank you, Chairman Cole, Member DeLauro, and honorable members of this committee.

In December of 2016, Congress passed the 21st Century Cures Act, which contained the Mental Health First Aid Act, which was on the top priorities of mine since coming to Congress back in 2009. And today, I simply ask that that funding level of nearly $15,000,000 be fully appropriated in the Fiscal Year 2018 budget.

Section 9010 reauthorizes grants to States and municipalities, Indian tribes, and nonprofit groups to train teachers and school personnel, emergency service personnel, and others to recognize the signs and symptoms of mental illness, to become familiar with resources in the community for people with mental illness, and to safely de-escalate crisis situations involving someone with a mental illness.

This grant program has been included in appropriations bills in years past and has enjoyed broad bipartisan support from Congress and the public. I cannot overstate how important these grants are to law enforcement and first responders.

The first step to helping someone suffering with a mental illness to get the help he or she needs is to be able to quickly spot the signs of that mental illness and know where to point that friend, the colleague, neighbor, or family members. These funds will help police officers, first responders, veterans advocates, and educators, and other spot the signs that get people the help that they need.

We hear about the state of our mental health system every day and the state of the VA dealing with injured veterans. We hear about police and first responders called to a scene where someone has become dangerous and they are not sure of the best way to respond. Section 9010 will help those people know instinctively how to respond so that the situations stay in control, and the risk of harm is decreased.

The kinds of education programs that this legislation will fund have been shown to be effective and efficient in teaching people the signs of mental illness and how to drop the stigma of that illness so that the people they live and work with can receive the appropriate help necessary.

I am thankful for the opportunity to address you here today and ask that the stated funding level be given to SAMHSA so that it may in turn help those that need the training the most.

I appreciate your time and the opportunity to address the committee. Thank you, Mr. Chairman.

Mr. COLE. Great to have you here, and acknowledge the gentlelady's great work on Cures and on the mental health component of that that our mutual friend, Mr. Murphy, did such great work on and you reported out in such wonderful bipartisan fashion, I think unanimously, out of your committee. So, I think he will be here later to talk about that.

Ms. JENKINS. Great. Thank you.

Mr. COLE. Any questions or comments from anybody else on the committee?

[No response.]

Mr. COLE. Well, I see my good friend, Ms. Kelly, has arrived. I am sorry I did not see you over there when you first got in, and good to have you here on the committee. I want to thank you for coming before, we will just call it the Labor-H Committee because it is a mouthful if you try to get it all out.

But we are delighted to have you here, and the gentlelady is recognized for 5 minutes for whatever testimony she cares to give.

[The statement of the Hon. Lynn Jenkins follows:]

Thank you Chairman Cole and Ranking Member DeLauro. In December 2016, after a long and hard fought battle, Congress passed the 21st Century Cures Act, which contained the Mental Health First Aid Act, one of my top priorities since coming to Congress in 2009. Today I ask that the funding level of $14,963,000 be fully appropriated for FY2018.

Section 9010, reauthorizes grants to states, and municipalities, Indian tribes, and nonprofit groups to train teachers, and school personnel, emergency services personnel, and others, to recognize the signs and symptoms of mental illness, to become familiar with resources in the community for people with mental illnesses, and for the safe deescalation of crisis situations involving someone with a mental illness. I cannot overstate how important these grants are to our law enforcement and first responders. The first step to helping someone suffering with a mental illness get the help he or she needs is to be able to quickly spot the signs of that mental illness and know where to point that friend, colleague, neighbor, or family member. Section 9010 will help police, first responders, veterans' advocates, teachers, and others spot the signs and get people help they need it.

It authorized a grant program that has been included in appropriations bills in years past and enjoyed great support from Congress and the public. These important groups will get educated in spotting signs of mental illness in the people they work and live with so that they can get help to those people.

We hear about the state of our mental health system every day and the state of the VA dealing with injured veterans. We hear about police and first responders called to a scene where someone has become dangerous and they are not sure of the best way to respond. Section 9010

will help those people know instinctively how to respond so that the situations stay in control and the risk of harm to anyone is lessened.

The kinds of education programs that this legislation will provide funding for have been shown to be effective and efficient at teaching people the signs of mental illness and how to drop the stigma of that illness so that someone in need can get help. We need this funding more than ever and I am glad that we have decided to take action here today.

I am thankful for the opportunity to speak in front of this Committee today and I ask that its stated funding level of $14,963,000 be given to SAMHSA so that it may in turn help those who need this training the most.

WEDNESDAY, MARCH 1, 2017.

**WITNESS**

**HON. ROBIN KELLY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS**

Ms. KELLY. Thank you, Mr. Chair, and Ranking Member, and all the committee members. I would like to thank you for the opportunity today to speak before you and testify on behalf of the families of Illinois' 2nd Congressional District, and on behalf of millions of Americans whose livelihoods are adversely impacted due to health inequities that exist in our Nation.

To those who do not know me, my name is Robin Kelly, and I chair the Congressional Black Caucus Health Brain Trust. I have never been of the belief that the zip code you are born in should never determine how long you live in this country or how healthy you are. Grandmothers have to decide between paying their electrical bill or paying for their diabetes medicine.

Parents should not have to decide between food in their refrigerator or paying for an $80 dental procedure. But those are decisions that are being made every day for far too many Americans, and too often they have devastating and fatal consequences.

Last Congress, I authored a report, the Kelly Report on Health Disparities in America, an official congressional analysis of the state of African-American health in the United States, that offers a blueprint for reversing negative health trends in communities of color. The Kelly Report outlines the grim state of black health in America and remedies to reverse the negative health statistics plaguing communities of color.

Consider this, African-Americans have higher rates of mortality than any other racial or ethnic group for eight of the top 10 causes of death. African-American cancer rates are 10 percent higher than white Americans. Blacks are nearly twice as likely to have diabetes than whites. African-Americans are 6 times more than likely than whites to be victims of homicide, and black youth especially do not have consistent access to the culturally sensitive trauma-informed mental healthcare that would alleviate their burden.

While blacks account for just 13 percent of the total U.S. population, they account for nearly half of all new HIV infections. Those are startling facts. In a broader public health context, there is still much to be done to address the fact that an estimated 1.5 million Americans suffer from Lupus. There is no reason we should not be able to find the root cause of Lupus and a cure.

We also must invest in and address the fact that mental illness is the leading cause of disability in developed countries like the United States. And we must address the often overlooked problem of oral health in America. People of color suffer from disproportionate rates of tooth loss, untreated dental care, and untreated tooth decay.

This committee has a tall task in ensuring that our appropriations priorities reflect the health needs of the most vulnerable in this Nation. It is a worthy goal, but it should be our mission. I ask that the committee support my request to invest in our most vulnerable. Fund health delivery sites in medically underserved areas whether they are urban, suburban, or rural, and my district is all

three, and place support programs that encourage primary care providers to practice in communities with shortages.

The request you will receive from me will ask that you prioritize health professional training programs, like the Minority Centers of Excellence and Health Careers Opportunities Program. Additionally, my office has put together a list of what we see as the most beneficial and impactful health programs for you to appropriate funds for this Labor, HHS cycle.

I thank the committee for the opportunity to testify today.

Mr. COLE. I want to begin by just thank the gentlelady for testifying not only behalf of her district, but on behalf of the Congressional Black Caucus as well. As I know the gentlelady recognizes, we actually have a champion on this committee from California, who has done probably more than——

Ms. KELLY. My mentor.

Mr. COLE [continuing]. Anybody in this Congress to focus on racial disparities, and treatments, and outcomes. My good friend, Ms. Lee, has been a leader in that for a long time. So, but we are delighted to have you there. Does anybody else care to make a comment or ask a question?

Ms. DELAURO. Just I would love to have the list of what your office put together on what the priorities are.

Ms. KELLY. We will get to that you.

Ms. DELAURO. Thank you very much. Thank you.

Mr. COLE. We thank the gentlelady, and I see my good friend from Pennsylvania, Mr. Fitzpatrick. You are next up. It is good to have you here.

[The statement of the Hon. Robin Kelly follows:]

Congresswoman Robin L. Kelly

Illinois Second Congressional District

February 22, 2017

I'd like to thank the Committee for this opportunity today to speak before you and testify on behalf of the families of Illinois' Second Congressional District, and on behalf of millions of Americans whose livelihoods are adversely impacted due to health inequities that exist in our nation.

To those who do not know me, my name is Robin Kelly, and I Chair the Congressional Black Caucus Health Braintrust. I have always been of the belief that the zip code you are born in should NEVER determine how long you live in this country, or how healthy you are. Grandmothers shouldn't have to decide between paying their electric bill or paying for their diabetes medicine. Parents should not have to decide between putting food in their refrigerator or paying for an $80 dental procedure.

But those are decisions that are being made every day for far too many Americans. And too often, they have devastating and fatal consequences.

Last Congress I authored a report – *The Kelly Report on Health Disparities in America* – an official Congressional analysis of the state of African American health in the U.S. that offers a blueprint for reversing negative health trends in communities of color.

The Kelly Report outlines the grim state of Black Health in America, and remedies to reverse the negative health statistics plaguing communities of color. Consider this:

- African Americans have higher rates of mortality than any other racial or ethnic group for 8 of the top 10 causes of death
- African American cancer rates are 10% higher than white Americans
- Blacks are nearly twice as likely to have diabetes than whites
- African Americans are six times more likely than whites to be victims of homicide, and Black youth especially do not have consistent access to the culturally sensitive, trauma-informed mental health care that would alleviate their burden
- While Blacks account for just 13% of the total U.S. population, they account for nearly half of all new HIV infections

Those facts are startling.

In a broader public health context, there is still much to be done to address the fact that

- An estimated 1.5 million Americans suffer from Lupus
- There is no reason we shouldn't be able to find the root causes of lupus and a cure.

We must also invest in and address the fact that mental illness is the leading cause of disability in developed countries like the U.S.

And we must address the often overlooked problem of oral health in America. People of color suffer from disproportionate rates of tooth loss, untreated dental caries, and untreated tooth decay.

This Committee has a tall task in ensuring that our appropriations priorities reflect the health needs of the most vulnerable in this nation. It's a worthy goal, but it should be our mission.

I ask that the Committee support my requests to invest in our most vulnerable. Fund health delivery service sites in medically underserved areas (urban and rural) and place support programs that encourage primary care providers to practice in communities with shortages.

The requests you'll receive from me will ask that you prioritize health professions training programs, like the Minority Centers of Excellence and Health Careers Opportunities Program.

Additionally, my office has put together a list of what we see as the most beneficial and impactful health programs for you to appropriate funds to for this Labor, HHS cycle.

I thank the Committee for the opportunity to testify today.

Yield.

WEDNESDAY, MARCH 1, 2017.

**WITNESS**

**HON. BRIAN FITZPATRICK, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF PENNSYLVANIA**

Mr. FITZPATRICK. Thank you, Mr. Chairman, Ranking Member DeLauro, and members of the subcommittee. Thanks for your time today.

And I wanted to take the opportunity to address the subcommittee, and I know there are a lot of challenges that we face as a Congress. One of the most significant ones affecting our district and I know affecting so many of our districts is the grip of opioid abuse and heroin addiction, overdose deaths.

And I just wanted to thank the committee first and foremost for your time, and strongly encourage full funding for this opioid epidemic and related cancer research programs. The provision in the CARA Act, the Comprehensive Addiction and Recovery Act, as well as NIH Innovation Projects and state responses to opioid abuse in the 21st Century Cures Act are in need of full funding, as well as the NIH.

Mr. Chairman and Ranking Member, prescription opioid misuse continues to devastate Americans nationwide. According to the Centers for Disease Control and Prevention, drug overdoses involving prescription opioid and heroin overdoses have quadrupled since 1999, and it continues to claim lives in all of our districts. I know from north to south in our district, just last year alone we saw a 50 percent increase in heroin-related overdose deaths, which is unbelievable.

And at the same time, while we have seen this significant increase, law enforcement officials and first responders have tirelessly worked to save lives. Diana Rosati, who is the head of the Bucks County Drug and Alcohol Commission in our district, recently reported that police departments throughout our district saved 263 residents in our district through the use of Narcan, which is an opioid overdose emergency treatment.

And her statement was, "While the number of lives saved from accidental overdose is an amazing number, it speaks to the magnitude of this issue and the need for treatment to follow through." And many of our police chiefs have likened it to putting a band-aid on a bleeding artery. Narcan is a great treatment to save lives, but prevention is really the key, and that's why I am here to talk to you today.

Thoughtfully designed, the CARA statute utilized a balanced strategy encompassing six pillars: prevention, treatment, recovery support, criminal justice reform, overdose reversal, and law enforcement. Within the jurisdiction of the subcommittee, authorized funding by CARA for HHS included grants that will significantly aid States with much-needed resources and tools.

Just to name a few things that grant funding will accomplish, first it would reduce the number of opioid-related deaths by assisting States and expanding access to opioid overdose reversal drugs, such as Narcan, and also educating healthcare professionals by developing and providing training manuals and developing new strat-

egies for pharmacists to dispense opioid overdose reversal medication.

It will also help accomplish reducing relapses and help fully recover patients by expanding availability of evidence-based medication, assisted treatment, and other clinical appropriated services to areas with high rates of rapid increases of heroin or opioid abuse. And it will also, through building connections between recovery community organizations that will strengthen outreach, reduce substance abuse disorder stigma, and reduce substance abuse cases in pregnant or postpartum women by demonstrating a pilot program that will better support family-based services, identify gaps along the continuum of care, and encouraging new approaches for service delivery.

In addition, the 21st Century Cures Act also contained funding to combat the opioid epidemic. Specifically, the remaining $500,000,000 would supplement opioid abuse prevention and treatment activities by providing funding for States to improve prescription drug and monitoring programs, implement prevention activities, train healthcare providers, and expand access to treatment programs.

And I just want to thank the committee for their time today and just bring to your attention this really important issue that is affecting all of our districts. Certainly it is affecting mine in a staggering way.

Thank you, Mr. Chairman, and thank you, Ranking Member DeLauro.

Mr. COLE. Thank you. I want to thank you for your thoughtful testimony, and particularly in the areas that you focused on. Probably as a former FBI agent, you saw the opioid crisis up close and personal, the way that a lot of us have not. We did, you know, appropriate the Cures portion of that and the continuing resolution, I think, on the opioid issue. And if we can ever get our bill out. It is something I will continue to harangue on, and I know my good friend shares my frustration.

This year, we had a very substantial increase in NIH funding. We will have a very substantial increase again if we can just get the bill out in some form and across the floor. So, we appreciate you highlighting them because on a bipartisan basis, this committee shares those priorities.

Ms. DELAURO. Mr. Chairman, just to tell you that just to increase what the chairman has said. In our 2017 budget request, there is a rural opioid overdose reversal. It is $10,000,000. There are several SAMHSA programs, Medicaid Assistance Treatment Program, $50,000,000. You have got opioid treatment programs. SAMHSA, while it did not do the buprenorphine program, grants to present prescription opioid drug overdose. There is that effort under SAMHSA, strategic prevention for prescription drugs.

And CDC is what you spoke about in terms of helping States to set up this monitoring. I just would add one more point to you. Take a very hard look at what may be coming down the pike with regard to Medicaid and Medicaid expansion and overall Medicaid funds, because Medicaid is one of the prime ways in which people are getting the opportunity to have their treatment and it being insured and covered.

Thank you, Mr. Chairman.

Mr. COLE. Would anybody else care to ask a question or make a comment?

[No response.]

Mr. COLE. Well then, my good friend is excused. Thank you very much for your testimony.

I see my good friend and fellow Appropriations Committee member, Mr. Price from North Carolina, is here. And, Mr. Price, it is always a pleasure to have you on either side of the dais under any circumstances. So, we look forward to whatever testimony you care to give us.

And my good friend is recognized for 5 minutes.

[The statement of the Hon. Brian Fitpatrick follows:]

STATEMENT OF

REPRESENTATIVE BRIAN FITZPATRICK OF PENNSYLVANIA'S EIGHTH DISTRICT

BEFORE THE SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN SERVICES,

EDUCATION AND RELATED AGENCIES

COMMITTEE ON APPROPRIATIONS

UNITED STATES HOUSE OF REPRESENTATIVES

MARCH 1, 2017

I would like to thank Chairman Cole, Ranking Member DeLauro and other members of the Subcommittee on Labor, Health and Human Services, Education and Related Agencies for holding this hearing. As this subcommittee develops appropriations for the Department of Health and Human Services (HHS), I strongly encourage the full funding for opioid epidemic related programs and cancer research programs. This includes provisions of the Comprehensive Addiction and Recovery Act (CARA), NIH innovation projects and state responses to opioid abuse in the 21st Century Cures Act, and funding the National Institutes of Health.[1, 2]

Prescription opioid misuse continues to devastate Americans nationwide. According to the Centers for Disease Control and Prevention, drug overdoses involving prescription opioids and heroin have quadrupled since 1999. The opioid epidemic continues to claim lives from each of our districts. From Levittown to Lower Salford, no part of my district is left unaffected. Last year in Bucks County, opioid related deaths rose by 50 percent.[3] In neighboring Montgomery County, opioid overdoses claimed a staggering 240 lives – up 36 percent from the previous year.

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[1] Comprehensive Addiction and Recovery Act, Public Law No. 114-198, July 22, 2016.
[2] 21st Century Cures Act, Public Law No. 114-255, December 13, 2016.
[3] Bucks County Courier Times, Chilling Record: Opioid Fatalities, January 31, 2017.

At the same time, however, law enforcement officials and first responders have tirelessly worked to save lives. Diane Rosati of the Bucks County Drug and Alcohol Commission recently reported that Bucks County police departments have saved over 263 residents through naloxone, an opioid overdose emergency treatment nasal spray. "While the number of lives saved from accidental overdose is an amazing number, Ms. Rosati added, "it speaks to the magnitude of the issue and need for treatment follow through."

Thoughtfully designed, CARA utilizes a balanced strategy encompassing six pillars: prevention, treatment, recovery support, criminal justice reform, overdose reversal, and law enforcement. Within the jurisdiction of this subcommittee, authorized funding by CARA for HHS include grants that will significantly aid states with much needed resources and tools. Grant funding will (to name a few):

- reduce the number of opioid related deaths by (a) assisting states in expanding access to opioid overdose reversal drugs like naloxone, and (b) educating health care professionals by developing or providing training manuals and developing new strategies for pharmacists to dispense opioid overdose reversal medication (pursuant to standing order).
- reduce relapses and help fully recover patients by (a) expanding the availability of evidence-based medication assisted treatment and other clinical appropriate services to areas with high rates or rapid increases in heroin or opioid abuse; and (b) through building connections between recovery community organizations that will strengthen outreach, reduce the substance abuse disorder stigma; and

- reduce substance abuse cases in pregnant and postpartum women by developing a pilot program that will better support family-based services, identify gaps along continuum of care, and encouraging new approaches for service delivery.

In addition to CARA, the 21st Century Cures Act also contained funding to combat the opioid epidemic. Specifically, the remaining $500 million would supplement opioid abuse prevention and treatment activities by providing funding for states to improve prescription drug monitoring programs, implement prevention activities, train healthcare providers, and expand access to treatment programs.

Second, I would like to bring to the subcommittee's attention to the importance of funding the National Institutes of Health (NIH). NIH has served a pivotal role in basic cancer research and its success is evident in treatments we see today. More remarkably, in 1991, an NIH partnership with a then small company called Genzyme would lead to the development of one of the first orphan drugs, Ceredase (now Cerezyme) to treat a rare disease affecting an estimated 10,000 people worldwide.[4, 5] Today, the US boasts in housing the best innovators in biology and medicine research, producing groundbreaking drugs and more research publications than any other country.[6]

In consideration of time, I would like to mention funding for the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK). NIDDK conducts research on many of the most common, costly, and chronic conditions. This includes diabetes, digestive diseases, and liver disease (to name a few). In my district, I had the privilege of meeting with research

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[4] The Pharma Letter, Cerezyme Approved in USA, June 6, 1994.
[5] The Washington Post, The High Cost of Rare Diseases: When Patients Can't Afford to Buy Lifesaving Drugs, By Larry Thompson, June 25, 1991.
[6] Forbes, The Most Innovative Countries in Biology and Medicine, By Matthew Herper, March 23, 2011. Whitman, Glen and Raymond Raad. Bending the Productivity Curve: Why America Leads the World in Medical Innovation. November 18, 2009. Cato Institute.

scientists at the Baruch S. Blumberg Institute, one of the leading global labs focused on Hepatitis B (HBV) research. Dr. Tim Block and his team discussed the significance of this disease and the need for continued research. While HBV is preventable through vaccination, an estimated 2.2 million Americans live with this life-threatening disease. HBV has been on the rise in recent years, and in some studies, the rise was linked to drug abuse.[7, 8, 9, 10] Eventually, in most cases, HBV will lead to liver cirrhosis or liver cancer. The patient will then need a liver transplant which is dependent on donor availability and if they are an eligible candidate. The procedure is a large financial undertaking. Including physician costs, anti-rejection antibiotics and pain drugs, rehabilitation, follow-up care, and testing, the final bill can exceed $500,000.[11]

The costs of current treatment methods for HBV are by far higher when compared to a drug that cures. Hepatitis C, for example, is curable. [12, 13, 14, 15] When compared to its

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[7] US Centers for Disease Control and Prevention, Increases in Acute Hepatitis B Virus Infections — Kentucky, Tennessee, and West Virginia, 2006–2013, By Aaron M. Harris, Kashif Iqbal, Sarah Schillie, James Britton, Marion Kainer, Stacy Tressler, and Claudia Vellozzi, January 29, 2016, *Weekly* 65(3): 47-50.

[8] Portland Herald Press, Fueled by Heroin Crisis, Hepatitis B Cases Rise in Maine, by Joe Lawlor, September 5, 2016.

[9] Kris Kowdley, Chia Wang, Sue Welch, Henry Roberts, and Carol Brosgart, Prevalence of chronic Hepatitis B Among Foreign-Born Persons Living in the United States by Country of Origin, *Hepatology* 56, no. 2 (2012): 422-433.

[10] Ashley Simmons, The Epidemiology of Hepatitis B in West Virginia, Prepared for the West Virginia Department of Health and Human Services, November 19, 2015.

[11] United Network for Organ Sharing, Financing a Transplant: The Costs, 2011.

[12] Evangelos Cholongitas and George Papatheodoridis, Sofosbuvir: A Novel Oral Agent for Chronic Hepatitis C, 2014, *Annals of Gastroenterology*, 27(4): 331-337.

[13] Michael Smith, et. al, Ledipasvir-Sofosbuvir Interferon-/Ribavirin-Free Regimen for Chronic Hepatitis C Virus Infection, March 2015, *Week 14*, 49(3): 343-350.

[14] Brian Lam, et. al, Sofosbuvir (Sovaldi) for the Treatment of Hepatitis C, June 2014, *Expert Review of Clinical Pharmacology*, 7(5): 555-566.

[15] Sean McConachie, et. al, New direct-acting antivirals in hepatitis C therapy: a review of sofosbuvir, ledipasvir, daclatasvir, simeprevir, paritaprevir, ombitasvir and dasabuvir, January 2016, *Expert Review of Clinical Pharmacology*, 9(2): 287-302.

contemporaries and predecessors, Sovaldi is the least burdensome option when considering its efficacy, length of therapy, side effects, and cost.

The social and financial burden of diseases like HBV do not only impact patients and their loved ones, but the economic effect of low efficacy treatments is burdensome to government. Medicare, which is expected to become insolvent by 2028, is the largest single payer for liver transplants, averaging at $188,000 across Parts A and B.[16, 17] Observing national expenditures, the United Network for Organ Sharing has estimated that the cost of care for each year's cohort is about $5.6 billion.[18]

Investing in medical research and combating the opioid epidemic are two very significant agendas HHS should focus on. As a member of the Congressional Addiction, Treatment and Recovery Caucus and the Bipartisan Heroin Task Force, I strongly urge this subcommittee to fully fund opioid related activities through CARA and 21st Century Cures. I also ask that full funding be appropriated to NIH as the institutes will continue to serve a vital role in treating, preventing, and curing diseases. Thank you for your time and consideration.

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[16] Congressional Research Service, Medicare: Insolvency Projections, By Patricia Davis, October 5, 2016
[17] Health Resources & Services Administration, OPTN/SRTR 2012 Annual Data Report: Liver, 2012, 73.
[18] Modern Healthcare, Transplant Providers Dispute Changes to Allocating Donated Livers, By Sabriya Rice, September 20, 2014.

WEDNESDAY, MARCH 1, 2017.

**WITNESS**

**HON. DAVID PRICE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NORTH CAROLINA**

Mr. PRICE. That is a rather expansive welcome, so thank you. I appreciate the chance to be here.

Ranking Member DeLauro, colleagues on both sides, thank you so much for this chance to testify on behalf of the National Service Program. I am a co-chair along with Doris Matsui of the National Service Caucus. That is a bipartisan group of nearly 80 members, and I bring Doris' regrets for not being able to testify with me here today.

National Service has a proud history in the U.S. President Kennedy first called for a domestic volunteer program to complement the Peace Corps in the early 1960s, and that inspired President Johnson to create the Volunteers in Service to America, VISTA, under the Economic Opportunity Act of 1964. VISTA quickly expanded and was codified by Congress in the early 70s with the bipartisan Domestic Volunteer Service Act, legislation that outlined the specific mission and goals of national service in relation to the needs of the country.

Some years later, the Corporation for National and Community Service, or CNCS, was founded to consolidate these efforts, support the programs that we are familiar with today: AmeriCorps, Senior Corps, and what was formerly known as Serve America.

Today, the Corporation for National Service is guided by the principles of putting the needs of local communities first, strengthening public/private partnerships, and assisting with the accessibility of grant funding to rural. And I know there are economically distressed communities.

Most colleagues are familiar with the benefits and success of AmeriCorps, a program established to provide opportunities for motivated and dedicated Americans to specifically engage in State and local projects. Every year, over 80,000 Americans immerse themselves in these programs that address community needs or respond to disasters.

And I say most colleagues are aware of this. I actually do not think the general public is necessarily aware of the reach of AmeriCorps, and the extent to which local organizations they participate and value are undergirded by AmeriCorps support. Habitat for Humanity would be a good example. You can scarcely imagine those Habitat projects being organized in the efficient way they are without the support of AmeriCorps.

Senior Corps, largely developed under President Nixon, has connected our Nation's older generations with people and organizations in need across the country. Senior Corps members become coaches, mentors, contributing their career skills and expertise to the community. Here, the trademark program is Foster Grandparents, and most of us have heard of that, and we know that it enriches the lives of young people with volunteers age 55 and over serving local organizations committed particularly to the betterment of children.

And then finally, the Social Innovation Fund catalyzes and mobilizes public and private funds to transform the impact that local nonprofits have on communities. As of March of last year, the Social Innovation Fund leveraged $295,000,000 of Federal investment to reach commitments of more than twice that value.

So, National Service works by engaging young people, providing services to military families, helping communities succeed. Through service, and we need to understand the benefit this has to those who serve as well as those who are served. Through service, highly motivated young Americans can participate in career-related service opportunities, such as working with the Community Health Corps, increasing their experience, their earning potential, as they give back to the community.

Additionally, a generation held back by increasing student debt can now seek alternatives to paying for their education. And we know National Service leverages substantial private investments from a small public investment.

In my district, we host over 350 AmeriCorps volunteers, 162 Senior Corps volunteers, working with local universities, housing authorizes, various nonprofits. The young people who serve and the not so young people who serve have a lasting impact on my district and on the State, sustaining communities, allowing them flourish for future generations.

So, my colleagues, in this time of political uncertainty, we need to remember that National Service is not partisan. Its roots are not partisan, and the way it operates is not partisan. Republican Presidents from Nixon to George W. Bush supported these programs, and President Bush encouraged all Americans to devote 4,000 hours of their lives to service in the aftermath of September 11th.

So, I believe this a goal implemented by a series of programs that we can agree on, give a new generation of young people a means to make a difference for their country.

So, thank you for the opportunity to advocate on behalf of the Corporation for National Service and its good works and to support the funding. Thank you.

Mr. COLE. Good to have my friend's testimony as always, and just to make a quick point, reinforce a quick point that he made on the bipartisanship of this program. The last director, who has since retired, Wendy Spencer, I think is known by this committee very well, and served under both Democratic and Republican administrations with great distinction in a very bipartisan way. So, I thank my friend for his testimony.

Are there any other comments or questions?

Ms. DELAURO. Just to say thank you. Thank you for your continued support and advocacy for a program that really helps our young people understand what their responsibilities are and the moral responsibility they have to their communities and to their country. We both have lived through a time when this money was eliminated, but we saw the light on both sides of the aisle to make sure that the funding is there and it continues to be there, and including the Social Innovation Fund because of what it does with third parties.

And our hope is that we have got, I think except for the Senate on the Social Innovation Fund, the House side is very much in sup-

port of what you are doing, Mr. Price. And we will wait to see what 2018 is about, and we will advocate again, and I know you will be. Thank you so much.

Thank you.

Mr. COLE. Any other questions or comments?

[No response.]

Mr. COLE. With that, Mr. Price, thank you very much for your testimony.

I see my good friend, Mr. Long, from Missouri is arriving, and so he is recognized and is next up. It is good to have my friend here, and the gentleman is recognized for 5 minutes to make whatever remarks he cares to to the committee.

[The statement of the Hon. David Price follows:]

**Congressman David Price**

**Testimony regarding National Service to the Labor HHS Subcommittee**

- Good afternoon Chairman Cole, Ranking Member DeLauro, and the distinguished Members of the Subcommittee. Today I am speaking on behalf of the National Service Caucus, a bipartisan group of nearly 80 Members. My colleague and fellow caucus co-chair, Rep. Doris Matsui, sends her regrets for not being able to testify with me.

- I will begin my remarks with a brief history and summary of National Service. National volunteer programs that established the fundamentals for National Service began as early as the 1960s under President John F. Kennedy, who was eager to establish a domestic service program similar to the Peace Corps before the premature ending of his tenure. President Lyndon Johnson adhered to the wishes of our late president by establishing volunteer programs designed to engage older Americans and engage young volunteers by establishing the Volunteers in Service to America (VISTA) program.

- VISTA quickly expanded and codified by Congress in the early 1970s with the bipartisan Domestic Volunteer Service Act, outlining the specific mission and goals of National Service in relation to our country. A mere two decades later, the Corporation for National and Community Service, or CNCS, was established, creating the larger programs that we are familiar with today: AmeriCorps, Senior Corps, and what was formerly known as Serve America.

- It was conservative author William F. Buckley Jr. that wrote in his book "Gratitude: Reflections on What We Owe to Our Country" that "participation in the community should take more active form than merely paying taxes, buying and selling in the marketplace, and voting." Buckley consistently advocated a strong case for national civic service, recognizing the proven capacity of the government to mobilize young people through

educational opportunities to serve the most vulnerable populations in our country.

- National Service quickly became center to our national discourse after the tragedies that ensued on September 11, 2001. At the 2002 State of the Union Address, President George W. Bush called on Americans to devote two years, or 4,000 hours, to volunteer service during their lifetimes.

- Today, CNCS is guided by the principles of putting the needs of local communities first, strengthening public-private partnerships, assisting with the accessibility of grand funding to rural and economically distressed communities, among other strong mission principles.

- Many of you are familiar with the benefits and successes of AmeriCorps, a program established to provide opportunities for motivated and dedicated Americans to civically engage in state and local projects. Each year, over 80,000 Americans immerse themselves in these programs that address community needs or respond to disasters.

- Senior Corps, largely developed under President Richard Nixon, has connected our nation's older generations with people and organizations in need across the country. Senior Corps members become coaches and mentors, contributing their career skills and expertise to grow communities. One of the largest programs is the Foster Grandparents program, which enriches the lives of young people with volunteers age 55 and over by serving local organizations committed to the betterment of children.

- Last, the Social Innovation Fund, or SIF, catalyzes and mobilizes public and private funds to transform the impact that local nonprofits have on communities. As of March 2016, SIF leveraged $295 million of federal investment to reach commitments of more than twice the value. The vital goal of SIF is simply to determine what works to alleviate community-specific problems and sustaining those practices to benefit more people.

- National Service works by engaging young people, providing services to military families and helping communities succeed. Through service, highly motivated young Americans can participate in career-related service opportunities such as servicing with the Community Health Corps, increasing their earning potential. Additionally, a generation held back by increasing student debt can now seek alternatives to paying for their education.

- The unique nature of National Service stems from its ability to leverage a small public investment to receive substantial private investments, allowing the maintenance of economic sustainability for projects and missions. Additionally, grants are state and local-centric, allowing for the specific knowledge of communities to dictate efficient and effective distribution to areas in need. Rural and urban areas alike receive grants tailored to the needs of the communities.

- In my district, we host over 350 AmeriCorps volunteers and 162 Senior Corps volunteers, serving with several universities in my district, local housing authorities, and local educational nonprofits, to name a few. Those that serve have a lasting impact on my district and the state, allowing for communities to sustain and flourish for future generations.

- National Service is not just a "bleeding heart" policy, but rather a core belief of our country with bipartisan roots. This agency propels a new generation a new generation of young people to have a place to make a difference in their country.

- Again, thank you for this opportunity to advocate on behalf of this essential national agency and I encourage the subcommittee to diligently review the nationwide effects of National Service.

WEDNESDAY, MARCH 1, 2017.

**WITNESS**

**HON. BILLY LONG, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MISSOURI**

Mr. LONG. Good morning, Chairman Cole, and Ranking Member DeLauro, and members of the subcommittee. Thank you for allowing me to come before the subcommittee today to speak in support of AmeriCorps.

A lot of you all have met my oldest daughter, Kaleen, who is a pediatrician, and I know Rosa helped her along the way. And she was born on May the 22nd, my oldest daughter.

On May 22nd, 2011, we were celebrating her birthday party, along with another friend of ours who had a birthday on the day before or the day after hers. And we were over at some friends' home that did not have a basement in it. And it came over the news that there was a tornado right outside of town, Springfield, Missouri.

There were debris, so we said, hey, this house does not have a basement, we need to run home. So, we went to our house with a basement. It was not a tornado right outside of Springfield. It was a tornado that had struck an EF-5 70 miles away from Springfield. But there were hospital X-rays that traveled 70 miles and set down right outside of Springfield, so that was the power and strength of this tornado.

That was May 22nd, 2011, a devastating EF-5 tornado. And the tornado killed 161 people, injured over a thousand, destroyed 7,000 homes. This is in a town of 50,000 people with a population of more than 50,000, and 1,500 square miles of tornado. It affected a considerable part of the city.

People did not know how to get around. The first thing the city did was go out and write street names and names on the street. People who lived in Joplin, Missouri their whole lives could not find their way around. There were no trees. There were no landmarks, nothing left. The tornado tore a path 22 miles long, 6 miles wide, majored EF-4 to EF-5. It resulted in the greatest death toll from a single tornado in 6 decades, 7th worse in recorded history. Last night, we had another tornado in Missouri that killed at least one individual.

I will never forget this catastrophic event, and I am here today to testify to the subcommittee on how AmeriCorps and the Corporation for National and Community Services resources helped my congressional district recover. And I have got to tell you that this event changed my attitude on a congressman's role, a senator's role, a President's role, a governor's role because before I had always thought, when I see a natural disaster and the President rolls in, or the governor rolls in, or the senator rolls in, or the congressman, my attitude was I bet the local people wish the President had not come, and the senator had not come, and the congressman because they are right in the middle of the way trying to fix things.

But I was 180 degrees wrong on that. My role as a congressman was cemented in my mind that week. I spent 8 days, I missed a full week of votes here in Washington. I stayed home. I was on the ground for 8 days in a row there in Joplin, Missouri.

AmeriCorps. As many of you know, the Corporation for National and Community Service, CNCS, is an independent Federal agency and one of the largest programs is AmeriCorps. CNCS acts much like a foundation and is the Nation's largest grant maker, investing in locally-driven service and volunteering efforts focused on several high priority areas, including disaster relief.

CNCS funds more than 3,000 organizations and is constantly expanding their reach and impact. The result of this investment are more engaged citizens, greater economic opportunity, less dependence on government and stronger communities.

National Service has a strong bipartisan history as you know. National Service is a historically bipartisan, politically popular, and cost-effective strategy for engaging citizens, strengthening communities, creating jobs, and uniting the Nation.

Over the past 8 decades, Presidents from both political parties have proposed and created with Congress programs that have enabled Americans to serve local communities for a significant period of time. National Service helps local leaders solve community challenges. Through participation in AmeriCorps, National Service members help communities recover after natural disasters, just like they did in Joplin, Missouri.

National Service is extremely cost effective. In 2015, CNCS generated $1,260,000,000 in outside resources from private businesses, foundations, and other sources, an amount exceeding the Federal appropriation. Every Federal dollar invested in AmeriCorps is matched by more than 2 dollars from donations and in-kind support from non-CNCS sources, including business and philanthropy.

For every $1 the Federal government invests in National Service, there is a nearly $4 return on the investment. Federal agencies can utilize National Service Corps members to perform duties that align with the Agency's mission, a low cost, like FEMA Corps, which is estimated to save $60,000,000 annually.

AmeriCorps members and volunteers were indispensable in the recovery efforts after the Nation's deadliest tornado in nearly 60 years ripped through Joplin, Missouri in my district. Within hours after the tornado struck, AmeriCorps members arrived in Joplin to begin working with local authorities assisting in every way possible. They established a missing persons hotline, removed tons of debris, provided homeowner assistance and case work, operated donation and distribution warehouses, coordinated donations, and managed a large-scale volunteer operation.

I would like to share some fast facts about AmeriCorps and the Joplin tornado. 359 AmeriCorps members served in Joplin. 76,000 hours served by AmeriCorps members. 75,000 volunteers coordinated through the AmeriCorps Recovery Center. 520,000 volunteer hours reported by AmeriCorps Recovery Center. 2,200 volunteer groups registered. 2,200 completed homeowner requests. 6,000 damaged or need assessments completed. 20,000 meals served in the disaster area. 732 homes mucked or gutted. 130,000 total volunteers, including volunteers serving through other groups. 798,000 total volunteer hours, including volunteers serving through other groups.

In addition to all of this, Joplin city officials reported that the city received donations, resources, and volunteer hours totaling

$17,700,000. AmeriCorps members were instrumental in coordinating this influx of volunteers and donations, which effectively aided the recovery and saved the city more than $17,700,000 in disaster costs. As you can see, the impact AmeriCorps members and volunteers had in my congressional district after this devastating tornado were indispensable to recovery efforts in Joplin.

Again, I appreciate the committee's continued willingness to listen to the views of members like myself. I know the full Appropriations Committee will face some tough decisions on spending priorities. For this reason, I respectfully ask for support of continued level funding to AmeriCorps and Corporation for National and Community Service.

Mr. COLE. I want to thank the gentleman for his testimony, and just note for the record, as he knows, 2 years later, almost to the day, my community went through precisely the same experience that yours did in Joplin. And we got the same tremendous, splendid help from AmeriCorps that you did. They deployed dozens of people on the ground who were absolutely invaluable in the recovery.

So, I appreciate you being here and making that statement. It is very important to the committee to hear things like that.

Mr. LONG. Thank you.

Mr. COLE. Any other comments?

Ms. DELAURO. No.

Mr. COLE. Okay.

Mr. LONG. Thank you all.

Mr. COLE. We appreciate it very much.

I am going to recognize my good friend from Maryland just in the order of people who have arrived. Next up, good to have you here.

Just so the committee knows, we got the joint host Red Bear, you know, the new splendid book on Eisenhower, so a little plug there.

Mr. DELANEY. Thank you again for that, Mr. Chairman.

Mr. COLE. And someday you guys need to look at Mr. Delaney's bill and my bill on social security so we can fix that problem, too. It is a very bipartisan approach that I think would be well advised for the Administration and Congress to pick up and move along.

But with that, it is good to have my friend here. He is recognized for 5 minutes for whatever remarks he cares to make.

[The statement of the Hon. Billy Long follows:]

**Rep. Billy Long (MO-7) Member's Day Testimony for the Record**
House Committee on Appropriations
Subcommittee on Labor, Health and Human Services, Educations, and Related Agencies
Wednesday, March 1, 2017

**Opening**

Good morning Chairman Cole, Ranking Member DeLauro and Members of the Subcommittee. Thank you for allowing me to come before this Subcommittee today to speak in support of AmeriCorps.

On Sunday, May 22, 2011, a devastating EF-5 tornado swept through my district in the town of Joplin, Missouri. The tornado killed 161 people, injured over 1,000, and destroyed over 7,000 homes and businesses. With a population of more than 50,000 and a population density near 1,500 per square mile, the tornado affected a considerable part of the city. The tornado tore a path 22.1 miles long, six miles of it measuring EF-4 or EF-5 all of which in Joplin. It resulted in the greatest death toll from a single tornado in six decades; eight worst in recorded U.S. history

I will never forget this catastrophic event and I'm here today to testify to this Subcommittee how AmeriCorps and the Corporation for National and Community Service (CNCS) resources helped my Congressional District recover.

**Personal story from Rep. Long regarding the Joplin tornado*

**AmeriCorps**

As many of you know, the Corporation for National and Community Service (CNCS) is an independent federal agency and one of its largest programs is AmeriCorps. CNCS acts much like a foundation and is the nation's largest grantmaker investing in locally driven service and volunteering efforts focused on several high-priority areas including disaster relief.

CNCS funds more than 3,000 organizations and is constantly expanding their reach and impact. The results of this investment are more engaged citizens, greater economic opportunity, less dependence on government, and stronger communities.

*National service has a strong, bipartisan history.*

National service is a historically bipartisan, politically popular, and cost-effective strategy for engaging citizens, strengthening communities, creating jobs, and uniting the nation. Over the past eight decades, presidents from both political parties have proposed, and created with Congress, programs that have enabled Americans to serve local communities for a significant period of time.

*National service helps local leaders solve community challenges.*

Through participation in AmeriCorps, national service members help communities recover after natural disasters (like Joplin, MO).

*National service is extremely cost-effective.*

In 2015, CNCS generated $1.26 billion in outside resources from private businesses, foundations, and other sources - an amount exceeding the federal appropriation. Every federal dollar invested in AmeriCorps is matched by more than two dollars from donations and in-kind support from non-CNCS sources, including business and philanthropy. For every one dollar the federal government invests in national service, there is a nearly four dollar return on investment. Federal agencies can utilize national service corps members to perform duties that align with agency missions at a low cost, like FEMA Corps, which is estimated to save $60 million annually.

**Joplin, MO and AmeriCorps**

AmeriCorps members and volunteers were indispensable to the recovery efforts after the nation's deadliest tornado in nearly 60 years ripped through Joplin, Missouri.

Within hours after the tornado struck, AmeriCorps members arrived in Joplin to begin working with local authorities assisting in every way possible. They established a missing person's hotline, removed tons of debris, provided homeowner assistance and casework, operated donation and distribution warehouses, coordinated donations, and managed a large-scale volunteer operation.

I would like to share some "fast facts" about AmeriCorps and the Joplin Tornado:

- 359 AmeriCorps Members served in Joplin
- 76,879 Hours served by AmeriCorps Members
- 75,786 Volunteers coordinated through AmeriCorps Recovery Center
- 520,102 Volunteer hours reported by AmeriCorps Recovery Center
- 2,222 Volunteer groups registered
- 2,226 Completed homeowner requests
- 6,053 Damage or needs assessments completed
- 20,000 Meals served in disaster areas
- 732 Homes mucked and/or gutted
- 129,479 Total volunteers (includes volunteers serving through other groups)

- 798,623 Total volunteer hours (includes volunteers serving through other groups)

In addition to all of this, Joplin city officials reported that the city received donated resources and volunteer hours totaling $17.7 million dollars. AmeriCorps members were instrumental to coordinating this influx of volunteers and donations, which efficiently aided their recovery and saved the city more than $17.7 million dollars in disaster costs.

As you can see, the impact AmeriCorps members and volunteers had in my Congressional District after this devastating tornado were indispensable to the recovery efforts in Joplin, MO.

**Conclusion**

Again, I appreciate the Committee's continued willingness to listen to the views of Members like myself. I know the full Appropriations Committee will face some tough decisions on spending priorities. For this reason, I respectfully ask for support of continued level federal funding to AmeriCorps and the Corporation for National and Community Service.

WEDNESDAY, MARCH 1, 2017.

**WITNESS**

**HON. JOHN DELANEY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MARYLAND**

Mr. DELANEY. Thank you, my good friend from Oklahoma and the chairman of this committee, and I want to also thank the ranking member. And I want to applaud the whole committee for doing a members' day like this. I am not sure what other committees do such a thing, but under the category of someone who always seeks best practices, this is obviously a best practice that every committee should pursue.

I come here today to speak about the topic of basic research in general and funding for the NIH in particular. I think everyone knows that NIH is really a singular institution. There is nothing quite like it in the United States, and, quite frankly, there is nothing quite like it in the world. And it is very important to my State, the State of Maryland, and it is very important to my district. But it really is very important for the country and the world for that matter.

And our country faces very serious and significant issues as it relates to public health, human health, and disease. And while we have made significant progress across the last several decades, I think much of that progress would fall under the category of incremental progress, and we have not really been able to make the transformative progress we really need to do against some of these conditions, such as cancer, Alzheimer's, autism, the opioid addiction crisis, terrible crisis in this country, and so many rare diseases that go unnoticed, although the President did point one out yesterday, and I thought that was a high point of his remarks.

And we are at a unique moment in time if you think about the opportunities to really make transformative progress against these conditions because several positive things are converging in the scientific community right now. Computing power, big data, technologies that have emerged from the Human Genome Project really position the research community to be probably in the best position they have been in a long period of time to really make some of those transformative gains that we need to make.

Unfortunately, the private sector, which makes very important investments in research, is somewhat constrained right now because what has happened in corporate America, driven by the dynamics of a market-based system, which I am not drawing any judgments against, but it has clearly encouraged corporate America to have a much shorter time horizon as it relates to the investments that they make.

So, if you think about it in the context of a time when it has never been better to make investments because of the technologies that are available, yet the private sector in many ways is in the worse position to make investments than they have ever been. It feels to me like this is an opportune time for the government to really increase its investment in basic research, which is what I am encouraging us to do here today.

And the good news is we have an institution that has a remarkable track record, not only in terms of the scientific discovery that

they make, and that is really their role. They really take scientific discovery and they translate it into human health, and public health, and disease solutions. So, we have an institution that has an unbelievable track record in doing this both in terms of improving the lives of the people who are affected by these conditions, but also in terms of producing actionable research that has really transformed our economy.

In fact, if you look back over 50 years of data, the number one investment the United States government has made in terms of anything that is material in terms of our budget, the best investment has been the investment in basic research. It has an economic multiplier of almost 3 to 1, and that is only counting the direct investment.

So, not only is investment in research the humane thing to do, the moral thing to do, the thing it will do that will change the lives of so many people who are affected by these diseases and their families and their communities, but it also makes good bottom line sense for the country. If we actually scored this differently, if we scored it dynamically, I think it would clearly be the conservative thing to do because to the extent you can make investments that save money down the line, those are generally viewed as prudent, fiscally conservative, and smart things to do.

So, again, I want to thank the chairman for giving me this opportunity, the ranking member. I want to thank the whole committee for giving members the chance to talk about things they care about. Again, NIH is very important.

I think we are at a unique moment in time when you think about externalities that have contributed to a dynamic where research can probably have the highest return on scientific discovery and investment in our lifetimes. And I think we will miss this golden opportunity to really make not the incremental progress, not the small steps that so many fabulous researchers, and investigators, and physicians, and scientists have made across the last 10 years based on what has been available to them, but to really make transformative progress, move the ball far down the field. And it could really transform our society and economy in many ways.

So, that is what I wanted to chat with you here today about, and I appreciate again, Mr. Chairman, you giving me this opportunity. And, again, I applaud the committee for creating these chances for members.

Mr. COLE. Well, first of all, we appreciate the testimony. And in full, you know, full disclosure, we want to give Chairman Frelinghuysen credit here because he is the one that mandated that we do this in every subcommittee, and I think it is an excellent suggestion on his part, and we benefit from it.

You are preaching to the choir on NIH here, but it is a sermon we like to hear over and over and over again. This committee for 3 years in a row on a bipartisan basis has made regular visits out to the NIH. Last year we had the largest increase in funding for NIH in a dozen years. That sounds like a big deal, but we have been flat funded basically. So, we are just catching up. We also had the largest increase in Alzheimer's funding ever, and very much agree with you. I mean, we are spending $170,000,000,000-odd a

year taking care of Alzheimer's patients. And if we could either cure or just slow down——

Mr. DELANEY. Yes.

Mr. COLE [continuing]. That disease, we could save billions of dollars, and obviously, much more importantly, improve millions of lives. So, it is something this committee takes seriously.

If we can get the 2017 bill out, the good news is that we will have another substantial increase for NIH. And I want to compliment, frankly, my good friend, Roy Blunt, in the Senate and Patty Murray, his ranking member, because they have worked hand-in-hand with us on that, and been a leader. So, it has been an area of bipartisan cooperation.

And, believe me, my friend's points are well made, and agreed with on a bipartisan basis in this committee.

Mr. DELANEY. Thank you, Mr. Chairman.

Ms. DELAURO. Thank you very much, Mr. Chairman. And to my colleague, this committee has had a history on a bipartisan way, several years under the chairmanship of John Porter we doubled the amount of money for the NIH. As the chairman pointed out, subsequently we have seen, you know, that those numbers decreased, but there was a substantial $2,000,000,000 increase in 2015.

But so that you do know, and, you know, your comments are appropriate that we are still $7,500,000,000 below where we were in 2010. And that means those discoveries, those young researchers that you are speaking about may not have an opportunity, and we are very mindful of that on this committee. And advocacy from people like yourself and others will help us to close that gap. But as importantly, to get a larger allocation for the subcommittee that is one-third of the non-defense discretionary budget in this country.

Thank you.

Mr. DELANEY. Great. Thank you again.

Mr. COLE. Thank you. I see my good friend from New Jersey is here, so Mr. MacArthur, you are recognized. It is great to have you here to appear before this committee. And look forward to your testimony.

The gentleman is recognized for 5 minutes for whatever remarks he cares to make.

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WEDNESDAY, MARCH 1, 2017.

**WITNESS**

**HON. THOMAS MACARTHUR, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY**

Mr. MACARTHUR. Thank you, Mr. Chairman. Well, thank you again, Mr. Chairman. I am here today as the co-chairman of the bipartisan Heroin Task Force, and I appreciate the opportunity to testify today.

I am here basically to strongly urge the subcommittee to remember and to take to heart the dire urgency of our heroin and opioid epidemic. It is claiming 33,000 American lives a year. We have taken important steps in authorizing funding in the Comprehen-

sive Addiction and Recovery Act, CARA, and in 21st Century Cures.

I have seen, as I am sure some of you have, this epidemic up close and personal. In my county, Ocean County, New Jersey, and New Jersey has a death rate from overdose 3 times the national average, and my home county is the epicenter in my State. We are losing somebody from an overdose every 43 hours in my county. My constituents are losing friends, loved ones, colleagues. I have lost people that I know as well, and perhaps you have as well.

The damage that this crisis causing is no respecter of geography, demographic differences, age, race, ethnicity. It does not discriminate.

As the co-chairman of the bipartisan Heroin Task Force, I am very grateful for the work that has already been done to address the heroin and opioid epidemic. With the passage of CARA and 21st Century Cures, we took great steps forward to help our communities. Both of these landmark pieces of legislation authorized funding to combat the epidemic, and I am grateful that we recognize the extreme importance of these appropriations by including both funding for CARA and 21st Century Cures as budget anomalies in both continuing resolutions last year.

Let me talk about CARA just for a moment. It authorized funding for numerous grant programs, including helping States purchase opioid reversal drugs, like Narcan; helping States train pharmacists in how to dispense opioid reversal drugs; helping States improve their substance monitoring programs; helping States train their first responders in how to administer opioid overdose reversal drugs; helping States, local governments, nonprofits, Indian tribes, any group and area that has a high rate of heroin or opioid abuse expand their evidence-based treatment and intervention activities, including medication assisted treatment, or MAT, services.

CARA helped recovery community organizations to develop and expand their services. It helped States treat pregnant and postpartum women who suffer substance abuse disorders. It helped education efforts, drug monitoring programs. I could go on. CARA funded and supported a lot of State and local programs that help with prevention, treatment, and recovery. And I am grateful again for the work that we have done.

I would add as an aside that last year in our continuing resolution, we included $37,000,000 for CARA grant programs. $20,000,000 went to the Department of Justice, and $17,000,000 went to HHS, specifically the Substance Abuse and Mental Health Services Administration, or SAMHSA. That $17,000,000 has yet to get out to the communities, and I would encourage us to urge HHS to get past the bureaucratic delays and get these funds. They have already been appropriated. Let us get them out to the communities where they can do some good.

And then, 21st Century Cures also authorized a billion dollars over 2017 and 2018 to support State responses to the opioid abuse crisis. Congress appropriated $500,000,000 of that in our CR budget anomaly last year. It is critically important that we appropriate the remaining $500,000,000 of those funds.

144,000,000 Americans die every day to a drug overdose. Of those, 91 are dying from heroin or opioid-related overdose. Drug

abuse is killing our communities, and heroin and opioid abuse is driving the problem.

On behalf of myself, my bipartisan Heroin Task Force, co-chair, Representative Annie Kuster from New Hampshire, which has also been hit hard by this, on behalf of the over 80 members of the Heroin Task Force, and on behalf of all of the communities we represent, I beg you to consider fully funding the Comprehensive Addiction and Recovery Act and the 21st Century Cures Act as it relates to opioid and heroin addiction in 2018.

And with that, I thank you for the opportunity to be here and to make my case. It is really a disturbing problem, Chairman, and we all need to do everything we can.

Mr. COLE. Well, I thank the gentleman for his testimony. And, again, this is an area that this subcommittee does have tremendous interest in, tremendous bipartisan support for. We were happy to do what we did last year. We would prefer a regular order bill where we could do more.

And as my good friend from Connecticut has pointed out, appropriately and correctly, a lot of what we can do will depend on what kind of allocation we get. It really is that simple. We cover a wide range here, and, you know, if we have a very substantial cut in our top line funding in some of the things that I know that my friend would want to do and this committee would want to do, it simply will not be possible. So, we are waiting to see how that all plays out.

But your advocacy makes a big difference, and we are delighted you came to make the case that, again, the committee very much on a bipartisan basis agrees with.

Ms. DELAURO. Thank you very much, Mr. Chairman, and thank you for your testimony. Earlier today, Congressman Fitzpatrick testified on this issue. And I would just let you know that as the chair has said, there are several initiatives in the 2017 Labor, HHS budget that deal with mental health services through SAMHSA and the CDC, and taking a look at assisting and trying to deal with monitoring programs with regard to opioids.

I would be remiss if I did not mention this as I did to him. You need to take a hard look at what may be coming down the pike with regard to Medicaid and Medicaid expansion. There has been a lot of discussion about that. Sometimes people do not realize all that that includes, including the opportunity for people who are in these circumstances with regard to addiction to be able to get treatment. That is the way they are getting their healthcare.

And if that is curtailed or cut back, that we may see larger numbers of people who are untreated. Certainly that is not the direction you want to go or this committee wants to go in. And so, I would just mention that to you as well.

Thank you very much.

Mr. MACARTHUR. I share your concern on Medicaid.

Ms. DELAURO. Thank you.

Mr. COLE. The chair recognizes for her first words in an official session here, a new member of our committee, the gentlelady from Massachusetts.

Ms. CLARK. Thank you, Mr. Chairman. And I just want to again thank you for your advocacy and your work in picking up the lead-

ership role on the caucus that none of us want to belong to, but we are forced to because this is really is an equal opportunity killer. And we will work with you in any way we can to help open up treatment and help our neighbors and community members who are dying in our States.

And I also associate myself with the comments of the ranking member because Medicaid really is a lifeline for many of the families who are struggling.

So, thank you again for coming today. Thank you, Mr. Chairman.

Mr. COLE. With that, the gentleman is excused. Thank you again for your testimony.

The gentlelady from Texas. It is wonderful to have our good friend here, so we look forward to Ms. Jackson Lee's testimony. The gentlelady is recognized for 5 minutes for whatever comments she cares to make to the committee.

[The statement of the Hon. Thomas MacArthur follows:]

Testimony of Representative Tom MacArthur to the House Committee on Appropriations
Subcommittee on Labor, Health and Human Services, Education and Related Agencies

Regarding the Heroin and Opioid Epidemic

Members' Day Hearing March 1, 2017
Submitted for the Record February 22, 2017

Mr. Chairman:

Thank you for the opportunity to testify today. As the subcommittee on Labor, Health and Human Services, Education and Related Agencies crafts its appropriations bill for FY18, I strongly urge this subcommittee to remember and take to heart the dire urgency of the heroin and opioid epidemic that is killing over 33,000 Americans every year, and fully fund both the Comprehensive Addiction and Recovery Act, and the opioid epidemic response funds authorized by 21st Century Cures Act [1]

I have seen this epidemic up close and personal. In Ocean County, NJ – my home county – someone dies of an overdose, on average, once every 43 hours.[2] My constituents are losing their friends, colleagues, and loved ones to this crisis. I have lost friends, too. And I know that many of the Members of this Subcommittee represent areas devastated by heroin and opioid abuse – they, too, are hearing stories from their constituents who have lost people they love. Perhaps they, too, have lost people themselves. The damage that the heroin and opioid epidemic is visiting on the

[1] CDC data indicates that there were 52,404 U.S. deaths due to drug overdose in 2015, of which 33,091 (63.1%) involved an opioid. See Rudd RA, Seth P, David F, Scholl L. *Increases in Drug and Opioid-Involved Overdose Deaths — United States, 2010–2015.* Morbidity and Mortality Weekly Report (MMWR) 2016; 65:1445–1452. https://www.cdc.gov/mmwr/volumes/65/wr/mm655051e1.htm

[2] See: "Ocean County may have suffered more than 200 overdose deaths in 2016." DeOliveira, Dianne. NJ 101.5. January 3, 2017. http://nj1015.com/ocean-county-may-have-suffered-more-than-200-overdose-deaths-in-2016/
"New Jersey's Heroin Epidemic". Lassiter, Jay. January 8, 2017. http://observer.com/2017/01/wtf-heroin-pt-1/

American people is no respecter of geographic or demographic differences. We are all in this together.

As Members of Congress, regardless of party or region, we have all heard the frustration and sometimes desperation of our communities as they struggle to respond to this epidemic. We have seen the dedication of our law enforcement, first responders, medical professionals, and treatment experts as they do their best to fight the swell of substance abuse and overdose deaths. And we all know that they need us to do our part.

As Co-Chairman of the Bipartisan Heroin Task Force, I am very proud of the work that Congress has done to address the heroin and opioid epidemic. With the passage of the Comprehensive Addiction and Recovery Act (CARA) and the 21st Century Cures Act, we took strong steps forward. But our work on this is far from over, and we owe it to our constituents to ensure the efforts we started last year do not fall by the wayside. Both these landmark pieces of legislation authorized funding to combat this epidemic. I am grateful that the Congress has already recognized the extreme importance of these appropriations by including CARA and 21st Century Cures funding as budget anomalies in both Continuing Resolutions last year. It is critically important that as we look forward to FY18, Congress fully appropriate the funds authorized by CARA and 21st Century Cures.

The Comprehensive Addiction and Recovery Act authorized funding for numerous grant programs, including many under the jurisdiction of the Department of Health and Human Services (and under umbrella of this subcommittee's appropriation responsibilities), by which the Department can help states and local stakeholders combat this crisis. Some of the HHS actions authorized by CARA for HHS include grant programs which will:

- Help states access and purchase opioid overdose reversal drugs like naloxone, which has saved countless lives.
- Help states train pharmacists on the how to dispense opioid reversal drugs pursuant to standing orders, which can greatly improve access to these lifesaving drugs.
- Help states establish or improve State controlled substance monitoring programs.
- Help states train First Responders in how to administer opioid overdose reversal drugs.
- Help states, local governments, nonprofit organizations, and Indian tribes that have a high rate of heroin or opioid abuse expand their evidence-based treatment and intervention activities, including medication-assisted treatment (MAT) and other services.
- Help recovery community organizations to develop and expand their services to the community. These "recovery community organizations" are nonprofits run by people from the community who are in recovery themselves, that use community resources to help achieve long-term recovery success.
- Help states better treat pregnant and postpartum women who suffer from substance use disorders.
- Help states implement and demonstrate comprehensive and integrated initiatives to respond to the crisis, including educational efforts, prescription drug monitoring programs,

These are the kinds of assistance that CARA authorized HHS to give to our communities. Not to mention what CARA authorized in regards to the Department of Justice and other agencies. (And I am grateful to my colleagues on the Heroin Task Force who are testifying to other appropriate subcommittees on those topics.) Our states and local communities badly need this assistance. It is vital that CARA be fully funded in FY18.

Likewise it is imperative that we fully appropriate the remaining funds authorized by the 21st Century Cures Act. That act authorized $1billion over FY17 and FY18 to support state responses to the opioid abuse crisis. Congress appropriated $500 million of that in our CR budget anomaly last year. It is critically important that Congress fully appropriate the remaining $500 million of these funds. Our state governments and local communities are in urgent need of this support.

One-hundred and forty-four Americans die every day to drug overdoses. Of those, 91 die from heroin or opioid related overdoses.[3] Drug abuse is killing our communities, and heroin and opioid abuse is driving the problem. Our communities need Congress to continue to fight for them. On behalf of myself and my Bipartisan Heroin Task Force co-Chair Rep. Ann McLane Kuster of New Hampshire, on behalf of the over 80 members of the Heroin Task Force, and on behalf of all the communities in which our constituents and fellow Americans are being lost and losing one another to this epidemic, I ask the Subcommittee on Labor, Health and Human Services, Education and Related Agencies to fully fund the Comprehensive Addiction and Recovery Act and the 21st Century Cures Act in FY18 as a matter of extreme and urgent importance.

[3] "144 a Day: Understanding the Numbers". Addiction Policy Forum. December 23, 2016. http://www.addictionpolicy.org/single-post/2016/12/23/144-a-Day-Understanding-the-Numbers

WEDNESDAY, MARCH 1, 2017.

**WITNESS**

**HON. SHEILA JACKSON LEE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS**

Ms. JACKSON LEE. Mr. Chairman, thank you. To the ranking member, thank you. To all of the members, thank you very much. The evidence of your selection on this committee already indicates your understanding and your passion on these issues.

I am a fan of Hubert Humphrey, so just allow me to just offer his words: "The moral test of government is how it treats those who are in the dawn of life, the children, those who are in the twilight of life, the aged, and those in the shadows of life, the sick, the needy, and the handicapped." And you have both the joy and pain, having a committee that deals with all of these issues.

I want to highlight this morning educational opportunity, health research, and security, economic opportunity, and workforce safety, and other programs that I think that are very important.

Over the past 48 hours, the President has met with historically black colleges. I would imagine that they speak for a number of colleges that serve underserved individuals. And so, the whole idea of having access to year-round Pell Grants, it really meets people where they are in life. And so, I would hope that, as you said, Chairman Cole, it is all in the allotment, the appropriation that you get as a committee, but if you would consider that. And as I understand it, the President indicated his interest in year-round Pell Grants.

$370,000,000 for strengthening historically black and universities and PBIs, which, again, deals with opportunity, preparing the workforce for the 21st century. There are a hundred historically black colleges in America, and we believe each of them has found its niche of serving people who are really first time generation students, along with, coming from Texas, Hispanic-serving institutions as well.

And I know your both affection and advocacy for Native Americans. We need to be able to include them in the educational stairs. Certainly in Texas, they have a strong presence there as well.

I support the robust funding for the Child Care Development Block Grant, and I thank you, Congresswoman DeLauro, for your advocacy on those issues. The Federal TRIO Program, which is low-income and serves about 760,000.

I would like to emphasize $500,000,000 for individuals for disabilities. I am a strong advocate of community colleges and those with disabilities are able to access those colleges. $25,000,000 for minority centers of excellence, provide health professional schools, magnet school assistance. It is the only Federal education grant program designed to reduce racial and socioeconomic segregation. There have been some questions about magnet programs, but I have seen them bring people of disparate economic backgrounds together.

$25,000,000 for construction for historically black colleges, a huge commitment. My daughter is on the Harris County School Board, and there was a rumor that they were going to get rid of Head Start. And they had more people in their board meeting than

they have ever seen in their life of service fighting to not eliminate Head Start. And so, I vigorously support it. It is 50 years old plus, but there is such evidence that it works. $10,000,000,000 for Head Start.

$5,100,000,000 for community health centers. I want to focus a little bit on that. I cannot tell you how effective federally qualified health community centers are. I do not think I have enough in my congressional district or the State of Texas, and I remember President Bush and I, G.W., had a debate about how many were in Texas. And I think he found out that I won, that at that time of his leadership that we had not grown them. They are growing now, and they really do serve in the capacity that we want them to do.

The National Institutes of Health, there is no doubt about medical research. Last evening, the President spoke about rare disease. $34,500,000,000 I think with the Cures Act and a number of other advocacies that we need to get in front of the healthcare system. I just heard a report this morning of more people born in the 1990s have the rectal cancer, and we are seeing new diseases every day. So, I would appreciate your consideration.

$302,000,000 for the National Institute of Minority Health and Health Disparities. One of the first amendments I offered as a new member of Congress was around the health disparities and that agency or that area in HHS. $35,000,000 to fully support the CDC's Childhood Lead Poisoning, which still exists. $10,000,000 for the Violence Against Women.

I am a strong supporter for school-based health clinics. They have sort of, some that go up, some go down. Some schools are doing it, some are not, but 2 million students nationwide are being helped. And there are many students in schools where school nurses can detect conditions at home, and also school-based clinics can help the family have access to healthcare.

$50,000,000 for the Homeless Veterans Reintegration Program. That is one of the major areas on behalf of veterans is particularly homelessness. Once they get housing, how do they get reintegrated, their health conditions, and all that is important.

$327,000,000 for family planning, of course, in compliance with the law, 4,200 health centers nationwide. Provides important screening for cancer, HIV, family planning services.

On the economic opportunity and workforce, I am a big supporter, and I hope that you will consider it. It has been around for 50 years, but that is the Job Corps Program. I think more of our youth need to be in the Job Corps Program as opposed to the gang corps program. And Job Corps, of course, is people go away, 126 campuses in 50 States. I do not know whether we have an ability to expand them, but I would just say that they generate more than it might seem in terms of cost.

If you can get people out of their element and give them skills, this $1,700,000,000. It is an amazing reformation to get a city kid and put him in a rural area, and focus on changing their life, their skills, and what their commitment.

Certainly, the support of the Nursing Workforce. I support $600,000,000 for OSHA. We are known for a safe workplace.

Finally, let me offer the support for services for survivors of torture, $400,000,000 for our trafficking victims, and $2,000,000 for refugee and entrant assistance.

So, I close with two points, and that is on the refugee resettlement. We have been dealing with refugees in my community for decades. Let me be very frank. In the course of all of the discourse and hysteria, my State is not participating, but my agencies are, and they are settling Syrian refugees. They are settling over the years Vietnamese refugees. They are settling refugees from Somalia. They are settling refugees from China to a certain extent, people who are fleeing persecution, but the point is that they are very important.

And I hear the gavel, so the last point is, Mr. Chairman, is this is not the authorization committee, but I am absolutely opposed to the repeal of the Affordable Care Act, and I think there will be a greater burden on the Appropriations, HHS Subcommittee if the Affordable Care Act is repealed and we are without the safety net for the American people.

And I thank you for your indulgence. I yield back.

Mr. COLE. No, I thank the gentlelady as usual. Her testimony is thoughtful and comprehensive, and we are very grateful to have it.

Ms. DELAURO. Just many, many thanks. The programs you mentioned have a profound effect on people's lives, and that is what this committee does, so we are mindful. Thank you very much.

Mr. COLE. Appreciate it.

Ms. JACKSON LEE. Thank you.

Mr. COLE. The gentlelady from New Hampshire is now recognized. It is good to have you here, Ms. Kuster. You are recognized for 5 minutes to address whatever concerns or make whatever remarks you care to make to the subcommittee.

[The statement of the Hon. Sheila Jackson Lee follows:]

**CONGRESSWOMAN SHEILA JACKSON LEE (TX-18)**

**STATEMENT BEFORE THE**
**COMMITTEE ON APPROPRIATIONS**
**SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN SERVICES, AND RELATED AGENCIES**

**MEMBER DAY HEARING ON**
**LABOR, HEALTH AND HUMAN SERVICES, AND RELATED AGENCIES APPROPRIATIONS ACT FOR FY2018**

**THURSDAY, MARCH 1, 2017**
**10:00 A.M.**
**2358-C RAYBURN**

*Chairman Cole, Ranking Member DeLauro and distinguished Members of the Subcommittee:*

- As the Ranking Member of the Judiciary Subcommittee on Crime, Terrorism, Homeland Security, and Investigations, let me offer my appreciation and thanks to to Chairman Cole and Ranking Member DeLauro for the difficult work and choices that must be made to produce a truly bipartisan LHHS spending bill, and for their commitment to producing a bill that fairly reflects the interests and priorities of the American people.
- Mr. Chairman, I understand that my entire statement will be made part of the record so I will keep my remarks brief. In the few minutes allotted I wish to highlight four areas which warrant the Committee's continuing attention and support:

1. Educational Opportunity;
2. Health Research and Security;
3. Economic Opportunity and Workforce Safety; and
4. Other Important Programs

## I. EDUCATIONAL OPPORTUNITY

**I support reinstating year-round access to Federal Pell Grants**

- I request that the Fiscal Year 2018 Labor, Health and Human Services, Education and Related Agencies Subcommittee mark to reinstate access to year-round need-

based Pell Grants to increase college accessibility for undergraduate and certain post baccalaureate students to promote access to postsecondary education.

**I support $369.5 million for Strengthening Historically Black Colleges and Universities and PBIs**

- These funds provide the cornerstone of federal support for HBCUs and PBIs.

**I support robust funding for Child Care and Development Block Grant**

- Access to high quality and affordable child care empowers families to work but recent funding supports only one in six of the children eligible for this assistance.

**I support the Federal TRIO Programs**

- TRIO serves students from low-income families in which neither parent earned a college degree. TRIO serves about 760,000 students in every state and territory, including veterans and disabled students.

**I support $500,000,000 for Individuals with Disabilities Education Act**

- When IDEA passed, the federal government pledged to pay 40 percent of the Average Per Pupil Expenditure in IDEA Part B grants to states. However, funding has always fallen short of this commitment and exacerbates the challenges facing states and local school districts.

**I support $25,000,000 for the Minority Centers of Excellence**

- The Centers of Excellence provides support for health professions schools that prioritize educating and training enhancement to increase opportunities for underrepresented minorities to enter and successfully complete a health professions education.

**I support robust funding for Magnet Schools Assistance Program (MASP)**

- The Magnet Schools Assistance Program (MSAP) provides grants to local school districts to establish, expand, and improve public magnet schools. It is the only federal education grant designed specifically to reduce racial and socioeconomic segregation, as well as promote educational equity and diversity in the classroom.

**I support $25 million for the Historically Black College and University (HBCU) Capital Financing Program**

- Funds provide a low-cost alternative to traditional sources of capital financing for HBCUs seeking to improve capital projects (e.g. academic and residential facilities on their campuses). An increase in loan subsidies by $4.5 million would support $85 million in new loans to approximately 2-8 additional institutions for a total annual loan volume of $390 million.

**I support $10 billion for Head Start**

- Head Start is the most successful, longest running, national school readiness program in the United States. It provides comprehensive education, health, nutrition, and parent involvement services to low income children and their families. All evidence supports the importance of early cognitive development. Children in the program score higher on school readiness measures and social competence.

## II. HEALTH RESEARCH AND SECURITY

**I support $5.1 billion for the Community Health Centers (CHCs)**

- Funding the Health Center program at $5.1 billion strengthens the ability of health centers to provide integrated, high-quality primary care.

**I support $34.5 billion for the National Institutes of Health (NIH)**

- The National Institutes of Health (NIH) are our nation's preeminent medical research centers and represent our best hope for finding cures, improving treatments, and gaining a better understanding of the diseases and conditions that affect millions of Americans.

**I support $302 million for National Institute of Minority Health and Health Disparities (NIH)**

- NIMHD funds and supports scientific research aimed to improve minority health and eliminate health disparities by establishing the scientific basis for existing health disparities faced by racial/ethnic populations in the United States.

**I support $35 million to fully support the CDC Childhood Lead Poisoning Prevention program**

- Even small amounts of lead can cause serious health problems. The impact of lead poisoning ranges from reductions in cognitive function, developmental delays, behavior modification, learning disabilities, seizures, comas, and even death.

**I support $10 million for the Violence Against Women Health Initiative**

- This program provides funding for states to develop a public health response to abuse by strengthening the health care system's identification, assessment, and response to victims and by educating health care providers.

**I support strong funding for School-Based Health Centers (SBHCs)**

- SBHCs provide access to health care that is highly beneficial, cost-effective, and convenient for nearly 2 million students nationwide. Usage of SBHCs improves health outcomes, while reducing health care costs, and has many documented academic benefits.

**I support $50 million for the Homeless Veterans' Reintegration Program**

- It is the only nationwide program exclusively focused on helping Veterans experiencing homelessness reintegrate into the workforce.

**I support $327,000,000 for Family Planning**

- Title X of the Public Health Service Act supports 4,200 health centers nationwide and provides what is often the only access to preventive care like cancer screenings and HIV testing, as well as family planning services, for the low-income and uninsured.

## III. Economic Opportunity and the Workplace

**I support $1.78 billion for the Job Corps program**

- For over 50 years, Job Corps has successfully educated and trained more than 2.7M young adults for jobs in high demand industries and trades. Today, Job Corps' 126 campuses across all 50 states provide a safe living, learning and disciplined residential setting that allows at-risk youth to gain the employment and work skills

that America's employers seek. Nearly 88% of graduates are employed, enlisted in the military or enrolled in higher education within six months of graduation.

**I support for the Title VIII Nursing Workforce Development Programs**

- These programs support the supply and distribution of qualified nurses to meet our nation's healthcare needs, and provide support for institutions that educate nurses for practice in rural and medically underserved communities.

**I support $600,000,000 for OSHA**

- Daily, about 13,000 U.S. workers sustain on-the-job injuries requiring a medical consultation, 11 workers die from unintentional work injuries, and 145 workers die from work-related diseases, all at an estimated $4.8 billion weekly cost to our economy. OSHA is the main federal agency charged with addressing these workplace health and safety issues.

## IV. Other Important Programs

**I support $23,000,000 for the Services to Survivors of Torture program**

- This funding supports treatment centers in 22 states and the District of Columbia that provide rehabilitative services to torture survivors.

**I support $400 million for the Implementation of Trafficking Victims Protection**

- This funding for the Office of Refugee Resettlement (ORR) is needed to implement the Trafficking Victims Protection Reauthorization Act of 2008 and serve foreign national victims; to provide shelters for child victims of human trafficking.

**I support $2.95 million for the Refugee and Entrant Assistance Funding.**

This funding will help the Office of Refugee Resettlement (ORR) assist states and local communities welcome and support refugees and other vulnerable populations on their path to self-sufficiency.

## Conclusion

- Mr. Chairman, I thank you and the Ranking Member for your leadership and for extending me this opportunity to share my major priorities with the Subcommittee.

WEDNESDAY, MARCH 1, 2017.

**WITNESS**

**HON. ANN KUSTER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW HAMPSHIRE**

Ms. KUSTER. Thank you so much, Mr. Chair. I appreciate it. And to our ranking member and all my colleagues, thank you so much. Now, it is an honor to be before all of you, and my remarks will be succinct.

I am here to request full funding of all addiction programs across all agencies within Department of Health and Human Services. And I also ask the committee to ensure full funding for both the Comprehensive Addiction and Recovery Act and the 21st Cures Act.

I am the founder and co-chair, and I think you just heard from my co-chair, Mr. MacArthur, of the very successful bipartisan Heroin Task Force. We represent more than 85 members of Congress, both sides of the aisle, and we are very proud of the work that we did last year passing 18 bills in the House. And the funding in CARA, thank you for all your work on that, and 21st Century Cures. But these programs are incredibly important to address really what has become a nationwide crisis around substance use disorder, and particularly opiate abuse and misuse.

In 2015, the Centers for Disease Control and Prevention found that over 50,000 people died due to drug overdoses, and the primary driver is opiates and heroin use. This crisis is not showing any signs of slowing down. In fact, the National Institute on Drug Abuse reports that opiate misuse is on the rise, and at a rate that overshadows all over controlled substances.

The epidemic transcends all demographics at this point and all regions of the country, not just in urban areas by any means, but rural communities, red States, blue States. I frequently say to my colleagues, the heroin does not choose the R's and D's, and neither can we.

My largely rural home State of New Hampshire has become a new focal point for the crisis. In 2015, the Granite State suffered the second most overdoses per capita in the Nation for opioid overdoses. And I include in that a new drug synthetic opioid known as Fentanyl that has given a new cause for concern.

Our Task Force has a hearing just two weeks ago on synthetic drugs, and Fentanyl is known for extreme potency, 10 times or more stronger than heroin, and we are suffering the largest loss of life per capita.

We have become truly a trafficking corridor, and it has led to many tragic deaths, including my constituent, Carl Messinger, who was a young man, just finished college. He actually had been to treatment and was in recovery, but sadly he got a chest cold and took a medication that contained the opiate codeine. And unbeknownst to him or his family, that triggered drug seeking behavior, and he ended up within 24 hours reaching out, calling a dealer. His mother, who is with us in D.C.—she was my guest last night—found him on the bathroom floor from a death due to overdose of 100 percent Fentanyl.

So, we have a bill that is unrelated to your committee, but called Carl's Law about labeling. But I do bring that up just because the funding in the Comprehensive Addiction and Recovery Act and the 21st Century Cures Act is so important. Education, prevention, expanding, treatment, long-term recovery, and, of course, the law enforcement.

In CARA, Congress authorized dozens of new grant programs designed specifically to address this crisis. And in total, CARA authorized $181,000,000 in annual funding. In the Cures Act, Congress authorized an unprecedented $1,000,000,000 over 2 years, dedicated specifically to combating this public health crisis. And the money would be given straight to the States and provided flexibility to design programs best suited for the response in their community.

And I am pleased to note last week the Granite State submitted its request for over $3,000,000 in funding allocated to New Hampshire for 2017, but 2018 will need to be appropriated by this committee. Of course, CARA and Cures represent only a part of the coordinated response. Organizations like SAMHSA, the CDC, the FDA, and certainly NIH are critical for addressing the crisis.

And while opiates are the most clear and present danger surround substance abuse today, it is certainly not the only danger, and, more importantly, it does not occur in a vacuum. And I want to point out that the testimony to our task force from the CDC is that 4 out of every 5 heroin users has a co-occurring mental health disorder. And so, I also urge you to fully fund mental health treatment as well.

And I thank you, and I have ended up on time. [Laughter.]

Ms. KUSTER. Thank you so much. I appreciate it.

Mr. COLE. Exactly. Thank you for your very good work in this area on a bipartisan basis and your advocacy. Again, in a contentious Congress, this has made us united, Republicans and Democrats, as you appropriately pointed out in your testimony. And this committee will continue to work on a bipartisan to try and address those concerns which all of us share, and all of us have in our respective districts. It is just a tragedy unfolding before us, and it would be a tragedy if the committee did not have the means to do what needs to be done in this area.

Ms. KUSTER. Thank you very much.

Ms. DELAURO. Many, many, many thanks for your advocacy, and they are not just words. You are what they call operational. You make things happen, which is outstanding. And I to say to you, and I know Congresswoman Clark is on the Task Force and others, you need to help us with calling for what is a bigger allocation for this subcommittee——

Ms. KUSTER. Yes.

Ms. DELAURO [continuing]. So that we can address some of the incredibly serious needs that you have outlined, including mental health services and other kinds of services that we are addressing.

Ms. KUSTER. And this notion of long-term recovery. And I was pleased last night that the President mentioned treatment. He and all the other candidates got quite an education in our first in the Nation primary. I do not think they expected to come to New Hampshire and talk about heroin, but they learned a lot.

And I just had a meeting this week with the interim director of the Office of Drug Policy. I am hoping we will get the director soon. So, we will continue to work with you.

Thank you very much for your kind words. Thank you.

Mr. COLE. We appreciate it very much. Next, my good friend from New York, Mr. Faso, is recognized. It is great to have you here. And the gentleman is recognized for 5 minutes for whatever comments he cares to make.

[The statement of the Hon. Ann Kuster follows:]

**Written Testimony for Labor, Health and Human Services, and Education Subcommittee**

Hon. Ann McLane Kuster, New Hampshire's Second Congressional District

For March 1, 2017

Mr. Chairman and distinguished colleagues of the Subcommittee, thank you for providing an opportunity to speak before this committee. I come before you today to request full funding of addiction programs across all agencies within the Department of Health and Human Services. I also ask that this Committee ensure funding for both the *Comprehensive Addiction and Recovery Act* and the *21st Century Cures Act* are included in any full-year appropriation or continuing resolution this year. As the founder and co-chair of the Bipartisan Heroin Task Force, I represent more than 85 Members of Congress whose districts have been severely impacted by this crisis. We know that these programs present vital for states and local communities across the country to address substance use disorder, especially opioid misuse.

Drug addiction continues to be a serious problem in our country. In 2015, the Centers for Disease Control and Prevention found that over 50,000 people died due to drug overdose. The primary driver of that harrowing figure is opioid and heroin use; in 2015, 32,000 people died after overdosing on an opioid. Since 2008, drug overdose deaths have been the leading cause of accidental deaths in America, overtaking automobile deaths. That rise is due largely to opioid misuse.

And this crisis doesn't show signs of slowing down. The National Institute on Drug Abuse reports that opioid misuse is on the rise and at a rate that overshadows most controlled substances. For the last decade, heroin and opioid use has become a national public health

emergency. Due to the rise of both legal and illicit prescription opioid use, in part as a consequence of poor prescribing practices, this epidemic transcends all demographics. My largely rural home state of New Hampshire has become a new focal point of the crisis. In 2015, the Granite State suffered the second most overdose deaths per capita in the nation, due to opioid overdoses.

Most recently, the rise of a synthetic opioid known as fentanyl has given us all new cause for concern. Fentanyl and similar opioids are known for their extreme potency. Between 50 and 100 times stronger than heroin; a few salt-sized grains can kill a 250-pound human. My home state has been especially hard hit by fentanyl, suffering the largest loss of life per capita of any state in the country. We have become a trafficking corridor, bringing large amounts of fentanyl into our state.

While the potency of fentanyl provides drug dealers with a highly valuable product; a smaller quantity by weight can be "cut" and diluted to make a very large quantity for distribution. Due to its potency, drug dealers have started including very small quantities of fentanyl in other drugs, like cocaine and methamphetamine, to provide an added "kick" to their product. As substance use disorder so often works, people are driven to finding a more intense "high;" synthetic opioids like fentanyl provide the dealers with the ability to satisfy these urges, while creating extreme risks to users.

Poor diluting technique and the buyer's ignorance has led to many tragic deaths, including that of my constituent Carl Messinger. He was a recovering heroin addict who was prescribed cough

syrup which, unbeknownst to him, contained the opiate codeine, which caused him to relapse in to drug-seeking behavior. But instead of pure heroin, he unknowingly purchased heroin laced with fentanyl. He overdosed and passed away.

Congress last joined together on a bipartisan basis to pass two major pieces of bipartisan legislation that directly addressed the opioid epidemic: the *Comprehensive Addiction and Recovery Act* (CARA) and the *21st Century Cures Act.*

In CARA, Congress authorized dozens of new grant programs within the Department of Health and Human Services designed specifically to address the opioid crisis. Some of these grants were targeted to improve training of first responders to effectively handle overdose since they are often the first – and, last – medical professional a person overdosing will see. Other grants incentivized new treatment and intervention programs. While still other grant programs targeted populations uniquely at-risk, such as pregnant and postpartum women. In total, CARA authorized $181 million in annual funding. It is essential that these programs receive full funding; otherwise our communities will continue to suffer without the resources to mitigate the harm of this deadly drug.

In the Cures Act, Congress authorized an unprecedented $1 billion over two years dedicated specifically to combating this public health crisis. This money would be given straight to approved state agencies that are operating programs in response to substance use issues at the state level. This model provides remarkable flexibility to States with unique environmental and demographic factors. These States are empowered to design programs and leverage trusted local

and municipal organizations to use available resources most efficiently. I am pleased to note that last week, the Granite State submitted its request for the over $3 million in funding allocated to New Hampshire for fiscal year 2017. However, funding for fiscal year 2018 will be needed to ensure the good work established with this first round of funding can be continued.

Of course, *CARA* and *Cures* represent only part of our coordinated response to substance use in this country. Organizations like the Substance Abuse and Mental Health Services Administration, the Centers for Disease Control, the Food & Drug Administration, and research conducted at the National Institutes of Health represent dozens of programs operated by the Department of Health and Human Services, programs which are critical for assessing and responding to the dynamic nature of this crisis.

While opioids are the most clear and present danger surrounding substance use today, it is certainly not the only danger and, more importantly, it does not exist in a vacuum. The need to coordinate across law enforcement, first responders, community-based non-profits, and the medical community is important. But, coordination within the medical community is also crucial. We now know that simultaneous treatment of "co-morbidities," that is disorders that exist simultaneously and, sometimes, are symptomatic of one another, is crucial to resolving this crisis. In other words, we must be innovative to address the mental health issues that often presage substance use disorder. That innovation and praxis is the focus of efforts by professionals within HHS. We should endeavor to ensure they receive the maximum amount of resources so they can do their jobs and do them well. Thank you.

WEDNESDAY, MARCH 1, 2017.

**WITNESS**

**HON. JOHN FASO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK**

Mr. FASO. Thank you, Mr. Chairman, and Ranking Member DeLauro, and members of the committee. It is a pleasure to be here.

I have prepared remarks, which I will just ask to be submitted for the record.

And I would just like to, recognizing the committee's time constraints, so I would just like to summarize my remarks.

And this relates to the Low Income Home Energy Assistance Program funded through the Department of HHS. As you know, this program was created in 1991. It is really important in the northeast, in areas of our State in New York, and I know many other areas of the northeast. Rural do not have access to lower cost natural gas. Home heating oil, and propane, or wood are often the primary sources of heating one's home.

A recent of LIHEAP, the Low Income Home Energy Assistance Program, participants showed that these households are the most at risk in the Nation. According to HHS, more than 70 percent of LIHEAP recipient households contained at least one vulnerable person. This includes seniors over 60, children under 5, or individuals with disabilities. Many of these recipients have a history of just simply not being able to pay their home energy needs in the northeast for the winter. Nearly 50 percent skipped or paid less their entire bill, and almost 40 percent received a notice to disconnect or to discontinue their electricity or their home heating fuel.

Two years ago, we had a ferocious winter. It was very cold in the northeast. And it has been a bitter winter, although our ski areas perhaps are not as happy as that in the last winter certainly. This winter they had a little bitter of a reprieve on that.

But home heating oil is an extraordinarily expensive form of energy. It was nearly $4 a gallon 2 years ago. I know because I pay it myself at our home in Kinderhook. And it is vitally important the committee take cognizance of this important program for our low-income residents, and seniors, and disabled people throughout the Nation, but particularly in the northeast.

So, I would appreciate the committee's consideration and serious thought about the funding level for LIHEAP, and make sure that we have a level that is adequate and sufficient to meet the needs for folks in the winter.

And with that, I will conclude my testimony and give you an extra 2 minutes and 30 seconds, Mr. Chairman.

Mr. COLE. Well, of course, we will take advantage of your generosity. And just I want to first begin by thanking the gentleman for his testimony. It is an important issue. And, frankly, the prior Administration actually reduced LIHEAP funding in its budget request by about $3 to $400,000,000. We restored that in our bill on this committee and added $100,000,000 beyond it because, again, on a bipartisan basis we do think it is a serious problem. And so, the gentleman's advocacy is certainly noted and appreciated.

And at the end of the day, number one, help us get the 2017 bill out. If we do, you will like what is in it, and then from this perspective certainly. And then beyond that, you know, what we can do next year ultimately depends on what our allocation is going to be.

Ms. DELAURO. Thank you so much, and thank you for telling the tale of the northeast. We both have experienced the case where we are looking at particularly older Americans, seniors, where they do not heat their food to the temperature that is healthy. They are putting towels in front of doors in order to keep the cold out. And LIHEAP is so critically important, and it really is a lifeline for so many.

So, I appreciate your advocacy. If we can get the 2017 bill out, we want you to get to your friends on the Senate side and tell them to accede to the House number, which is a higher number. [Laughter.]

So, you have got your job cut out for you there, and help us get a higher allocation for 2018, my friend.

Mr. FASO. Well, Ms. DeLauro, I have only been here 2 months, but I will do my best. [Laughter.]

Ms. DELAURO. All right. Hear, hear. Thank you.

Mr. COLE. And just for the record, I spent 2 years in the gentlelady's district going to college actually, so it is cold in the north——

Ms. DELAURO. It is cold.

Mr. COLE. It is cold. We thank the gentleman.

Mr. FASO. Thank you so much.

Mr. COLE. Thank you.

Ms. DELAURO. Wisconsin, too.

Mr. COLE. With that, I see my good friend from Pennsylvania has arrived, and we want to recognize him for whatever testimony he cares to give. And on his way, I want to thank him for his extraordinary advocacy for the mentally ill and what he was able to accomplish in the Cures bill, and making sure that his legislation was merged into that, and this country begin to address a problem that, frankly, at the Federal level we have long ignored.

So, my friend is recognized for 5 minutes for whatever testimony he cares to give.

[The statement of the Hon. John Faso follows:]

**PREPARED TESTIMONY**

**Representative John Faso (NY-19)**

**March 1, 2017**
**House Appropriations Committee**
**Subcommittee on Labor, Health and Human Services, Education, and Related Agencies**

Chairman Cole, Ranking Member DeLauro, and Members of the Committee, thank you for the opportunity to testify today. I come before you to advocate for some of our nation's neediest families who are able meet their energy needs through the Low Income Home Energy Assistance Program (LIHEAP).

The Low Income Home Energy Assistance program was created in 1981 to support low-income households that pay a large share of income on immediate home energy costs. This program is the primary source of energy assistance for our nation's poorest families, helping close to 7 million low-income households who require assistance in paying energy bills.

A past national analysis of LIHEAP recipients concluded that nearly half skipped paying or paid less than their entire home energy bill, and more than one third received a notice to disconnect or discontinue their electricity or home heating fuel. Additionally, nearly 24 percent of LIHEAP recipients were unable to use their main source of heat at some point because their fuel service was suspended, they could not afford delivery or their system was broken. That's almost 1.5 million people who had to make the tough choice between heating their homes and other vital necessities.

In addition to providing assistance with home energy bills, LIHEAP also supports homeowners through weatherization and minor energy-related home repairs. This program helps to reduce energy costs for households by increasing energy efficiency through minor modifications. Roughly $31 million, or 8%, of New York's LIHEAP funding is spent on weatherization assistance, just a small fraction of the total funds allocated to the state.

Many families in my district heat their homes with heating oil which is one of the more expensive forms of energy, often costing more than natural gas and propane per BTU. Just two years ago, the price of home heating oil was nearly $4 per gallon, which could cost the average customer a few hundred to a few thousand dollars to fill their tank. Most Americans simply cannot afford to incur such a large expense. According to a recent study by the Federal Reserve, almost half of all American families would struggle to pay an emergency expense of more than $400, let alone a fuel-oil bill costing $1,000. LIHEAP is critically important to cover this gap by providing emergency assistance to eligible households with short-term crisis funding, particularly important during the long and harsh winters we experience in the Northeast.

Recent weather patterns along with a weak economy have increased demand for program services while funding has continually decreased. At the peak of funding in fiscal year 2010, Congress appropriated $5.1 billion to aid low-income families. Since that time national funding has fallen by 33 percent to roughly $3.09 billion. This reduction in funding has outpaced the decrease in the cost of home-heating energy sources which have all declined at a slower

rate. The purchasing power of the average home-heating benefit is now only around 30 percent of the actual cost of heating a home, compared to over 40 percent in fiscal year 2011. Every dollar spent through this program is simply not going as far to help vulnerable households.

This repeated reduction of funding has left many eligible households unable to receive any support from the program. In New York alone there are approximately 2.3 million LIHEAP-eligible households, but only 1 million of these households are being served by the program. This leaves an astonishing 56 percent of eligible households unaided.

The Low Income Home Energy Assistance Program is critical to ensuring that many of my constituents are able to heat and light their homes. This program helps ensure access to the most basic energy needs for society's most vulnerable. According to HHS data, 94 percent of recipient households in New York contain at least one vulnerable person including seniors, children under five, or an individual with a disability. We can't turn our back on our country's poorest and most vulnerable, which is why I ask that you consider adequately funding LIHEAP to better serve the constituents in my district and families across the country.

## WITNESS

### HON. TIM MURPHY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF PENNSYLVANIA

Mr. MURPHY. Well, you have laid out the problem that is before us, and we still have far to go.

We should all remember that innocence was shattered on that cold day in Connecticut just over 4 years ago in Sandy Hook Elementary School in Connecticut. But out of that darkness, the darkest of tragedies, has arisen a glimmer of hope as we did pass that landmark mental health reform signed into law on December 13th, 2016 as part of the 21st Cures Act.

As I wrote in the Pittsburgh Post Gazette back in 2012 following the Newtown tragedy, I said, "The common factor in too many mass tragedies is an underlying mental illness. The lessons for Americans from a horrifying tragedy is that we had better take off our blinders and deal with such illnesses, or we are sure to face the same problem again. It is not only what's in a person's hands that make their acts violent, it is what is in their mind."

Against that backdrop, in 2013 the Committee on Energy and Commerce, spearheaded by the Subcommittee on Oversight and Investigation, which I chair, began a national conversation, jump starting the process which resulted in the enactment of the first comprehensive reforms in 50 years. Our multi-year bipartisan, bicameral effort revealed a broken system, and informed our legislative response to overhaul the antiquated patchwork of ineffective programs.

Mental illness is no longer a subject whispered in hushed tones in the shadowy silence, but while more remains, tremendous strides have been made to help families and individuals in mental health crisis.

At the end of November 2016, while bill language was still being finalized, I made the observation that these problems are too large and the work so dear that we will not solve the mess of our mental health system with one bill. But the final bill came a long way. We did not get everything we wanted, but we wanted everything we got. And it was my pledge to the patients and families in mental health crisis now that I will not stop fighting to deliver treatment before tragedy.

And that is why I am here this morning to ask your help to translate the historic promises we made to families in mental crisis and to commitments and actions that will improve and save lives. The top changes are the improvements it makes to leadership and accountability at the Federal level for mental health and substance abuse programs being with the new office of the assistant secretary of mental health and substance abuse disorders. It is a position

that I hope and trust will be filled by a doctor, psychiatrist, or a psychologist.

Now, helping families in mental crisis, the act authorizes a number of existing programs. They will be at SAMHSA or in HHS. These include support for the Assisted Outpatient Treatment Grant Programs, which is a court-ordered treatment for individuals with serious mental illness who meet very strict legal criteria.

Often they are too ill to recognize they need medical care, but assuring timely and effective treatment, we have found that while protecting their right, we also find it reduces re-arrests, and re-hospitalizations, and homelessness, and other negative outcomes by over 70 percent. Studies have shown how court-ordered treatment in the community reduces taxpayer costs and cuts them in half. With that in mind, the legislation increases and extends an existing authorization for a grant program at AOT at SAMHSA for some $20,000,000. It is essential we do this.

In addressing pressing concerns there is a shortage of qualified mental health professionals. Half the counties in this country have no psychiatrists, no psychologists, no clinical social worker. And where there is no help, there is no hope. This bill also strengthens the mental and behavioral network workforce through education and training grants, clarification on eligibility for loan repayment programs, and codification of the Secretary's Minority Fellowship Program.

And it acts decisively to strengthen programs supporting mental health and substance abuse disorders, care for women, children and adolescents; an area that is a priority for all of us, including the White House.

Now, these are a few of the programs I mentioned. I will hand things over to you, Mr. Chairman, for this. But I do want to say that I understand budgets are tight, but with over 350,000 people dying in this country last year related to mental health problems, that is more people than have died in the combined U.S. combat roles in World War I, Vietnam, Korea, Bosnia, Desert Storm, Iraq, and Afghanistan. This investment of money will save lives.

And with that, I will take any questions.

Mr. COLE. Well, I want to again thank my good friend for his distinguished advocacy here. You have pushed Congress in the right direction in this area probably more than anybody that has served here in half a century. So, believe me, we take what you have to say very seriously.

And if the means are available, we are going to do what we can to address the problem. And we will hopefully begin to do in a sustained, ongoing fashion because it is a problem that obviously you do not solve in a year. And we are going to have, you know, problems in perpetuity, but my friend has made a really good start in focusing congressional interest on this, and, frankly, educating the rest of us about this with your own distinguished background in psychology.

So, I thank my friend.

Mr. MURPHY. I wish my parents would have been here to hear you say that. Thank you. [Laughter.]

Ms. DELAURO. I very much thank my colleague, who many years ago when I had a stress fracture of my hip, at the time of right

after 9/11, we were told to evacuate the Capitol, who, Mr. Chairman, along with another member, literally picked me up and got me out of the building and on to where we needed to be. That having happened 3 times, I figure the next time I was just going to stay and take my chances. [Laughter.]

But thank you. Thank you for your great work and your commitment to this effort. Over and over again the issue becomes there are not enough services, not enough treatment centers, not enough places for people to get the kind of treatment that they need. And it is particular true for children, in my view. And this is a public health crisis, and we need to treat it that way.

I would ask your help with regard to advocacy for the Mental Health Block Grant. And in this case, Mr. Chairman, the Senate is higher than the House is in this regard, but we know that this block grant, which is a mainstay for States and the services that they can provide, is historically below levels which it has been. And we need to look at that in a way that prioritizes the resources for the biggest problems that we have in this Nation. And this is clearly one of the biggest problems in this Nation.

So, I thank you for your great work and your advocacy.

Mr. MURPHY. Thank you. And I will continue in my capacity and to my commitment to do that. I know I have met with some governors and told them that outpatient care for the mentally ill is 20 times cheaper than jail. And so, but I should also tell you the Energy and Commerce Committee, what we found out is States are not keeping that data. They simply do not know what they do not know.

As they do that, I think they will do a better job of this, and I believe as part of the legislation we need——

Ms. DELAURO. Do we require that?

Mr. MURPHY. No. They have got to start collecting data on individuals to look at their lifetime of the illness costs because when they go into emergency rooms at $2 or $3,000 a day versus outpatient care, which is a few thousand a year, a couple thousand a year, versus jail, which could be $40,000 a year. That does not even include all the other criminal justice activities that goes with it, and really turning mental illness into a criminal justice problem.

It is not a crime to be mentally ill. We make it a crime, and that is a despicable thing we do in this country. These are small grants. Like I said, you can reduce arrests and incarcerations by 70 percent. And this is not to do all of it, but it is to get States to start that, then I believe they will discover themselves.

Ms. DELAURO. Well, maybe we can talk about how, you know, not talking about unfunded mandates on States, et cetera, because we cannot go down that road. That is always a problem. But to think about how we might be able to look at collecting the data then which allows us to make determinations——

Mr. MURPHY. Absolutely.

Ms. DELAURO [continuing]. That are beneficial. I would love to talk with you about it.

Mr. MURPHY. I would be happy to work with you on that.

Ms. DELAURO. Thank you.

Mr. MURPHY. Thank you.

Mr. COLE. We thank the gentleman for his testimony.

Mr. MURPHY. Thank you. I will leave these other materials here.

Mr. COLE. Thank you very much. And we have our last witness of the day, Mr. Panetta. Welcome to the committee. You must get tired of hearing this, but we all admire your father so much that, you know, we are always going to mention his distinguished service in this institution before he went on to serve the country so well as White House chief of staff, and director of the CIA, and obviously Secretary of Defense. Just an extraordinary career, and a heavy burden for you, I am sure. But, you know, what a wonderful mentor and role model you have, so we are delighted to have you here.

Mr. PANETTA. Thank you, Chairman Cole. I appreciate that.

Mr. COLE. And then recognized for 5 minutes for whatever testimony he cares to give.

[The statement of the Hon. Tim Murphy follows:]

**TESTIMONY FOR THE HONORABLE TIM MURPHY COMMITTEE ON APPROPRIATIONS SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES**

**March 1, 2017**

Innocence was shattered on a cold day in Connecticut just over four years ago. But out of this darkest of tragedies has risen a glimmer of hope, as the landmark mental health reforms signed into law on December 13, 2016, as part of the 21st Century Cures Act, were spurred by the events of Sandy Hook.

As I wrote in the Pittsburgh Post-Gazette on December 30, 2012, following the Newtown tragedy, "The common factor in many mass tragedies is an underlying mental illness. The lessons for Americans from the horrifying tragedy in Connecticut is that we had better take off our blinders and deal with such illness or we are sure to face the same problem again. It is not only what's in a person's hands that makes his act violent, it's what is in his mind."

Against this backdrop, in 2013, the Committee on Energy and Commerce, spearheaded by the Subcommittee on Oversight and Investigations which I chair, began a national conversation on serious mental illness, jumpstarting a process that

would result in the enactment of the first comprehensive reforms to our national mental health system in over 50 years, just under four years later.

Our multi-year, bipartisan, bicameral effort revealed a broken system and informed our legislative response to overhaul the antiquated patchwork of ineffective programs. Mental illness is no longer a subject for the shadows, and while more work remains, tremendous strides have been made to help families and individuals in mental health crisis.

At the end of November 2016, as the bill language was being finalized, I made the observation that while we won't solve the mess of our mental health system in one bill – and we didn't get everything we needed – we needed everything we got. It was my pledge to the patients and families in mental health crisis then, as it is now, that I will never stop fighting to deliver treatment before tragedy for those most in need.

And that's why I'm here this morning, to ask that you help to translate the historic promises we made to families in mental health crisis into commitments to action that will improve and indeed save lives. In addition to the improvements it makes to leadership and accountability at the federal level for mental health and substance

use programs, the Helping Families in Mental Health Crisis Reform Act of 2016 reauthorizes a number of existing, crucial programs at the Substance Abuse and Mental Health Services Administration and the Department of Health and Human Services while authorizing anew several others.

These include support for Assisted Outpatient Treatment (AOT) grant programs. Known by different names in different states, such as involuntary outpatient treatment or mandatory outpatient treatment, AOT is court-ordered treatment for individuals with serious mental illness who meet strict legal criteria. Often, they are too ill to recognize their need for medical care. By assuring timely and effective intervention for severe mental illness, AOT restores the capacity to exercise civil liberties and reduces the likelihood of the loss of liberty or life as a result of arrest, incarceration, hospitalization, victimization, suicide and other common outcomes of non-treatment.

While there have been innumerable studies pointing to the effectiveness of AOT in reducing re-arrests, re-hospitalizations and other negative outcomes, studies have also shown how court-ordered treatment in the community reduces taxpayer costs associated with untreated serious mental illness. With that in mind, the legislation

increases and extends an existing authorization for a grant program for AOT at SAMHSA.

Addressing pressing concerns over a shortage of qualified mental health professionals, the Helping Families in Mental Health Crisis Reform Act of 2016 also strengthens the mental and behavioral health work force through education training grants, clarification on eligibility for loan repayment programs, and codification of the Secretary's Minority Fellowship Program. It also acts decisively to strengthen programs supporting mental and substance use disorder care for women, children, and adolescents.

The programs mentioned above are but a few of the commitments to families and individuals in mental health crisis that our colleagues in the House and the Senate supported so overwhelmingly at the end of last year. Let us see these commitments through, fund the programs which have been authorized, and ensure that we can finally make a difference in the lives of thousands of our families, our neighbors, and our friends.

WEDNESDAY, MARCH 1, 2017.

**WITNESS**

**HON. JIMMY PANETTA, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA**

Mr. PANETTA. Thank you very much, Chairman Cole and Ranking Member DeLauro. I appreciate those opening comments. It is something I have grown up with. I am used to it. And I admit there are some pretty big shoes to fill, but I just look at it that it makes me a better person and it makes me work harder. So, thank you.

As you know, I am new to Congress, although I grew up with my father in this position for 16 years. It is still new to me, and it quite an honor that I get the chance to sit here in front of you and provide this testimony. So, thank you for this opportunity.

I hail from, I grew up on the Central Coast of California, the 20th Congressional District in California, a place where you may know John Steinbeck hailed from. He wrote a lot about that area, and he also wrote in his writings a lot about the quest for the American Dream.

Today I submit to you that that dream and our values are best served when we fund our educational programs. That is why I am here to urge you to provide strong funding for Title I, Head Start, CAMP and HEP, and the TRIO Programs. In districts like mine that have large gaps in educational attainment, these programs are crucial to supporting student development so that every child may write their own version of that American Dream.

The Head Start Program serves children who would not otherwise benefit from early education, with hands-on learning and wraparound services. That is why I respectfully request no less than the Fiscal Year 2017 funding level for that program.

In my district, Head Start operates seven programs and serves 2,680 children from infancy to age 5. Head Start's community engagement in particular lifts families up from poverty. For example, there is a family in my district that started their own daycare business after receiving job training from Head Start. That is an excellent example of leveraging a modest investment in Head Start into an economic livelihood for a formerly low-income family.

Before I came to Congress, I was a gang prosecutor in Monterey County. I saw firsthand the effects of limited access to a quality education and wraparound services. I saw too many kids appear in front of me in the courtroom when they should have stayed and been in the classroom. Title I levels the disparities between schools that are overwhelmed by a diverse set of students, like limited proficiency learners.

I represent 47 Title I school districts, and I do firmly believe that the kids in those kids need to be better served. I urge this committee to increase Title I funding above the Fiscal Year 2017 level and to also fund up to $1,000,000,000 for the student support and the academic enrichment grants. I believe that those two complementary funds target the underserved schools, and that can ensure an equitable education for all students.

The Central Coast is also appropriately named, not just the most beautiful district in the Nation, but also the salad bowl of the

world. There is a lot of agriculture there, and it relies and directly benefits from seasonal worker populations. I realize that many of them are from Latin America, but I have to tell you that their roots are now in our communities. They work hard. They pay taxes. And, yes, they do it in the pursuit of the American Dream.

One of my local community colleges, Hartnell College, has close to 800 students who can be called DREAMers, who fall under the DACA Program. CAMP HEP and the TRIO Programs serve those populations with the targeted support that they need, including one-on-one counseling to ensure at-risk students stay in school, and the financial aid assistance to ensure high school students graduate, attend, and succeed in college.

These programs drive economic mobility for these first general low-income students, as well as their families. That is why I request no less than the Fiscal Year 2017 funding level for those critical programs.

And finally, I come before you today to promote student loan forgiveness through public service. I am the grandson of Italian immigrants, and we learned that the American Dream is to give your children a better life. We were always told in my family, though, because we were allowed to live the reality of that dream, that we darn well better give back to the country and community that gave us so much.

That sentiment is why I am in front of you today. I believe that firmly. And I believe that young people want to live up to that ideal and to serve as well, yet I believe that they are hindered by the cost of their own education, including an enormous student loan debt. That is why I would like to see the expansion of student loan forgiveness through public service, so I urge the committee to strengthen and expand the public service programs that fall under that jurisdiction.

As members of Congress, all of us strive to improve the wellbeing of our constituents and, of course, our country. Education is the incubator of American innovation, prosperity, and economic quality. Education builds a foundation of success for our future generations. All of the programs I have referenced are crucial not only to my district, but to our country because all of the programs helps our children and our families achieve the American Dream.

Thank you very much.

Mr. COLE. I want to thank the gentleman for his testimony. I do know some of your areas because I read your dad's book, Worthy Fights. It is actually one of the best one of these things that there is to read. And so, I know a little bit about your roots and your community through that.

And I want to thank you for your advocacy here for these programs. Frankly, you know, the prior Administration put an emphasis on early childhood. We could not always match every dollar, but we increased every year. And particularly where early Head Start was concerned, I think they broke some new ground that—the research is pretty clear on this—that needed to be broken. And I think at that level we matched them dollar for dollar or pretty close. I know we did at least last year.

The TRIO Program, I share your admiration for. This committee actually has gone well above the prior Administration and the Sen-

ate both last year, and if we can get that 2017 bill out, we will again at some level. I have seen the same thing. I represent a district that has these same kind of challenges in terms of a lot of first generation kids that nobody has ever gone to college before, so things like GEAR UP and things like TRIO that prepare them so that if they get the opportunity, and obviously if they are in the TRIO Program, they have the opportunity, they go ahead and succeed because they need a level of support and mentorship, frankly, that with the best will in the world, the most supportive family. If nobody has ever gone to college before knowing exactly how to prepare to get there and exactly what you need to succeed there is, you know, terra incognita for a lot of our young people.

So, these are great programs. These are things this committee believes in very strongly on a bipartisan basis, and we look forward to working with you to try and do them. And, you know, again, what we can do, and I am going to say this in my closing remarks and then allow my good friend to say whatever she cares to, really does depend on the allocation that we get. And we are still in a little bit of suspense about that. We will be for a while.

But, again, if we get a good allocation, then a lot of the concerns that my friend has expressed in the programs that he has championed are programs that you will find bipartisan support for on this committee. But, you know, that will be the big issue for us. We will live within the allocation we have, but, you know, higher is better. It is a little bit easier for us to make this.

You know, we try to prioritize appropriately on this committee, and we try to do it in a bipartisan way. But, you know, again, these are tough decisions sometimes we have competing goods out there. We do not think we have a lot of bad programs to fund. We just think we have competing needs and a limited amount of resources.

But, you know, I thank my friend for being here.

Mr. PANETTA. Thank you.

Mr. COLE. I want to recognize my good friend, the ranking member for whatever remarks she cares to make in closing the committee hearing.

Ms. DELAURO. Thank you very, very much. It is really a delight to have before the subcommittee.

I want to thank you for your eloquence. We share a common heritage, and I can recall vividly visiting my mother, and I did not realize the method to her madness until I was an adult when she worked in the old sweatshops as a garment worker in the City of New Haven. She had me go up to see her and what it was about, and she would admonish me and say, get an education so that you do not have to do this.

Those words ring in my head every day as I know that they do with you and with your family background. And it is so true of so many families of our ethnic heritage and others.

And the chairman is right. This has been a committee that has been a strong supporter of Title I, of TRIO, of GEAR UP, all of these efforts. And I think we both fought with or at least had discussions with the prior Secretary of Education, and the role of early childhood education, and how we ought to spend substantial amounts of money on early childhood education.

I would just say this to you, and we mentioned this earlier, and the chairman did as well. If we are going to be looking at a $54,000,000,000 increase in defense, and I come from a defense dependent State, I say this, that that means that this subcommittee, which is about one-third of non-defense discretionary spending. So, after defense, we are the committee with the largest portfolio.

That means we are looking at about $18,000,000,000 in a cut if that were to occur. That just would be truly devastating. We could not sustain the needs of the programs that are under our jurisdiction.

So, I think we have to look very, very carefully at our budgets in terms of our values and our priorities, and education, in my view, has to be the highest priority that we are engaged in, in a commitment because it is the great equalizer. It really does not focus on your background, your income, your religion, your political party. It is about your God-given talent. That is what it is about.

And I think we have to look very carefully at the benefits of the budget and largesse of the budget and where those dollars are going, and education should not be short changed.

So, as the chairman pointed, we look for your advocacy when we are talking about what the share of the Labor, HHS Subcommittee should receive in terms of an allocation in order to meet the needs, so many of which you have outlined here this morning.

So, thank you so much for being here. I appreciate it.

Mr. COLE. Will the gentlelady yield for just one quick comment?

Ms. DELAURO. Yeah, be happy to.

Mr. COLE. I hate to hand you more ammunition, but, you know, you talk about defense and non-defense——

Ms. DELAURO. I will use it wisely.

Mr. COLE. I know you will. Actually, that is why I am handing the clip over to you. But, you know, it is not like we are going to cut veterans or homeland, so actually the share that would fall on this committee would be greater probably than even my friend has suggested.

And, you know, I say again, we will live within our allocation. We will do our job with what we have. But, yeah, you cannot balance the budget on the back of non-defense discretionary, and veteran-related, and homeland. There is just not enough money there. We could take every single dime of all the other subcommittees, and you would still be running. We are really talking about roughly a $400,000,000,000 pot of money here. It is a lot of money, but you could eliminate it all, and you would still be running deficits of about $200,000,000,000 a year. So, we are going to have to look to other ways, in my view.

But, again, governing is about making choices, and choices are made, we will live within those choices. But I want to tell my friend that I appreciate her advocacy. We do not always agree on everything, but we agree more than most people around here realize. And I appreciate the passion with which she approaches her job and the manner in which she represents the interests of the people that this committee is really important to because they are in many, many cases the most vulnerable people, the most needy people amongst us. And my friend's passion and concern is genuine and well placed.

Ms. DELAURO. Thank you very much.
Mr. COLE. With that, we close the hearing.
Mr. PANETTA. Thank you.
Mr. COLE. Thank you.
[The statement of the Hon. Jimmy Panetta and Members of Congress follow:]

JIMMY PANETTA
20TH DISTRICT, CALIFORNIA

COMMITTEE ON
AGRICULTURE

COMMITTEE ON
NATURAL RESOURCES

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Testimony before the House Appropriations Subcommittee on

Labor Health and Human Services and Education

Honorable Jimmy Panetta CA-20

March 1, 2017

Although new to Congress, I keenly understand the importance of the Appropriations Committee's annual check on our nation's priorities through the power of the purse. I am proud to represent the region that John Steinbeck detailed in his tales of the American Dream. I offer my testimony as I firmly believe that our nation's values are best served by funding the programs that foster the American Dream.

Therefore, I write to advocate for strong education funding. Federal funding for programs such as Title I, Head Start, CAMP and HEP, and TRIO are crucial to support student development so that every child may write their own version of the American Dream.

For this reason, I respectfully advocate for no less than the FY17 funding level for Head Start Head. A critical component of Head Start is family engagement. A family in my district started their own day care business after receiving job training from Head Start. This is an excellent example of leveraging a modest investment in Head Start into an economic livelihood for a formerly low income family.

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I request robust funding for the 47 Title I school districts in my district and the rest of the nation. This targeted funding levels disparities between students who all deserve an equitable education. I urge the Committee to support an increase in funding for Title I from the FY17 level and $1 billion for the Student Support and Academic Enrichment Grants.

As the Salad Bowl of the World, my agricultural district directly benefits from a large seasonal worker population. They have strong roots in our communities, work hard and pay taxes, in pursuit of the American Dream. CAMP/HEP and TRIO serve these populations with targeted support including one-on-one counseling to ensure at-risk students stay in school, and financial aid assistance to ensure high school students graduate and attend college. I request no less than FY17 funding levels for these critical programs.

I am a strong supporter of student loan forgiveness for those who choose public service and urge the Committee to strengthen and expand those public service programs under the jurisdiction of this Committee. Many young people are consumed by an eagerness to serve and affect change, but feel burdened by the cost of their own education. My own family's American Dream was achieved through public service. I am here today because of my family's commitment to helping others. I am honored to continue this legacy and hope to inspire future generations to public service.

As Members of Congress, we strive to improve the well-being of our constituents and country. Education is the incubator of American innovation, prosperity, and economic equality and builds the foundation of success for future generations. All of the programs I've referenced are crucial to my district and help children and families achieve their own success and enrich our community as a whole. Thank you for the opportunity to advocate on behalf of these programs.

Rep. Jenniffer Gonzalez-Colon
Puerto Rico (R-AL)

**Dear Chairman Frelinghuysen, Ranking Member Lowey, and Members of the Subcommittee on Labor, Health and Human Services, Education:**

I appreciate the opportunity to speak before the subcommittee on a matter of great importance—the ongoing outbreak of Zika virus in the U.S. territory of Puerto Rico.

As you may know, on December 31st, 2015, the Puerto Rico Department of Health reported the first locally acquired case of Zika infection on the island. By July of 2016, the Centers for Disease Control reported that nearly 6,000 individuals had been diagnosed with Zika including 700 pregnant women. The rate at which Zika spread in Puerto Rico compounded by the disturbing facts the medical community attributed to the virus created urgent circumstances on the island.

Zika is spread mostly by the bite of an infected *Aedes* species mosquito, which feeds during the day and night. These are the same mosquitos that spread dengue and chikungunya virus, which have previously ravaged Puerto Rico. In 2014 alone, chikungunya caused over a thousand hospitalizations and killed several others in Puerto Rico.

Pregnant women can pass Zika virus to her fetus during pregnancy and Zika can be passed through sex from a person who has Zika to his or her partners. Zika is a cause of microcephaly, a birth defect where a baby's head is smaller than expected, and

other severe brain defects. Zika has also been linked to Guillain-Barré, which causes muscle weakness and sometimes paralysis.

As a result, on August 12, 2016 Secretary Burwell declared a public health emergency of national significance in Puerto Rico relating to pregnant women and children born to pregnant women with Zika. I applaud Acting Secretary of HHS, Norris Cochran, for renewing the public health emergency declaration on January 31, 2017.

The effects of Zika are far-reaching and not isolated to causing infection in persons. The outbreak endangered Puerto Rico's self-sufficiency in blood supply, affected economic growth in an already fragile economy, and overwhelmed an overworked and under resourced health care sector.

The Puerto Rico Department of Health confirmed nearly 39,000 cases of Zika in 2016.

Congressman H. Morgan Griffith
9th District of Virginia
Written Testimony for the Record- LHHS Appropriations

Thank you for holding this hearing today to give us the opportunity to highlight matters of great importance to our districts and the country as you move forward in the appropriations process.

The first matter I would like to bring to your attention is specific to the 9th District of Virginia. I am a staunch believer in the importance of public education and that the power to make decisions should be held at the state and local levels and with parents and administrators, as they know the needs of their individual students much better than Washington does. The role of the Federal government is to assist in providing our local schools with funding so they can operate and provide our children with the best education possible.

In the 114th Congress, we made major reforms to the Federal government's role in K-12 education with the Every Student Succeeds Act, which I hope will successfully return the power of our children's education to the localities once fully implemented. However, my concern lays in funding cuts that several of my school districts will face because of the elimination of a hold harmless provision in Title II, Part A under what was formerly No Child Left Behind.

Title II, Part A funding is used to train and recruit high quality teachers and principals to increase academic achievement among students. I have been told that, due to a hold harmless provision in No Child Left Behind, population data and funding levels from 2001continued to be used in the formula implemented to calculate how much funding would be received by states and localities under this section of the law. Funding

received at the local level is the sum of two calculations: 1) 20% is determined by calculating the population of 5-17 year olds in the state versus all states; and 2) 80% is determined by the population of 5-17 year olds who come from families with incomes below the poverty line in the state versus all states. This money is especially beneficial in regions that may otherwise have a difficult time attracting highly qualified teachers.

While I understand that we cannot be using population data and funding levels from 2001 in our formulas to calculate the appropriate amount of funding each state and locality receive today, I do believe these cuts should be phased in so that school districts that are already hurting aren't faced with another dramatic cut to their resources. It is my understanding that the Every Student Succeeds Act did phase in cuts at the state level. The local school districts should be afforded the same opportunity to prepare for these steep cuts through gradual implementation.

Projections for my District show that a majority of cities and counties that I represent would lose funding. Some of these school districts, such as Buchanan and Dickenson, are projected to lose nearly 40% of their Title II, Part A funding for the 2017-2018 school year. Several of my counties are losing over $100,000 from this revenue stream alone. I have been told that in Wise County, this money funds five teaching positions.

Many school districts in rural, coal-dependent regions across the nation are already suffering as a result of reduced coal production and economic devastation. As jobs have exited the region, so have families in search of work elsewhere, which leads to the population loss that is the cause of this reduced Title II, Part A funding. This loss only intensifies the hardship that our school administrators, families, and students are

experiencing. Most Appalachian counties have already seen a reduction in revenues, millions of which was used to fund local school systems, because of the loss of coal severance taxes. Coal severance tax is money that mining companies pay to localities based on the value of coal tonnage that they mine. Counties in Southwest Virginia have seen their severance tax revenue drop by well over 50%, with some seeing losses of close to 80%, in less than a decade. Students and families that remain in the coalfields region shouldn't be further punished at the expense of a quality education. Additional funding cuts of the magnitude required under ESSA this year will result in fewer teachers being hired, less opportunity to use the latest technology in the classroom, and students falling behind their peers in other parts of the country.

Again, while I understand the importance of using the most current data when calculating the disbursement of Federal funding, we must also take into account the impact this loss will have on our communities and give them the opportunity to adequately prepare for cuts to their resources. I hope you all will consider including language in the FY18 LHHS Appropriations bill that will phase in these cuts for our local school districts and provide some relief to those who continue to face difficult decisions in the coming school year.

Next, I would like to turn your attention to a national matter - the Zika virus and need to dedicate additional federal resources to vector control, particularly for innovative vector control technology. While the Zika virus has not been in the forefront of the news lately, there are still active Zika cases in the United States. With the Spring and Summer months ahead, I worry that we will once again see an uptick in transmission which will

demand the Federal government's typical quick and reactionary response to public health outbreaks.

While there are several areas that demand funding in response to Zika outbreaks, including diagnostic capabilities and vaccine development, I am puzzled as to why such little funding has been designated to preventative measures, particularly vector surveillance, control and technology. While we must focus resources on diagnosing and treating those infected by the virus, it will be far more damaging and costly to the American people if Congress fails to appropriate sufficient funding to control and prevent the spread of Zika.

While the Centers for Disease Control and Prevention (CDC) Director has recognized the importance of mosquito-control in the government's efforts to combat Zika, vector control does not seem to have been deemed by the Department of Health and Human Services (HHS) to be one of the highest priorities in terms of allocated funding. I understand that vector control is typically a local responsibility and I appreciate the fact that the CDC is working to support these local efforts. However, more needs to be done to reduce the spread of disease by mosquitos since understanding and then suppressing the vector is key to controlling the spread of Zika or any other current or future virus transmitted by the mosquito.

For example, the Zika spending plan circulated by HHS in December allocates $350 million to support CDC's Zika response activities, including vector control. It is my understanding that as little as $25 million of the CDC funding would be devoted specifically to mosquito control. Mr. Chairman, this is ill advised.

Again, significant federal dollars have been dedicated to vaccine development. And while I agree wholeheartedly that vaccine development is important, these vaccines are not going to be available to the public for months, if not years.

On the other hand, innovative vector control technology, such as the Oxitec mosquito, exists today and is fully scalable. The Oxitec mosquito suppresses the *Aedes aegypti* mosquito population which is the prime vector for the Zika virus as well as dengue, yellow fever and chikungunya.

In fact, trials in several countries show that with the use of this mosquito, the *Aedes aegypti* mosquito population in treated areas may be reduced by over 90% in around six months. In the United States, the Food and Drug Administration is in the process of approving a field trial for the Oxitec mosquito in Monroe County, Florida. The safety of the product has been thoroughly evaluated by FDA, in conjunction with the Environmental Protection Agency (EPA) and CDC, and these agencies have concluded, within the context of another proposed field trial in Florida, that the Oxitec mosquito is unlikely to cause adverse impacts to human health or the environment.

The Subcommittee needs to be encouraging the use of this type of innovative, new vector control technology and provide funding to support efforts that can be used immediately, not months or years down the road.

Therefore, it is my hope the Appropriations Committee will dedicate significant funding to support new, innovative vector control initiatives as we continue to search for ways to treat and eradicate the Zika virus.

**PREPARED TESTIMONY**

**Congressman Peter Welch (VT-00)**

**March 1, 2017**
**House Appropriations Committee**
**Subcommittee on Labor, Health and Human Services, and Related Agencies**

Dear Chairman Tom Cole, Ranking Member Rosa DeLauro and Members of the Committee,

I am here today to request that you prioritize the Low Income Home Energy Assistance Program (LIHEAP) in your Fiscal Year (FY) 2018 appropriations bill by including no less than $4.7 billion for this program, which provides critical support to our most vulnerable citizens.

LIHEAP helps low-income households and seniors with their energy bills, providing vital assistance during both the cold winter and hot summer months. LIHEAP households are among the most vulnerable in the country. According to the National Energy Assistance Director's Association (NEADA), nearly 82 percent of Vermont's and 90 percent of the nation's LIHEAP recipients have at least one household member who is a child, elderly, or disabled. For these households, LIHEAP funding has been a lifeline during challenging economic times. Access to affordable home energy is not a luxury – it is a matter of health and safety.

I understand the ongoing discretionary budget challenges. However, I am deeply concerned that funding for LIHEAP has declined more than 30 percent in recent years. Moreover, the number of households eligible for assistance continues to exceed available funding. According to NEADA, the total number of households receiving LIHEAP assistance has declined by 15.5 percent between FY 2010 and FY 2015, from 8.1 million to 6.8 million. About 1.3 million low-income households have lost access to critical LIHEAP assistance and struggle to pay for the basic necessity of home energy in addition to other essentials like food and medicine.

Funding has declined by almost $1.7 billion since FY 2010, yet energy costs have remained high, reducing the purchasing power of LIHEAP assistance. Recipients have seen their average LIHEAP grant reduced by about $107 since 2010, from $520 in FY 2010 to $413 in FY 2015. The average LIHEAP grant is estimated to cover less than half of the average home heating costs for a household this winter, meaning that many low-income families and seniors will have fewer resources available to meet other basic needs.

As you finalize your FY 2017 Labor, Health and Human Services, Education and Related Agencies Appropriations bill, I ask that you take into account the great need for LIHEAP. I urge you to prioritize this program and restore funding to this program to a level no less than $4.7 billion.

Thank you for your attention to and consideration of this important request.

**The Honorable Colleen Hanabusa (HI-01)**
**U.S. House of Representatives**
**House Committee on Appropriations**
**Subcommittee on Labor, Health, and Human Services, Education, and Related Agencies**
**March 1, 2017**

Chairman Cole, Ranking Member DeLauro, and distinguished Members of the Subcommittee, thank you for the opportunity to testify before you today. In my testimony, I will highlight the importance of federal funding for Native Hawaiian Education and Native Hawaiian Health programs. As the host culture of the State of Hawaii, the obligation of the United States to this group cannot be understated. Congress has acknowledged this responsibility through the passage of various Congressional acts, including the Hawaiian Homes Commission Act of 1920 and United States Public Law 103-150, commonly known as the Apology Resolution, which was passed in 1993. It is imperative that we continue to address our country's special relationship with Native Hawaiians and the unique needs they face now and in the future.

**Native Hawaiian Education**

One area of critical need is in education, where Native Hawaiians have typically underperformed other groups in test scores and graduation rates. As a result, Congress included funding for Native Hawaiians in Title VII, Part B of the Education and Secondary Act of 1965, as amended, the purposes of which *(1) authorize and develop innovative educational programs to assist Native Hawaiians;(2) provide direction and guidance to appropriate Federal, State, and local agencies to focus resources, including resources made available under this part, on Native Hawaiian education, and to provide periodic assessment and data collection;(3) supplement and expand programs and authorities in the area of education to further the purposes of this title; and (4) encourage the maximum participation of Native Hawaiians in planning and management of Native Hawaiian education programs.*

Federal programs designed to address the educational needs of Native Hawaiians are critical to improving success rates for youth, from preschool through post-secondary education and beyond. Many of the federally-funded initiatives incorporate cultural and language components that supplement the traditional critical thinking and analysis found in conventional educational curricula. Reintegrating culturally-driven education into a curriculum facilitates an important process by which, students and their families are able to reestablish important connections to Hawaiian cultural self-identity, while pursuing educational excellence.

These programs also provide a foundation for students pursuing post-secondary or advanced degrees, programs where Native Hawaiians are dramatically under-represented. Federal resources are critical to increasing the number of Native Hawaiian students participating successfully in these programs.

Many Native Hawaiian educational organizations owe their success to federal appropriations. These programs have a proven track record of successfully implementing a variety of approaches to tackle the educational challenges that face Native Hawaiians at every level of education.

***Preschool Education***

Investing in preschool programs is a crucial first step in improving a young student's cognitive development. Preschool grantees of Native Hawaiian education funding provide a multitude of culturally-driven services early in a child's life that helps develop a strong foundation for attaining future educational success. This funding also allows for the integral professional development of preschool teachers; engages families through a multitude of support resources; and implements accurate assessment tools for student development and cognition. Family participation is a vital component of Native Hawaiian preschool programs. It is

especially vital in a facilitating a child's ability to develop a deeper cultural understanding, which enables students to participate confidently in their future educational endeavors.

For example, *'Aha Punana Leo* (APL), a grantee with numerous preschools in my district, has led efforts to revitalize the use of the Hawaiian language since 1984, when the language was on the brink of extinction. APL has since provided a high-quality preschool education for children conducted entirely in the Hawaiian language. The APL utilizes a "language nest" model that fully engages a child's family in the Hawaiian language curriculum. Parents are required to enroll in Hawaiian language classes held at the school and participate in school activities with the child as a condition of a child's admission to an APL preschool. Requiring parent participation serves a dual purpose in cultivating a culturally appropriate home environment for families to thrive, while encouraging active family participation in a child's education from the earliest possible stage. The services and programs provided by APL have led to a vast expansion of Hawaiian language immersion programs and are a leading source of curriculum material throughout the state and throughout the world.

***Environment & Socio-economic factors***

Improving educational success rates for Native Hawaiian youth also requires assessing a student's home environment and socio-economic footing. Many Native Hawaiian families come from economically disadvantaged backgrounds and many in that group are afflicted by poverty-living in communities that lack access to education resources. Federal funding provides children facing this reality with increased resources, targeted tools, and other basic life necessities that effectively offset the barriers that come with challenging home dynamics, greatly improving students' likelihood of success in school and beyond.

Grantees like *The Partners In Development Foundation* help countless poverty-stricken Native Hawaiian families through innovative initiatives like "Ka Pa'alana" and "Malama Mobile," which deliver critical services to families facing homelessness. Additionally, Partner's In Development partners with other community resource centers to maximize outreach efforts in communities with high incidences of poverty. Together with community partners, these programs remove access barriers and bring resources directly into communities in specially modified vans that serve as mobile educational resource and social service outlets.

The economic and social hardships faced by Native Hawaiian students also make it difficult for students to excel academically. As a result, federal educational funding is critical to providing culturally-relevant programs for at-risk Native Hawaiian youth and their families, regardless of their financial circumstances or ability to pay. The *Institute for Native Pacific Education and Culture (INPEACE)* provides crucial resources in the areas of Early Childhood Education and Workforce Development, while integrating both Hawaiian language and culture into their approach. The goal of INPEACE is to improve school readiness needs of at-risk Native Hawaiian children by concentrating on family inclusiveness and participation in every aspect of the child's educational experience. Since 1994, this organization has grown to serve more than 2,000 students annually by administering seven programs aimed at improving the educational success rates for at-risk Native Hawaiian students.

**Native Hawaiian Health**

Another significant area of need is Native Hawaiian Health. Congress understands the unique health needs of Native Hawaiians and enacted the Native Hawaiian Health Care Improvement Act ("NHHCIA") for the purposes of (1) raising the health status of Native

Hawaiians to the highest possible health level; and (2) providing existing Native Hawaiian health care programs with all resources necessary to effectuate this policy.

NHHCIA created *Papa Ola Lokahi*, an organization charged with executing the purposes of the law. This includes researching prevalent illnesses in the Native Hawaiian community, coordinating health care programs, and training Native Hawaiian cultural and medical practitioners and community educators. *Papa Ola Lokahi* has community health centers on Hawaii Island, Maui, Molokai, and Kauai. These health centers provide local rural communities with access to critical healthcare and services like dental care, nutritional counseling, and physical fitness. With diabetes, high blood pressure, and high cholesterol extremely prevalent in the Native Hawaiian community, these services are invaluable to improving the health of Native Hawaiians. *Papa Ola Lokahi* has worked diligently to improve Native Hawaiians' health, but needs federal support to continue their endeavors.

**Conclusion**

In summary, Native Hawaiians face educational, economic, and social hardships that inhibit their ability to lead healthy lives and contribute to the betterment and progress of our community. Congress must continue to uphold its commitment to Hawaii's indigenous people by appropriating funds that support the unique needs of Native Hawaiians.

Therefore, I support continued funding by this Congress to address the educational, economic, and social needs of Native Hawaiians, and I respectfully urge this committee to allocate robust funding to support crucial programs like these. Thank you for the opportunity to provide testimony.

# TESTIMONY OF INTERESTED INDIVIDUALS AND ORGANIZATIONS

WEDNESDAY, MARCH 8, 2017.

## CONNECTICUT CHILDREN'S MEDICAL CENTER

**WITNESS**

**JAMES E. SHMERLING, PRESIDENT AND CEO, CONNECTICUT CHILDREN'S MEDICAL CENTER**

Mr. COLE [presiding]. Good morning. It is my pleasure to welcome everyone—thank you—to the Subcommittee on Labor, Health, Human Services, and Education for a very special hearing. This is our public witness day, and it provides an opportunity for members of the public to come before this panel and draw our attention to particular issues of importance to them. I always look forward to hearing from our public witnesses as we learn as much about the challenges facing our people and what this subcommittee can do to help solve them.

Before we begin, I want to remind everyone that we need to strictly adhere to the 5-minute rule so that we will be able to keep closely the schedule and hear from everyone before votes are called. For our witnesses a 5-minute minute block will count down on the microphone box in front of you. When you have one-minute remaining, the light will turn yellow and you should begin to wrap up your testimony at that point. Remember that your full written statement will appear in the hearing record.

And just for purposes of the committee, this will obviously not be a question and answer and dialogue, although at the end of each witness I will certainly allow anybody that wants to to make a remark or ask a quick question. But let us try and move along just for the convenience of all the folks who have come a long way to be with us and to offer testimony.

And with that, I would like to turn to our ranking member, who has laryngitis today, so you guys be kind.

Ms. DELAURO. Thank you. Thank you, Mr. Chairman. This is really a delight to have this public witness hearing this year, express my gratitude as well to all of the witnesses. And thank you for taking the time to speak to us, but for all the work that you do on behalf of American families. And we are eager to hear from all of you, so I will be brief and I apologize for my voice. Nineteen witnesses, all aspects of the committee's jurisdiction: education, healthcare, programs that benefit everyone from infants to seniors, universities, STEM education, and much more.

The Labor HHS bill is called the people's bill. The reason for that is because it is about providing constituencies and people with op-

portunities to be able to get ahead. And they are the programs that directly impact the lives of Americans. So, I say thank you to you.

And I just want to make a point, that the range of programs here are so important, but you are all tireless in your advocacy on these issues, and we thank you for that.

The hearing that we had last week, both the chairman and I mentioned that we have got the potential for a $54,000,000,000 cut to non-defense discretionary spending. This would have a profound effect on the programs under the portfolio of Labor, Health, Education, and Human Services, because Labor HHS is one-third of non-defense discretionary spending, so that could potentially be a cut of about $18,000,000,000.

The chairman said last week, and I agree with him and I know he has been saying this, is that we cannot afford to balance the budget on the back of non-defense discretionary efforts. So, I think you will explain why you believe that the programs that you are espousing or the efforts that you are espousing are worthy and why we should be reinvesting urgently in your priorities.

So, I very, very much look forward to hearing your testimony this morning. Many thanks.

Mr. COLE. I thank the gentlelady, and with apologies ahead of time I may well mispronounce names. Feel free to correct me.

We have as our first public witness, is it Shermie?

Mr. SHMERLING. Shmerling.

Mr. COLE. Shmerling, okay. James Shmerling, the president and chief executive officer of the Connecticut Children's Medical Center. Sir, you are recognized for 5 minutes to offer whatever remarks you care to the committee.

Mr. SHMERLING. Thank you. Chairman Kohl, Ranking Member DeLauro, and members of the subcommittee, thank you for the opportunity to testify in support of the Children's Hospital Graduate Medical Education Program, or CHGME.

I am Jim Shmerling, president and CEO of Connecticut Children's Medical Center in Hartford, Connecticut. On behalf of Connecticut Children's and the Children's Hospital Association, I respectfully request that the subcommittee provide $300,000,000 for the CHGME Program in Fiscal Year 2018.

A robust pediatric workforce is essential to ensuring that all children can access high-quality medical care. CHGME supports this goal by providing funding for the training of pediatric providers at independent children's hospitals. Much as Medicare supports training and teaching hospitals that primarily serve adults, CHGME benefits children across the Nation by supporting the training of doctors who go on to care for children living in every State.

Since the program's beginning, CHGME has enjoyed strong bipartisan support in Congress under both Republican and Democratic leadership. For Fiscal Year 2016, Congress provided $295,000,000 for CHGME, the program's first funding increase since Fiscal Year 2010. For Fiscal Year 2017, both the House and Senate Labor Health and Human Service Appropriations Subcommittees recommended $300,000,000 in funding for CHGME.

Furthermore, bipartisan legislation reauthorizing CHGME through Fiscal Year 2018 was enacted in 2014, demonstrating the high level of ongoing support among lawmakers for the program.

Children's hospitals are extremely grateful for the strong commitment to the health of America's children.

Congress created CHGME in 1999 because it recognized that the absence of dedicated CHGME funding for freestanding children's teaching hospitals created gaps in training of pediatric providers, potentially threatening children's access to care. At that time, independent children's hospitals, like Connecticut Children's, were effectively left out of the Federal GME support provided through Medicare because we treat children, not the elderly.

Since 1999, the CHGME Program has had a tremendous impact. Although the 58 hospitals that currently receive CHGME funding compromise only 1 percent of all hospitals, they train half of all pediatric residents, more 7,000 annually, including 44 percent of all general pediatricians and 57 percent of all pediatric specialists.

To provide an example of the impact from my own hospital, Connecticut Children's is the academic home for the Department of Pediatrics at the University of Connecticut School of Medicine, and we serve as the principal training site for the university's pediatric residency program, the pediatric fellowship programs, and medical student pediatric education. We have 63 pediatric residents at any given time. They are engaged in learning onsite and in the Greater Hartford area.

CHGME funding supports the provision of their curriculum under the expertise of a highly-qualified faculty with a diverse population of patients and health needs. In 2016, 126 of our residency and fellowship program graduates were practicing in Connecticut. While many of their colleagues have moved on to practice all over the country, America's children rely on the training provided by hospitals like ours that receive CHGME funds.

CHGME has allowed children's hospitals to develop training programs in highly-specialized disciplines that target the unique needs of children. Some examples include pediatric surgical oncology, radiation oncology, pediatric pathology, and bone marrow transplantation. Only a small number of institutions provide training in those areas. CHGME is vital to maintaining and expanding programs focused on those sub-specialties.

However, while much has been achieved in strengthening the pediatric workforce, still more remains to be done. The national population of children continues to increase, and the number of children with complex medical conditions is growing at a faster rate than the overall child population, requiring an increasing number of specialty care providers. Nationwide, serious pediatric workforce shortages persist, most acutely among pediatric sub-specialties. Localized shortages of pediatric primary care providers also continue particularly in certain rural areas. Strengthening funding for CHGME will help all children and their families, including those with rare and complex conditions.

Even with CHGME, children's hospitals incur significant additional costs in support of their teaching missions. Without CHGME, hospitals will be at risk of having to cut back training experience in patient care services. This would negatively impact children's access to care and the future of the pediatric workforce.

We recognize that the current budget climate is extraordinarily challenging and Congress has a responsibility to carefully consider

the Nation's spending priorities. However, continued needs of the pediatric workforce, in particular with respect to specialty shortages, point to the necessity of strengthening funding for the program. Now is the time to take a step forward in pediatric medicine to ensure our children have access to health services they need.

On behalf of Connecticut Children's Medical Center, the Children's Hospital Association, and the children's families we serve, thank you for your past support for this critical program. We request we respectfully request that the subcommittee continue its bipartisan support of children's health and CHGME at its authorized funding level of $300,000,000 in the Fiscal Year 2018 Labor Health and Human Services Appropriations Bill. Thank you.

[The information follows:]

# Testimony for the Record

## In support of FY 2018 funding for the Children's Hospitals Graduate Medical Education (CHGME) Program

### Submitted to the Subcommittee on Labor, Health and Human Services (HHS), Education and Related Agencies, March 8, 2017, by James E. Shmerling, DHA, FACHE, President and Chief Executive Officer, Connecticut Children's Medical Center

The Children's Hospitals Graduate Medical Education (CHGME) program is administered by the Bureau of Health Workforce in the Health Resources and Services Administration at the Department of Health and Human Services. The statement testimony focuses on the purpose of CHGME and its benefit to all children. The testimony includes a request for the Subcommittee to appropriate $300 million for CHGME in Fiscal Year (FY) 2018.

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Chairman Cole, Ranking Member DeLauro and members of the Subcommittee, thank you for the opportunity to testify in support of the Children's Hospitals Graduate Medical Education (CHGME) program. I am Jim Shmerling, president and CEO of Connecticut Children's Medical Center in Hartford, Connecticut. On behalf of Connecticut Children's and the 220 members nationwide of the Children's Hospital Association, I wish to thank the Subcommittee and its leadership for their long history of support for CHGME and children's health.

A robust pediatric workforce is essential to ensuring that no child lacks access to high-quality medical care. The CHGME program supports this goal by providing funding for the training of pediatric providers at independent children's teaching hospitals, much as Medicare supports training in teaching hospitals that primarily serve adults. CHGME benefits all children, supporting the training of doctors who go on to care for children living in every state—in cities, rural communities, suburbs and everywhere in between.

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www.connecticutchildrens.org
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16011 College Blvd. | Suite 250 | Lenexa, KS 913-262-1436
www.childrenshospitals.org | © Children's Hospital Association

Since the program's beginning, CHGME has enjoyed strong bipartisan support in Congress under both Republican and Democratic leadership. For FY 2016, Congress provided $295 million for CHGME, the program's first funding increase since FY 2010. For FY 2017, both the House and Senate Labor-HHS-Education Appropriations Subcommittees recommended $300 million in funding for CHGME, equal to the program's full authorization. Furthermore, bipartisan legislation reauthorizing CHGME through FY 2018 was enacted in 2014, demonstrating the high level of ongoing support among lawmakers for the program. Children's hospitals are extremely grateful for this strong commitment to the health of America's children. At this time, I respectfully request that the Subcommittee provide $300 million for the CHGME program in FY 2018.

**Congress created CHGME in 1999 with bipartisan support because it recognized that the absence of dedicated GME funding for freestanding children's teaching hospitals created gaps in the training of pediatric providers, which potentially threatened access to care for children.** At that time, independent children's hospitals, like Connecticut Children's, were effectively left out of the federal GME support provided through Medicare because we treat children and not the elderly.

Since 1999, the CHGME program has had a tremendous impact. Although the 58 hospitals that currently receive CHGME funding comprise only 1 percent of all hospitals, they train half of all pediatric residents—more than 7,000 annually—including 44 percent of all general pediatricians and 57 percent of all pediatric specialists.

To provide an example of the impact of CHGME, my own hospital, Connecticut Children's, is the academic home for the Department of Pediatrics at the University of Connecticut School of Medicine, and we serve as the principal training site for the university's pediatric residency program, pediatric fellowship programs and medical student pediatric education. We enroll 63 pediatric residents at any given time. They are engaged in learning onsite and in the greater Hartford area. CHGME funding supports the provision of their curriculum under the expertise of a highly qualified faculty with a diverse population of patients and health needs.

In 2016, 126 of our residency and fellowship program graduates were practicing in Connecticut while many of their colleagues had moved on to practice all over the country. America's children rely on the training provided by hospitals like ours that receive CHGME funds.

CHGME has enabled children's hospitals to increase their overall training by more than 85 percent since the program began in 1999. In addition, the CHGME program has accounted for 72 percent of the growth in the number of new pediatric subspecialists being trained nationwide.

However, while much has been achieved in strengthening the pediatric workforce, much remains to be done. The national population of children is predicted to continue a growth rate of 3 percent through 2030. At the same time, the health care needs of the pediatric population are increasing. The number of children with complex medical conditions is growing at a faster rate than the overall child population, requiring an increasing number of specialty care providers.[i]

Unfortunately, funding to train the doctors who serve these children has not kept pace. Our nation's commitment to children's health care still lags behind our investment in adults with respect to workforce training. While children under 19 currently comprise about 24 percent of the U.S. population, only 9 percent of all federal support for graduate medical education is targeted toward training pediatric providers—including both CHGME and Medicare funding for pediatric residents.[ii]

Freestanding children's hospitals, which, as noted, train approximately half of all pediatricians, receive almost no federal GME support through Medicare. Furthermore, analysis commissioned by the Children's Hospital Association shows that at current funding levels, the average CHGME payment per full-time equivalent (FTE) resident represents only 45 percent of what Medicare GME provides to support training in adult teaching hospitals.

Nationwide, serious pediatric workforce shortages persist, most acutely among pediatric subspecialties. The most recent survey data available[iii] from children's hospitals shows the following wait times for scheduling appointments due to shortages:

- Developmental pediatrics – average wait time of 13 weeks
- Endocrinology – average wait time of 10 weeks
- Neurology – average wait time of nine weeks
- Pulmonology – average wait time of eight weeks
- Gastroenterology – average wait time of five weeks

Localized shortages of pediatric primary care also continue, particularly in certain rural areas.

Strengthening funding for CHGME will help all children and their families, including those children with rare and complex conditions. CHGME has allowed children's hospitals to develop training programs in highly specialized disciplines that target the unique needs of children—some examples include pediatric surgical oncology, radiation oncology, pediatric pathology and bone marrow transplantation. For some of these disciplines, only a small number of institutions provide training.[iv] Strong ongoing support is vital to maintaining and expanding programs focused on these subspecialties, and reductions in funding would slow the ability to train providers in areas of need. During a period of reduced CHGME funding earlier in this decade, some hospitals reported that their resident FTE levels, which had been increasing in response to demand, leveled off and even declined.

Even with CHGME, children's hospitals incur significant additional costs to support their teaching missions. These additional costs are particularly difficult to bear given that children's hospitals are typically large Medicaid providers, with more than 50 percent of the average number of days of care covered by Medicaid. Medicaid reimbursement levels in many states remain well below those of private insurance and other government programs. This creates another significant fiscal challenge for children's hospitals, particularly as state Medicaid programs have been scaled

back significantly in recent years. Without CHGME, hospitals will be at risk of having to cut back training experiences and patient care services, impacting children's access to care and the future pediatric workforce.

Furthermore, there are no adequate substitutes for CHGME to support training at freestanding children's hospitals. Other potential sources of support, such as Medicaid GME—which has been significantly reduced or eliminated in many states—or competitive grant funding, are not available to many children's hospitals and cannot support training on the scale necessary to meet current and future workforce needs.

The CHGME program is critical to protecting gains in pediatric health and ensuring access to care for children nationwide. We recognize that the current budget climate is extraordinarily challenging and that Congress has a responsibility to carefully consider the nation's spending priorities. However, continuing needs in the pediatric workforce, in particular with respect to subspecialty shortages, point to the necessity of strengthening funding for the program. Now is the time to take a step forward in pediatric medicine and ensure our children have access to the health care services they need.

On behalf of Connecticut Children's Medical Center, the Children's Hospital Association and the children and families we serve, thank you for your past support for this critical program. We respectfully request that the Subcommittee continue its history of bipartisan support for children's health and fund CHGME at its authorized funding level of $300 million in the FY 2018 Labor-HHS appropriations bill.

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[i] "Summary of Available Evidence and Methodology for Determining Potential Medicaid Savings from Improving Care Coordination for Medically Complex Children," p. vi, prepared for Children's Hospital Association by Dobson DaVanzo & Associates, issued October 2013.
[ii] U.S. Census Bureau; "Comparative Analysis of GME Funding for Children's Hospitals and General Acute Care Teaching Hospitals," prepared for Children's Hospitals Association by Dobson DaVanzo & Associates, issued April 2014.
[iii] "Pediatric Specialist Physician Shortages Affect Access to Care," Children's Hospital Association, issued August 2012.
[iv] "Percentage of Pediatric Specialists Trained at CHGME Recipient Hospitals," Children's Hospital Association, issued 2012.

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

## Witness Disclosure Form

Clause 2(g) of rule XI of the Rules of the House of Representatives requires non-governmental witnesses to disclose to the Committee the following information. A non-governmental witness is any witness appearing on behalf of himself/herself or on behalf of an organization other than a federal agency, or a state, local or tribal government.

Your Name, Business Address, and Telephone Number:
James E. Shmerling, DHA, FACHE
Connecticut Children's Medical Center, 282 Washington Street, Hartford, CT 06106
860-545-8551

1. Are you appearing on behalf of yourself or a non-governmental organization? Please list organization(s) you are representing.
   Children's Hospital Association
   Connecticut Children's Medical Center

2. Have you or any organization you are representing received any Federal grants or contracts (including any subgrants or subcontracts) since October 1, 2012 related to the agencies or programs funded by the Subcommittee?

   Yes ✓ No

3. Have you or any organization you are representing received any contracts or payments originating with a foreign government since October I, 2012 related to the agencies or programs funded by the Subcommittee?

   Yes No ✓

4. If your response to question #2 and/or #3 is "Yes", please list the amount and source (by agency and program) of each Federal grant (or subgrant thereof) or contract (or subcontract thereof), and/or the amount and country of origin of any payment or contract originating with a foreign government. Please also indicate whether the recipient was you or the organization(s) you are representing.

Signature: [redacted] Date: March 6, 2017

Payments received by Connecticut Children's Medical Center
from the Children's Hospitals Graduate Medical Education payment program

| Fiscal Year | Amount |
|---|---|
| FY2012 | $2,889,951 |
| FY2013 | $2,579,948 |
| FY2014 | $2,639,113 |
| FY2015 | $2,928,447 |
| FY2016 | $2,828,026 |
| FY2017(YTD) | $1,146,607 |

| Agency Name | Program Name | Intermediary Funding Source | Grant start date | Grant end date | CFDA # | FY2013 Expenditures |
|---|---|---|---|---|---|---|
| Department of Health and Human Services | Family Smoking Prevention and Tobacco Control Act Regulatory Research | University of Connecticut | 05/01/12 | 09/12/13 | 93.077 | $ 52,443.11 |
| Department of Health and Human Services | Disabilities Prevention | University of Massachusetts | 09/30/12 | 09/29/13 | 93.184 | $ 19,716.79 |
| Department of Health and Human Services | Centers for Disease Control and Prevention_Investigations and Technical Assistance | N/A | 09/30/11 | 06/29/14 | 93.283 | $ 48,092.47 |
| Department of Health and Human Services | Cancer Treatment Research | The Children's Hospital of Philadelphia | 03/01/12 | 02/28/14 | 93.395 | $ 8,326.26 |
| Department of Health and Human Services | Cancer Treatment Research | University of Connecticut Health Center | 07/01/13 | 06/30/14 | 93.395 | $ 15,968.00 |
| Department of Health and Human Services | Cancer Treatment Research | University of Connecticut Health Center | 08/09/12 | 06/30/13 | 93.395 | $ 69,720.34 |
| Department of Health and Human Services | Cancer Treatment Research | The Children's Hospital of Philadelphia | 03/01/12 | 07/02/14 | 93.395 | $ 71,427.01 |
| Department of Health and Human Services | ARRA - Trans-NIH Recovery Act Research Support | Duke University | 06/18/10 | 08/31/12 | 93.701 | $ 5,639.21 |
| Department of Health and Human Services | ARRA - Trans-NIH Recovery Act Research Support | The University of Vermont and State Agricultural College | 09/17/10 | 08/31/13 | 93.701 | $ 141,223.42 |
| Department of Health and Human Services | Lung Diseases Research | University of Pennsylvania | 04/01/11 | 03/31/13 | 93.838 | $ 5,535.97 |
| Department of Health and Human Services | Lung Diseases Research | University of Connecticut Health Center | 07/01/12 | 06/30/13 | 93.838 | $ 80,531.34 |
| Department of Health and Human Services | Lung Diseases Research | University of Connecticut Health Center | 07/01/13 | 06/30/14 | 93.838 | $ 27,422.15 |
| Department of Health and Human Services | Blood Diseases and Resources Research | N/A | 01/09/09 | 12/31/13 | 93.839 | $ 76,868.15 |
| Department of Health and Human Services | Arthritis, Musculoskeletal and Skin Diseases Research | Children's Hospital Medical Center | 08/01/12 | 07/31/13 | 93.846 | $ 142.28 |
| Department of Health and Human Services | Diabetes, Digestive, and Kidney Diseases Extramural Research | George Washington University | 03/01/10 | 02/28/14 | 93.847 | $ 4,369.23 |
| Department of Health and Human Services | Diabetes, Digestive, and Kidney Diseases Extramural Research | N/A | 05/01/12 | 04/30/14 | 93.847 | $ 1,694,425.14 |

| Agency Name | Program Name | Intermediary Funding Source | Grant start date | Grant end date | CFDA # | FY2013 Expenditures |
|---|---|---|---|---|---|---|
| Department of Health and Human Services | Extramural Research Programs in the Neurosciences and Neurological Disorders | Wayne State University | 08/01/11 | 07/31/13 | 93.853 | $ 14,824.93 |
| Department of Health and Human Services | Allergy, Immunology and Transplantation Research | N/A | 09/01/08 | 07/31/13 | 93.855 | $ 109,194.74 |
| Department of Health and Human Services | Allergy, Immunology and Transplantation Research | University of Connecticut Health Center | 07/01/12 | 06/30/13 | 93.855 | $ 62,797.45 |
| Department of Health and Human Services | Allergy, Immunology and Transplantation Research | University of Connecticut Health Center | 07/01/13 | 06/30/14 | 93.855 | $ 10,440.32 |
| Department of Health and Human Services | Allergy, Immunology and Transplantation Research | Massachusetts General Hospital | 09/01/12 | 08/31/13 | 93.855 | $ 14,815.99 |
| Department of Health and Human Services | Allergy, Immunology and Transplantation Research | Massachusetts General Hospital | 09/01/13 | 08/31/14 | 93.855 | $ 1,287.34 |
| Department of Health and Human Services | Child Health and Human Development Extramural Research | Children's Hospital Medical Center | 08/01/11 | 07/31/13 | 93.865 | $ 27,535.06 |
| Department of Health and Human Services | Child Health and Human Development Extramural Research | Children's Hospital Medical Center | 08/01/13 | 07/31/14 | 93.865 | $ 6,925.07 |
| Department of Health and Human Services | Child Health and Human Development Extramural Research | N/A | 06/01/13 | 03/31/14 | 93.865 | $ 74,226.62 |
| Department of Health and Human Services | IL-1 Inhibition in systematic Juvenile Idiopathic Arthritis, Randomize, Double Blinded Placebo Controlled Multicenter Trial | Montefiore Medical Center | 07/01/08 | 12/31/12 | 93.HHSN2682 | $ 12,229.21 |
| Department of Health and Human Services | National Center for Research Resources | University of Connecticut Health Center | 07/01/12 | 06/30/13 | 93.389 | $ 9,353.00 |
| Department of Health and Human Services | Maternal and Child Health Federal Consolidated Programs | State of Connecticut Department of Public Health | 07/01/12 | 06/30/13 | 93.110 | $ 25,751.28 |
| Department of Health and Human Services | Maternal and Child Health Federal Consolidated Programs | State of Connecticut Department of Public Health | 07/01/13 | 06/30/14 | 93.110 | $ 6,693.10 |

| Agency Name | Program Name | Intermediary Funding Source | Grant start date | Grant end date | CFDA # | FY2013 Expenditures |
|---|---|---|---|---|---|---|
| Department of Health and Human Services | Maternal and Child Health Federal Consolidated Programs | District of Columbia Department of Health | 04/22/13 | 04/21/14 | 93.110 | $ 35,453.45 |
| Department of Health and Human Services | Maternal and Child Health Services Block Grant to the States | State of Connecticut Department of Public Health | 07/01/12 | 06/30/13 | 93.994 | $ 140,239.34 |
| Department of Health and Human Services | Maternal and Child Health Services Block Grant to the States | State of Connecticut Department of Public Health | 07/01/13 | 06/30/14 | 93.994 | $ 47,247.99 |
| Department of Health and Human Services | Maternal and Child Health Services Block Grant to the States | State of Connecticut Department of Public Health | 10/01/12 | 09/30/13 | 93.994 | $ 29,744.31 |
| Department of Health and Human Services | Coordinated Services and Access to Research for Women, Infants, Children, and Youth | University of Connecticut Health Center | 08/01/12 | 07/31/13 | 93.153 | $ 30,166.41 |
| Department of Health and Human Services | Coordinated Services and Access to Research for Women, Infants, Children, and Youth | University of Connecticut Health Center | 08/01/13 | 07/31/14 | 93.153 | $ 3,150.37 |
| Department of Health and Human Services | Stephanie Tubbs Jones Child Welfare Services Program | State of Connecticut Department of Children and Families | 07/01/12 | 06/30/13 | 93.645 | $ 165,735.64 |
| Department of Health and Human Services | Stephanie Tubbs Jones Child Welfare Services Program | State of Connecticut Department of Children and Families | 07/01/13 | 06/30/14 | 93.645 | $ 47,455.07 |
| Department of Health and Human Services | Children's Health Insurance Program | State of Connecticut Department of Social Services | 07/01/12 | 06/30/13 | 93.767 | $ 359,644.61 |
| Department of Health and Human Services | Children's Health Insurance Program | State of Connecticut Department of Social Services | 07/01/13 | 06/30/14 | 93.767 | $ 100,430.30 |
| Department of Health and Human Services | Grants for Primary Care Training and Enhancement | University of Connecticut Health Center | 07/01/12 | 06/30/13 | 93.884 | $ 35,518.81 |
| Department of Health and Human Services | Grants for Primary Care Training and Enhancement | University of Connecticut Health Center | 07/01/13 | 06/30/14 | 93.884 | $ 12,310.26 |

| Agency Name | Program Name | Intermediary Funding Source | Grant start date | Grant end date | CFDA # | FY2013 Expenditures |
|---|---|---|---|---|---|---|
| Department of Health and Human Services | National Bioterrorism Hospital Preparedness Program | State of Connecticut Department of Public Health | 07/01/12 | 06/30/13 | 93.889 | $ 17,940.27 |
| Department of Health and Human Services | National Bioterrorism Hospital Preparedness Program | State of Connecticut Department of Public Health | 07/01/13 | 06/30/14 | 93.889 | $ 6,582.67 |
| Department of Health and Human Services | National Bioterrorism Hospital Preparedness Program | State of Connecticut Department of Public Health | 07/01/12 | 06/30/13 | 93.889 | $ 18,751.91 |
| Department of Health and Human Services | National Bioterrorism Hospital Preparedness Program | State of Connecticut Department of Public Health | 07/01/13 | 06/30/14 | 93.889 | $ 6,257.04 |
| Department of Health and Human Services | National Bioterrorism Hospital Preparedness Program | State of Connecticut Department of Public Health | 07/01/12 | 06/30/13 | 93.889 | $ 21,383.17 |
| Department of Health and Human Services | National Bioterrorism Hospital Preparedness Program | State of Connecticut Department of Public Health | 07/01/13 | 06/30/14 | 93.889 | $ 7,514.58 |
| Department of Health and Human Services | HIV Emergency Relief Project Grants | University of Connecticut Health Center | 03/01/12 | 02/28/13 | 93.914 | $ 25,555.71 |
| Department of Health and Human Services | HIV Emergency Relief Project Grants | University of Connecticut Health Center | 03/01/13 | 02/28/14 | 93.914 | $ 28,735.56 |
| Department of Health and Human Services | Immunization Cooperative Agreements | State of Connecticut Department of Public Health | 10/01/12 | 09/30/13 | 93.268 | $ 31,128.75 |

| Agency Name | Program Name | Intermediary Funding Source | Grant start date | Grant end date | CFDA # | FY2014 Expenditures |
|---|---|---|---|---|---|---|
| Department of Health and Human Services | Disabilities Prevention | American Thrombosis and Hemostais Network/University of Massachusetts | 09/30/13 | 09/29/14 | 93.184 | $ 22,155.99 |
| Department of Health and Human Services | Disabilities Prevention | American Thrombosis and Hemostais Network/University of Massachusetts | 09/30/14 | 09/29/15 | 93.184 | $ 96.49 |
| Department of Health and Human Services | Centers for Disease Control and Prevention_Investigations and Technical Assistance | N/A | 09/30/11 | 08/29/14 | 93.283 | $ 41,135.99 |
| Department of Health and Human Services | Cancer Treatment Research | University of Connecticut Health Center | 07/01/13 | 06/30/14 | 93.395 | $ 47,916.99 |
| Department of Health and Human Services | Cancer Treatment Research | University of Connecticut Health Center | 07/01/14 | 06/30/15 | 93.395 | $ 16,479.49 |
| Department of Health and Human Services | Lung Diseases Research | University of Connecticut Health Center | 07/01/13 | 06/30/14 | 93.838 | $ 80,966.33 |
| Department of Health and Human Services | Lung Diseases Research | University of Connecticut Health Center | 07/01/14 | 06/30/15 | 93.838 | $ 27,308.49 |
| Department of Health and Human Services | Diabetes, Digestive, and Kidney Diseases Extramural Research | N/A | 05/01/12 | 04/30/15 | 93.847 | $ 2,137,399.82 |
| Department of Health and Human Services | Allergy, Immunology and Transplantation Research | University of Connecticut Health Center | 07/01/13 | 06/30/14 | 93.855 | $ 46,285.01 |
| Department of Health and Human Services | Allergy, Immunology and Transplantation Research | Massachusetts General Hospital | 09/01/13 | 08/31/14 | 93.855 | $ 6,635.66 |
| Department of Health and Human Services | Allergy, Immunology and Transplantation Research | Oregon Health & Science University/University of Connecticut Health Center | 07/01/13 | 12/31/14 | 93.855 | $ 22,531.47 |
| Department of Health and Human Services | Allergy, Immunology and Transplantation Research | University of Connecticut Health Center | 07/01/14 | 06/30/15 | 93.855 | $ 14,646.08 |
| Department of Health and Human Services | Allergy, Immunology and Transplantation Research | University of Connecticut Health Center | 07/17/14 | 06/30/15 | 93.855 | $ 6,647.53 |
| Department of Health and Human Services | Child Health and Human Development Extramural Research | Cincinnati Children's Hospital Medical Center | 08/01/13 | 07/31/14 | 93.865 | $ 26,208.25 |

| Agency Name | Program Name | Intermediary Funding Source | Grant start date | Grant end date | CFDA # | FY2014 Expenditures |
|---|---|---|---|---|---|---|
| Department of Health and Human Services | Child Health and Human Development Extramural Research | N/A | 06/01/13 | 03/31/15 | 93.865 | $ 254,049.21 |
| Department of Health and Human Services | Child Health and Human Development Extramural Research | University of Connecticut | 09/01/14 | 02/28/15 | 93.865 | $ 1,694.67 |
| Department of Health and Human Services | Drug Abuse and Addiction Research Programs | University of Connecticut Health Center | 08/01/14 | 07/31/15 | 93.279 | $ 3,347.63 |
| Department of Health and Human Services | Alcohol Research Programs | University of Connecticut Health Center | 08/01/14 | 06/30/15 | 93.273 | $ 1,085.53 |
| Department of Health and Human Services | Maternal and Child Health Federal Consolidated Programs | State of Connecticut Department of Public Health | 07/01/13 | 06/30/14 | 93.110 | $ 28,100.07 |
| Department of Health and Human Services | Maternal and Child Health Federal Consolidated Programs | District of Columbia Department of Health | 04/22/13 | 05/30/14 | 93.110 | $ 116,444.85 |
| Department of Health and Human Services | Maternal and Child Health Services Block Grant to the States | State of Connecticut Department of Public Health | 07/01/13 | 06/30/14 | 93.994 | $ 140,473.01 |
| Department of Health and Human Services | Maternal and Child Health Services Block Grant to the States | State of Connecticut Department of Public Health | 07/01/14 | 06/30/15 | 93.994 | $ 1,446.48 |
| Department of Health and Human Services | Maternal and Child Health Services Block Grant to the States | State of Connecticut Department of Public Health | 07/01/14 | 06/30/15 | 93.994 | $ 51,004.75 |
| Department of Health and Human Services | Coordinated Services and Access to Research for Women, Infants, Children, and Youth | University of Connecticut Health Center | 08/01/13 | 07/31/14 | 93.153 | $ 13,399.63 |
| Department of Health and Human Services | Coordinated Services and Access to Research for Women, Infants, Children, and Youth | University of Connecticut Health Center | 08/01/14 | 07/31/15 | 93.153 | $ 2,940.04 |
| Department of Health and Human Services | Stephanie Tubbs Jones Child Welfare Services Program | State of Connecticut Department of Children and Families | 07/01/13 | 06/30/14 | 93.645 | $ 167,796.93 |
| Department of Health and Human Services | Stephanie Tubbs Jones Child Welfare Services Program | State of Connecticut Department of Children and Families | 07/01/14 | 06/30/15 | 93.645 | $ 55,388.71 |

| Agency Name | Program Name | Intermediary Funding Source | Grant start date | Grant end date | CFDA # | FY2014 Expenditures |
|---|---|---|---|---|---|---|
| Department of Health and Human Services | Children's Health Insurance Program | State of Connecticut Department of Social Services | 07/01/13 | 06/30/14 | 93.767 | $ 354,458.76 |
| Department of Health and Human Services | Children's Health Insurance Program | State of Connecticut Department of Social Services | 07/01/14 | 06/30/15 | 93.767 | $ 101,001.32 |
| Department of Health and Human Services | Grants for Primary Care Training and Enhancement | University of Connecticut Health Center | 07/01/13 | 06/30/14 | 93.884 | $ 29,668.28 |
| Department of Health and Human Services | Grants for Primary Care Training and Enhancement | University of Connecticut Health Center | 07/01/14 | 06/30/15 | 93.884 | $ 12,311.11 |
| Department of Health and Human Services | National Bioterrorism Hospital Preparedness Program | State of Connecticut Department of Public Health | 07/01/13 | 06/30/14 | 93.889 | $ 22,247.64 |
| Department of Health and Human Services | National Bioterrorism Hospital Preparedness Program | State of Connecticut Department of Public Health | 07/01/13 | 06/30/14 | 93.889 | $ 18,742.96 |
| Department of Health and Human Services | National Bioterrorism Hospital Preparedness Program | State of Connecticut Department of Public Health | 07/01/13 | 06/30/14 | 93.889 | $ 18,070.58 |
| Department of Health and Human Services | National Bioterrorism Hospital Preparedness Program | State of Connecticut Department of Public Health | 07/01/14 | 06/30/15 | 93.889 | $ 7,811.59 |
| Department of Health and Human Services | National Bioterrorism Hospital Preparedness Program | State of Connecticut Department of Public Health | 07/01/14 | 06/30/15 | 93.889 | $ 4,997.19 |
| Department of Health and Human Services | National Bioterrorism Hospital Preparedness Program | State of Connecticut Department of Public Health | 07/01/14 | 06/30/15 | 93.889 | $ 4,916.96 |
| Department of Health and Human Services | HIV Emergency Relief Project Grants | University of Connecticut Health Center | 03/01/13 | 02/28/14 | 93.914 | $ 15,237.62 |
| Department of Health and Human Services | HIV Emergency Relief Project Grants | University of Connecticut Health Center | 03/01/14 | 02/28/15 | 93.914 | $ 29,071.60 |
| Department of Health and Human Services | Immunization Cooperative Agreements | State of Connecticut Department of Public Health | 10/01/13 | 09/30/14 | 93.268 | $ 530,860.00 |

| Agency Name | Program Name | Intermediary Funding Source | Grant start date | Grant endd date | CFDA # | Fy2015 Expenditures |
|---|---|---|---|---|---|---|
| Department of Education | Special Education-Grants for Infants | Minnesota Department of Education | 09/30/14 | 09/29/15 | 84.181 | $ 109,000.00 |
| Department of Health and Human Services | Maternal and Child Health Federal C | Wyoming Department of Health | 06/01/14 | 07/31/15 | 93.110 | $ 53,256.00 |
| Department of Health and Human Services | Maternal and Child Health Federal C | Epilepsy Foundation of New Jersey | 07/01/15 | 06/30/16 | 93.11 | $ 6,000.00 |
| Department of Health and Human Services | Coordinated Services and Access to Research for Women, Infants, Children, and Youth | University of Connecticut Health Center | 08/01/2014 | 07/31/2015 | 93.153 | $ 7,386.82 |
| Department of Health and Human Services | Coordinated Services and Access to Research for Women, Infants, Children, and Youth | University of Connecticut Health Center | 08/01/15 | 07/31/16 | 93.153 | $ 1,889.27 |
| Department of Health and Human Services | Disabilities Prevention | American Thrombosis and Hemostais Network/University of | 09/30/14 | 9/29/2015 | 93.184 | 24,358.62 |
| Department of Health and Human Services | Mental Health Research Grants | University of Connecticut | 08/01/15 | 1/31/2016 | 93.242 | 2,437.37 |
| Department of Health and Human Services | Alcohol Research Programs | Rhode Island Hospital | 09/20/15 | 9/19/2016 | 93.273 | 348.22 |
| Department of Health and Human Services | Alcohol Research Programs | University of Connecticut Health Center | 08/01/2014 | 7/31/2016 | 93.273 | 9,062.39 |
| Department of Health and Human Services | Drug Abuse and Addiction Research Programs | University of Connecticut Health Center | 08/01/2014 | 7/31/2016 | 93.279 | 21,283.89 |
| Department of Health and Human Services | Cancer Treatment Research | Childrens Hospital of Philadelphia | 03/01/14 | 2/29/2016 | 93.395 | 56,640.00 |
| Department of Health and Human Services | Cancer Treatment Research | Childrens Hospital of Philadelphia | 03/01/14 | 2/29/2016 | 93.395 | 10,000.00 |
| Department of Health and Human Services | Cancer Treatment Research | Childrens Hospital of Philadelphia | 03/01/14 | 2/29/2016 | 93.395 | 7,500.00 |
| Department of Health and Human Services | Cancer Treatment Research | University of Connecticut Health Center | 07/01/2014 | 06/30/2015 | 93.395 | 51,884.68 |
| Department of Health and Human Services | Cancer Treatment Research | University of Connecticut Health Center | 07/01/15 | 6/30/2016 | 93.395 | 19,934.97 |
| Department of Health and Human Services | Professional and Technical Services | Missouri Department of Health and Senior Services | 12/01/14 | 09/30/15 | 93.505 | $ 97,524.00 |
| Department of Health and Human Services | Stephanie Tubbs Jones Child Welfare Services Program | State of Connecticut Department of Children and Families | 07/01/2014 | 06/30/2015 | 93.645 | $ 165,111.29 |
| Department of Health and Human Services | Stephanie Tubbs Jones Child Welfare Services Program | State of Connecticut Department of Children and Families | 07/01/15 | 06/30/16 | 93.645 | $ 54,547.12 |
| Department of Health and Human Services | Children's Health Insurance Program | State of Connecticut Department of Health and Human Services | 07/01/2014 | 06/30/2015 | 93.767 | $ 331,528.58 |

| Agency Name | Program Name | Intermediary Funding Source | Grant start date | Grant endd date | CFDA # | Fy2015 Expenditures |
|---|---|---|---|---|---|---|
| Department of Health and Human Services | Children's Health Insurance Program | State of Connecticut Department of Health and Human Services | 07/01/15 | 06/30/16 | 93.767 | $ 81,087.00 |
| Department of Health and Human Services | Cardiovascular Diseases Research | n/a | 09/09/15 | 8/31/2016 | 93.837 | 11,725.24 |
| Department of Health and Human Services | Lung Diseases Research | University of Connecticut Health Center | 07/01/2014 | 06/30/2015 | 93.838 | 81,850.14 |
| Department of Health and Human Services | Lung Diseases Research | University of Connecticut Health Center | 05/15/15 | 3/31/2016 | 93.838 | 15,019.39 |
| Department of Health and Human Services | Arthritis, Musculoskeletal and Skin Diseases Research | Cincinnati Children's Hospital Medical Center | 08/01/10 | 7/31/2015 | 93.846 | 2,496.00 |
| Department of Health and Human Services | Arthritis, Musculoskeletal and Skin Diseases Research | Cincinnati Children's Hospital Medical Center | 04/01/15 | 3/31/2016 | 93.846 | 13,629.16 |
| Department of Health and Human Services | Diabetes, Digestive, and Kidney Diseases Extramural Research | n/a | 05/01/2012 | 04/30/2017 | 93.847 | 2,035,259.20 |
| Department of Health and Human Services | Diabetes, Digestive, and Kidney Diseases Extramural Research | George Washington University | 3/1/2010 | 2/28/2015 | 93.847 | 1,040.00 |
| Department of Health and Human Services | Allergy and Infectious Diseases Research | University of Connecticut Health Center | 07/01/2014 | 11/30/2015 | 93.855 | 44,056.37 |
| Department of Health and Human Services | Allergy and Infectious Diseases Research | University of Connecticut Health Center | 07/17/2014 | 6/30/2016 | 93.855 | 12,818.98 |
| Department of Health and Human Services | Allergy and Infectious Diseases Research | University of Connecticut Health Center | 07/01/15 | 6/30/2016 | 93.855 | 48,434.34 |
| Department of Health and Human Services | Allergy and Infectious Diseases Research | University of Connecticut Health Center | 07/01/2013 | 12/31/2014 | 93.855 | 2,559.67 |
| Department of Health and Human Services | Child Health and Human Development Extramural Research | n/a | 06/01/2013 | 03/31/2015 | 93.865 | 124,726.64 |
| Department of Health and Human Services | Child Health and Human Development Extramural Research | University of Connecticut | 09/01/2014 | 02/28/2015 | 93.865 | 8,772.33 |
| Department of Health and Human Services | Child Health and Human Development Extramural Research | Drexel University | 03/01/15 | 5/31/2016 | 93.865 | 18,144.70 |
| Department of Health and Human Services | Grants for Primary Care Training and Enhancement | University of Connecticut Health Center | 07/01/2014 | 06/30/2015 | 93.884 | $ 34,506.49 |
| Department of Health and Human Services | National Bioterrorism Hospital Preparedness Program | State of Connecticut Department of Health | 07/01/2014 | 06/30/2015 | 93.889 | $ 18,774.41 |
| Department of Health and Human Services | National Bioterrorism Hospital Preparedness Program | State of Connecticut Department of Health | 07/01/2014 | 06/30/2015 | 93.889 | $ 15,002.81 |
| Department of Health and Human Services | National Bioterrorism Hospital Preparedness Program | State of Connecticut Department of Health | 07/01/2014 | 06/30/2015 | 93.889 | $ 14,547.04 |

| Agency Name | Program Name | Intermediary Funding Source | Grant start date | Grant endd date | CFDA # | Fy2015 Expenditures |
|---|---|---|---|---|---|---|
| Department of Health and Human Services | National Bioterrorism Hospital Preparedness Program | State of Connecticut Department of Health | 07/01/15 | 06/30/16 | 93.889 | $ 4,185.60 |
| Department of Health and Human Services | National Bioterrorism Hospital Preparedness Program | State of Connecticut Department of Health | 07/01/15 | 06/30/16 | 93.889 | $ 5,097.16 |
| Department of Health and Human Services | National Bioterrorism Hospital Preparedness Program | State of Connecticut Department of Health | 07/01/15 | 06/30/16 | 93.889 | $ 4,661.40 |
| Department of Health and Human Services | HIV Emergency Relief Project Grants | University of Connecticut Health Center | 03/01/2014 | 02/28/2015 | 93.914 | $ 23,560.40 |
| Department of Health and Human Services | HIV Emergency Relief Project Grants | City of Hartford | 03/01/15 | 02/28/16 | 93.914 | $ 50,802.29 |
| Department of Health and Human Services | Maternal and Child Health Services Block Grant to the States | State of Connecticut Department of Health | 07/01/2014 | 06/30/2015 | 93.994 | $ 153,111.38 |
| Department of Health and Human Services | Maternal and Child Health Services Block Grant to the States | State of Connecticut Department of Health | 07/01/15 | 06/30/16 | 93.994 | $ 51,056.33 |
| Department of Health and Human Services | Maternal and Child Health Services Block Grant to the States | State of Connecticut Department of Health | 07/01/15 | 06/30/16 | 93.994 | $ 2,585.26 |
| Department of Health and Human Services | Maternal and Child Health Services Block Grant to the States | State of Connecticut Department of Health | 07/01/2014 | 06/30/2015 | 93.994 | $ 18,553.52 |
| Department of Education | Race to the Top Early Learning Challenge | Vermont Department of Education | 07/01/14 | 12/31/15 | 84.412A | $ 113,069.00 |
| Department of Health and Human Services | Affordable Care Act (ACA) Maternal, | Maine Quality Counts | 07/01/15 | 09/30/15 | 93.505 & 93.991 | $ 18,000.00 |

| Agency Name | Program Name | Intermediary Funding Source | Grant Start Date | Grant end Date | CFDA # | FY16 Expenditures |
|---|---|---|---|---|---|---|
| Department of Health and Human Services | Blood Disorder Program: Prevention, Surveillance, and Research | University of Massachusetts | 09/30/15 | 9/29/2016 | 93.08 | $ 24,573.81 |
| Department of Health and Human Services | Injury Prevention and Control Research and State and Community Based Programs | State of Connecticut Department of Public Health | 2/1/2016 | 8/31/2016 | 93.136 | $ 23,490.00 |
| Department of Health and Human Services | Injury Prevention and Control Research and State and Community Based Programs | State of Connecticut Department of Public Health | 9/1/2016 | 8/31/2017 | 93.136 | $ 5,828.67 |
| Department of Health and Human Services | Coordinated Services and Access to Research for Women, Infants, Children, and Youth | University of Connecticut Health Center | 08/01/15 | 07/31/16 | 93.153 | $ 1,941.01 |
| Department of Health and Human Services | Coordinated Services and Access to Research for Women, Infants, Children, and Youth | University of Connecticut Health Center | 1/1/2016 | 7/31/2016 | 93.153 | $ 11,148.40 |
| Department of Health and Human Services | Coordinated Services and Access to Research for Women, Infants, Children, and Youth | University of Connecticut Health Center | 8/1/2016 | 7/31/2017 | 93.153 | $ 2,656.11 |
| Department of Health and Human Services | Mental Health Research Grants | University of Connecticut | 08/01/15 | 1/31/2016 | 93.242 | $ 4,912.95 |
| Department of Health and Human Services | Alcohol Research Programs | University of Connecticut Health Center | 08/01/2014 | 7/31/2017 | 93.273 | $ 5,444.61 |
| Department of Health and Human Services | Alcohol Research Programs | Rhode Island Hospital | 09/20/15 | 8/31/2017 | 93.273 | $ 33,664.28 |
| Department of Health and Human Services | Drug Abuse and Addiction Rese | University of Connecticut Health Center | 08/01/2014 | 7/31/2016 | 93.279 | $ 14,997.05 |
| Department of Health and Human Services | Cancer Treatment Research | Children's Hospital of Philadelphia | 03/01/14 | 2/29/2019 | 93.395 | $ 12,397.65 |
| Department of Health and Human Services | Cancer Treatment Research | Children's Hospital of Philadelphia | 03/01/14 | 2/29/2016 | 93.395 | $ 65,875.00 |
| Department of Health and Human Services | Cancer Treatment Research | Children's Hospital of Philadelphia | 03/01/14 | 2/29/2019 | 93.395 | $ 6,426.41 |
| Department of Health and Human Services | Cancer Treatment Research | University of Connecticut Health Center | 07/01/15 | 6/30/2016 | 93.395 | $ 50,115.03 |

| Agency Name | Program Name | Intermediary Funding Source | Grant Start Date | Grant end Date | CFDA # | FY16 Expenditures |
|---|---|---|---|---|---|---|
| Department of Health and Human Services | Stephanie Tubbs Jones Child Welfare Services Program | State of Connecticut Department of Children and Families | 07/01/15 | 06/30/16 | 93.645 | $ 165,952.88 |
| Department of Health and Human Services | Stephanie Tubbs Jones Child Welfare Services Program | State of Connecticut Department of Children and Families | 7/1/2016 | 6/30/2017 | 93.645 | $ 42,681.39 |
| Department of Health and Human Services | Child Abuse and Neglect State Grants | State of Connecticut Department of Children and Families | 10/01/15 | 6/30/2016 | 93.669 | $ 35,390.95 |
| Department of Health and Human Services | Children's Health Insurance Program | State of Connecticut Department of Social Services | 07/01/15 | 06/30/16 | 93.767 | $ 409,673.00 |
| Department of Health and Human Services | Children's Health Insurance Program | State of Connecticut Department of Social Services | 07/01/16 | 06/30/17 | 93.767 | $ 108,138.72 |
| Department of Health and Human Services | Cardiovascular Diseases Research | n/a | 09/09/15 | 8/31/2017 | 93.837 | $ 295,540.65 |
| Department of Health and Human Services | Lung Diseases Research | University of Connecticut Health Center | 05/15/15 | 3/31/2017 | 93.838 | $ 55,938.89 |
| Department of Health and Human Services | Arthritis, Musculoskeletal and Skin Diseases Research | Cincinnati Children's Hospital and Medical Center | 04/01/15 | 3/31/2016 | 93.846 | $ 12,956.17 |
| department of Health and Human Services | Diabetes, Digestive, and Kidney Diseases Extramural Research | n/a | 05/01/2012 | 04/30/2017 | 93.847 | $ 2,076,316.75 |
| Department of Health and Human Services | Allergy and Infectious Diseases Research | University of Connecticut Health Center | 07/01/2014 | 11/30/2015 | 93.855 | $ 8,295.21 |
| Department of Health and Human Services | Allergy and Infectious Diseases Research | University of Connecticut Health Center | 07/17/2014 | 6/30/2017 | 93.855 | $ 2,415.00 |
| Department of Health and Human Services | Allergy and Infectious Diseases Research | University of Connecticut Health Center | 07/01/15 | 6/30/2016 | 93.855 | $ 124,573.55 |
| Department of Health and Human Services | Child Health and Human Development Extramural Research | n/a | 06/01/2013 | 3/31/2016 | 93.865 | $ 77.66 |
| Department of Health and Human Services | Child Health and Human Development Extramural Research | Drexel University | 03/01/15 | 5/31/2017 | 93.865 | $ 11,735.47 |
| Department of Health and Human Services | Child Health and Human Development Extramural Research | n/a | 09/01/16 | 8/31/2017 | 93.865 | $ 2,489.01 |
| Department of Health and Human Services | National Bioterrorism Hospital Preparedness Program | State of Connecticut Department of Public Health | 07/01/16 | 06/30/17 | 93.889 | $ 22,419.40 |

| Agency Name | Program Name | Intermediary Funding Source | Grant Start Date | Grant end Date | CFDA # | FY16 Expenditures |
|---|---|---|---|---|---|---|
| Department of Health and Human Services | National Bioterrorism Hospital Preparedness Program | State of Connecticut Department of Public Health | 07/01/16 | 06/30/17 | 93.889 | $ 14,507.84 |
| Department of Health and Human Services | National Bioterrorism Hospital Preparedness Program | State of Connecticut Department of Public Health | 07/01/16 | 06/30/17 | 93.889 | $ 15,242.60 |
| Department of Health and Human Services | National Bioterrorism Hospital Preparedness Program | State of Connecticut Department of Public Health | 07/01/16 | 06/30/17 | 93.889 | $ 3,534.00 |
| Department of Health and Human Services | National Bioterrorism Hospital Preparedness Program | State of Connecticut Department of Public Health | 07/01/16 | 06/30/17 | 93.889 | $ 5,096.11 |
| Department of Health and Human Services | National Bioterrorism Hospital Preparedness Program | State of Connecticut Department of Public Health | 7/1/2016 | 6/30/2017 | 93.889 | $ 4,781.23 |
| Department of Health and Human Services | National Bioterrorism Hospital Preparedness Program | State of Connecticut Department of Public Health | 7/1/2016 | 6/30/2017 | 93.889 | $ 4,010.44 |
| Department of Health and Human Services | HIV Emergency Relief Project Grants | City of Hartford | 03/01/15 | 02/28/16 | 93.914 | $ 58,553.99 |
| Department of Health and Human Services | HIV Emergency Relief Project Grants | City of Hartford | 3/1/2016 | 2/28/2017 | 93.914 | $ 58,359.67 |
| Department of Health and Human Services | Block Grants for Community Mental Health Services | State of Connecticut Department of Children and Families | 11/1/2015 | 6/30/2016 | 93.958 | $ 44,343.00 |
| Department of Health and Human Services | Block Grants for Community Mental Health Services | State of Connecticut Department of Children and Families | 7/1/2016 | 6/30/2017 | 93.958 | $ 13,786.01 |
| Department of Health and Human Services | Maternal and Child Health Services Block Grant to the States | State of Connecticut Department of Public Health | 07/01/15 | 06/30/16 | 93.994 | $ 153,848.29 |
| Department of Health and Human Services | Maternal and Child Health Services Block Grant to the States | State of Connecticut Department of Public Health | 07/01/15 | 06/30/16 | 93.994 | $ 17,414.32 |
| Department of Health and Human Services | Maternal and Child Health Services Block Grant to the States | State of Connecticut Department of Public Health | 7/1/2016 | 6/30/2017 | 93.994 | $ 51,168.20 |
| Department of Health and Human Services | Maternal and Child Health Services Block Grant to the States | State of Connecticut Department of Public Health | 7/1/2016 | 6/30/2017 | 93.994 | $ 5,141.71 |

Mr. COLE. Thank you. That is pretty good, only 12 seconds over. [Laughter.]

You set the bar high for everybody else. We thank you very much for your testimony.

Mr. SHMERLING. Thank you.

Mr. COLE. We will hear from our next witness, please. Welcome. We have, is it Erin, is it Shiffring?

Ms. SIEFRING. Siefring.

Mr. COLE. Siefring. Thank you very much. Again, forgive me for butchering names, to testify on behalf of the Computer Science Education Coalition. So, the gentlelady is recognized for 5 minutes, and we would be delighted to receive your testimony.

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WEDNESDAY, MARCH 8, 2017.

## COMPUTER SCIENCE EDUCATION COALITION

### WITNESS

### ERIN SIEFRING, CHAIR, COMPUTER SCIENCE EDUCATION COALITION

Ms. SIEFRING. Thank you. Chairman Cole and Ranking Member DeLauro, I am Erin Siefring, chair of the Computer Science Education Coalition. Thank you for the opportunity to testify before you and all the members of the subcommittee today on a critical issue that greatly impacts the economic competitiveness and national security of the United States, K through 12 computer science education.

Our country is falling far behind in this area with real impacts to our homeland security and our economic base. Prioritizing funding at the Department of Education for computer science education by the subcommittee can address this problem and give Americans the tools they need to protect our country and grow the economy.

Computer science is a foundational skill for 21st century jobs. This skill is in high demand in our military and throughout the private sector. However, the United States is failing to take the necessary steps to equip our current and future workforce with the computer science skills needed to fill these positions to remain globally competitive.

The crisis in computer science funding extends to defending the homeland against cyber threats. Cybersecurity attacks against the United States are on the rise. But as the Center for Strategic and International Studies explains, there are only about a thousand security specialists in the United States who have the specialized skills to operate effectively in cyberspace. However, the United States needs about 10,000 to 30,000 such individuals.

This shortage decreases our country's ability to defend itself in a time where a single bad actor with an advanced knowledge of computers, networks, and cybersecurity can do immense damage to the United States just by hitting the enter key on their laptop. To reverse this trend and bolster our national security, an investment in computer science education is needed now. Failure to make this investment in a timely manner will only compound the problem going forward and increase the national security risk to the United States.

Already less than half of K through 12 classrooms in the United States teach computer science. Yet according to Code.org, computer science-based employment will make up two-thirds of all projected new jobs in the science, technology, engineering, and mathematics, or STEM, fields. The United States K through 12 education system simply is not graduating students with the computer science skills needed to meet the current or growing demand for computer science jobs.

Today's students need to be learning about algorithms, how to make an app, code, or do robotics. These are the critical thinking skills today's students need to become the innovators and cyber warriors of tomorrow. These skills are needed throughout the economy. There are currently over 50,000 good paying computing jobs unfilled across the country. They are unfilled in large part because we are not making the investment necessary in computer science education. Indeed, computing jobs are the number one source of new wages in the United State.

To fill these job openings in recent years, American companies have often had to import talent from across the globe. In fact, the majority of high-skilled immigration is for computer scientists, and almost 60 percent of skilled worker visas granted were for computer science operations. Our failure to invest in our future has forced U.S. businesses to recruit overseas for positions that could be filled domestically.

To address this issue, last year America's leading CEOs, educators, and nonprofit leaders united with 28 Republican and Democrat governors, including then Governor Mike Pence, to send a letter to Congress asking for funding to provide every student in every school the opportunity to learn computer science. The signatories included Fortune 100 CEOs across multiple industries, which illustrates how many sectors of our economy are impacted by the current skills gap in computer science.

State and private efforts are vital, but not enough on their own to fix the skills gap in computer science. We are lagging behind other nations that have prioritized the teaching of this critical subject. A Federal investment is necessary to amplify and accelerate the work already being done around this issue in the United States.

Since the Computer Science Education launched a year ago today, there has been significant bipartisan support for computer science education in both the House and the Senate. The coalition appreciates the robust demonstration of bipartisan leadership.

An investment in computer science education by this subcommittee will be an investment in our country's future. The Computer Science Coalition urges the members of this subcommittee and Congress to prioritize an investment in computer science education to help defend the homeland and keep our economy strong.

Thank you for your time and attention to this critical matter.

[The information follows:]

Written Testimony of Erin Siefring, Chair of Computer Science Education Coalition, for U.S. House Appropriations subcommittee on Labor, Health and Human Services, Education, and Related Agencies

"The Impact of Computer Science Education on the National Security and Economic Competitiveness of the United States in the 21st Century"

March 8, 2017

Chairman Cole, Ranking Member DeLauro, I am Erin Siefring, chair of the Computer Science Education Coalition—a broad-based coalition with over 100 members representing a cross section of businesses, non-profits and educational organizations.

Thank you for the opportunity to testify before you and all the members of the Subcommittee on Labor, Health and Human Services, and Education today on a critical issue that greatly impacts the economic competitiveness and national security of the United States: K-12 computer science education. Our country is falling far behind in this area with real impacts to the homeland and our economic base. A prioritization by the subcommittee can address this problem, and give Americans the tools they need to protect our country and grow the economy.

Computer science is a foundational skill for 21st century jobs. This skill is in high demand in our military and throughout the private sector. However, the United States is failing to take the necessary steps to equip our current and future workforce with the computer science skills needed to fill these positions. Critical jobs throughout our economy are going unfilled due to a lack of Americans qualified in computer science. The result is a weakened homeland and an economy not reaching its potential.

Today, cybersecurity threats and espionage are on the rise, but the ability of the United States to defend itself against these kinds of attacks is on the wane due to a shortage of qualified workers in computer science.

As the Center for Strategic and International Studies explained, "There are only about 1,000 security specialists in the United States who have the specialized skills to operate effectively in cyberspace; however, the United States needs about 10,000 to 30,000 such individuals." This dearth of talent decreases our country's ability to defend itself in a time where a single actor with advanced knowledge of computers, networks and cyber security can do immense damage to the nation just by hitting the enter key on their laptop.

For example, in June 2015, the Office of Personnel Management reported that an intrusion into its systems compromised personnel records of about 4 million current and former federal employees. Records obtained by USA Today revealed that hackers infiltrated the Department of Energy's computer system over 150 times between 2010 and 2014.[1]

Cyber threats to our nation go well beyond our electric grid and strike at the heart of our economy. In fact, just in one day, a "glitch" was blamed for causing the suspension of trading on the New York Stock Exchange for nearly four hours, the grounding of all United Airlines flights, and the malfunction of the Wall Street Journal's web site. The damaging effects of these asymmetrical attacks can be mitigated if

we give our cyber warriors the education in computer science that they need. Failure to deal with this issue now will only compound the problems going forward and increase America's national security risk.

Today, less than half of K-12 classrooms across America teach computer science,[ii] yet it is projected that computing jobs will grow at double the rate of all other jobs over the next few years.[iii] According to Code.org, computer science based employment will make up two-thirds of all projected new jobs in the science, technology, engineering and mathematics, or STEM fields.

The United States simply doesn't have enough home grown talent equipped with the computer science skills needed to meet the current or growing demand for computer science jobs. There are currently over 500,000 good paying computing jobs unfilled across the country.[iv] For example, New Jersey currently has 22,593 open computing jobs.[v] The average salary for a computing occupation in the state is $100,529, almost double the average salary of $54,950[vi]. This is a trend that is happening throughout the country.

Computing jobs are the number one source of new wages in the United States. Unfortunately, our nation's failure to adequately invest in computer science has resulted in many of these jobs being lost overseas. To fill these job openings in recent years, companies have often had to import talent from across the globe. In fact, the majority of high-skilled immigration is for computer scientists[vii] and almost 60% of "skilled worker" visas granted were for computer science occupations.[viii] If we are to reverse this trend and empower our citizens to create an economy where people buy and hire in the United States, Congress must invest in K-12 computer science education now.

To compete for the jobs of this century, our students need to be learning about algorithms, how to make an app, code, or do robotics. These are the critical thinking skills today's students need to become the innovators and cyber warriors of tomorrow. And, basic computer science literacy will make them better cyber citizens.

Absent a robust pipeline of American workers trained in computer science, our economy will fall behind our competitors who have already taken significant steps to prioritize the teaching of computer science in their countries. For example, the United Kingdom and Australia have made computer science a compulsory part of their primary school curriculum, and Germany has gone as far as to make computer science mandatory at all grade levels.

American students have not been afforded the same opportunity, which limits their creative potential and employment opportunities. The jobs are there for them here at home, but our lack of investment in computer science education has put these jobs out of their reach. At the same time, our competitors are on the move, making the investments to prepare their student for computer science jobs.

Computer science skills are needed in white collar jobs and blue collar jobs. Wired Magazine highlighted the lengths to which computer science has permeated our economy in the December column, The Next Blue Collar Job is Coding.[ix]

These jobs are in areas such as machine maintenance, agriculture, and auto mechanics. For example, there are more lines of code in a modern car than the space shuttle. Without Americans to do these jobs our transportation infrastructure will be at greater risk. In order for the United States to have a robust manufacturing base, we need the roads, tunnels, and ports to bring our goods to market. We need computer science education to keep this infrastructure up to date. We need workers trained to run the

robots, and program the computers that will keep commerce humming.

While there is currently no federal funding dedicated to this critical challenge, many across the United States understand that this needs to change and have been proactive in their efforts to facilitate that change.

Virtually all parents see computer science education as a good use of resources at their child's school[x] and states and districts have been leading the charge when it comes to expanding access to computer science education in K-12 classrooms. For example, in Arkansas, Gov. Asa Hutchinson put in place a Computer Science Initiative, which calls for offering computer coding classes at every high school in the state. After he signed this bill in 2015, Gov. Hutchinson said, "Of all the big-ticket items we've dealt with this legislative session, this relatively small-ticket item may have the greatest long-term impact."[xi]

Last year, America's leading CEOs, educators, and non-profit leaders united with 28 Republican and Democratic governors to send an open letter[xii] to Congress, asking for funding to provide every student in every school the opportunity to learn computer science. The signatories included now-Vice President Mike Pence, Fortune 100 CEOs across multiple industries, such as the nation's largest technology companies, retailers, telecom firms, airlines, investment companies, entertainment companies, hotels, and manufacturers, which further illustrates how many industries are impacted by the current skills gap in computer science and have a vested interest in their being a robust pipeline of individuals with computer science skills going forward.

Industry has stepped up to the plate, as well. But, state and private efforts are not enough to move this critical subject forward. We are behind and a federal investment is necessary to amplify and accelerate the work already being done around this issue. An initial federal investment will help us to catch up and move forward on a positive trajectory.

Since the Computer Science Education Coalition launched a year ago today, bi-partisan support for computer science education has gained traction in both the House and the Senate. That bipartisan support can even be seen on this committee, where members from both sides of the aisle have been actively engaged on this issue.

On behalf of the Computer Science Education Coalition, I would like to take a moment to thank those on the committee for the time and energy they have invested in this critical issue. Specifically, Chairman Cole (R-OK) and Rep. Fleischmann (R-TN), who have been champions of this issue. Both have taken time to visit classrooms in their districts to understand first-hand what teachers, parents, and students are saying about computer science. In addition, Rep. Barbara Lee has been actively working to advance this critical subject, and introduced a Congressional resolution[xiii] last year calling for greater transparency and access to computer science education for all students to ensure greater diversity in the tech sector.

Many others in Congress have signed onto letters in support of funding K-12 computer science education. A reasonably sized redirection of existing federal funds to computer science education for our country's students will help to reverse our current trajectory. A small step from this subcommittee in support of computer science education can help secure our place as the leaders in computer innovation now and in the future.

Even with increased investment in this critical issue, we won't suddenly produce the homegrown talent we need to keep pace with future demands. It takes time to change the course of a ship the size of America. That is why focusing on K-12 computer science education is so important.

Studies show that students who are exposed at an early age are significantly more likely to pursue computer science in college. Girls who take AP computer science in high school are 10 ten times more likely to major in computer science in college. African-American and Latino students who take this course in high school are over seven times more likely to major in this field.[xiv]

In addition to the economic and national security benefits integrating the teaching of computer science into our elementary, middle, and high schools could have, exposure to computer science at a young age has the potential to address the diversity and gender gap in computer science fields.

America's shortage of qualified workers in computer science threatens America's role as an innovation leader in a globally competitive world and undermines our national security. Until computer science education is a national priority we will continue to lose jobs overseas and become less safe here at home. That's the reality of the situation.

An investment in computer science is an investment in the future of this country. The Computer Science Education Coalition urges the members of this committee and Congress to prioritize this critical subject as the development of Labor, Health and Human Services, and Education spending bill moves forward. Even with tight budgets, an investment in computer science must be prioritized as it will equip American's with the skills needed to compete for and fill computing jobs, bolster America's economic competitiveness, and help America remain safe and secure in the decades ahead.

Thank you for your time and attention to this critical matter.

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[iii] Bureau of Labor Statistics Employment Projections. https://www.bls.gov/emp/tables.htm

[iv] Code.org, Promote Computer Science. https://code.org/promote

[v] Code.org, Support K-12 Computer Science Education in New Jersey. https://code.org/advocacy/state-facts/NJ.pdf

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[viii] Office of Foreign Labor Certification, US Department of Labor. http://blog.code.org/post/116568172243/with-all-the-national-debate-on-immigration-i

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[xii] CS Education Coalition, in partnership with Code.org. Offer Computer Science in Our Public Schools. https://www.change.org/p/offer-computer-science-in-our-public-schools-csforall

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[xiv] College Board, AP Students in College: Analysis of Five-Year Academic Careers, 2007. http://research.collegeboard.org/sites/default/files/publications/2012/7/researchreport-2007-4-ap-students-college-analysis-five-year-academic-careers.pdf

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

## Witness Disclosure Form

Clause 2(g) of rule XI of the Rules of the House of Representatives requires non-governmental witnesses t o disclose to the Committee the following information. A non-governmental witness is any witness appearing on behalf of himself/herself or on behalf of an organization other than a federal agency, or a state, local or tribal government.

Your Name, Business Address, and Telephone Number:

ERIN SIEFRING
314 Vista Tarito
San Clemente, CA 92672
202-754-0642

1. Are you appearing on behalf of yourself or a non-governmental organization? Please list organization(s) you are representing.

Computer Science Education Coalition

2. Have you or any organization you are representing received any Federal grants or contracts (including any subgrants or subcontracts) since October 1, 2012 related to the agencies or programs funded by the Subcommittee?

Yes (No)

3. Have you or any organization you are representing received any contracts or payments originating with a foreign government since October I, 2012 related to the agencies or programs funded by the Subcommittee?

Yes (No)

4. If your response to question #2 and/or #3 is "Yes", please list the amount and source (by agency and program) of each Federal grant (or subgrant thereof) or contract (or subcontract thereof), and/or the amount and country of origin of any payment or contract originating with a foreign government. Please also indicate whether the recipient was you or the organization(s) you are representing.

Signature: [redacted]

Date: 3/4/2017

Mr. COLE. You might care to comment quickly on this or ask a question.

Mr. FLEISCHMANN. Thank you, Mr. Chairman, and Ms. Siefring. I appreciate this, and to my Democratic colleagues as well. This is an area where we've had tremendous bipartisan cooperation and support.

Just about a week and a half ago in Chattanooga, my hometown, we went over to the Howard High School. The members of your coalition were there. I went to an elementary school where second graders actually taught me how to code. It is really incredible the enthusiasm that the students have. Employers need this. The students need it, and I am going to be working with Ms. Lee, my colleague from the other side of the aisle—she is not here yet today—from Oakland.

One of the other areas, too, that I would respectfully suggest we all work together is in the inner city because we have a lot of underserved schools in the inner city. I was just so impressed again at Howard High School.

But thank you for your efforts. I am going to continue to be an advocate and look forward to the bipartisan cooperation on this key issue. And I thank the chairman for his continued support as well.

Mr. COLE. Certainly well-behaved second graders could teach this Congress a great deal actually. [Laughter.]

Ms. DELAURO. Mr. Chairman, just for the record——

Mr. COLE. Certainly.

Ms. DELAURO [continuing]. Ms. Lee is at the MilCon hearing this morning, so otherwise she would be here joining Mr. Fleischmann. Thank you.

Mr. COLE. Absolutely. We want to thank you for your testimony, and we will certainly take it under consideration. And next witness, please.

Welcome. Good to have you here, you bet. Ms. Pyper Davis, the executive director of Educare, Washington, D.C. The gentlelady is recognized for 5 minutes to deliver remarks.

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WEDNESDAY, MARCH 8, 2017.

## EDUCARE WASHINGTON, D.C.

### WITNESS

### PYPER DAVIS, EXECUTIVE DIRECTOR, EDUCARE WASHINGTON, D.C.

Ms. DAVIS. Thank you. Chairman Cole, Ranking Member DeLauro, and members of the subcommittee, thank you for the opportunity to testify today on the critical need for all children, especially low-income children, to have access to affordable, high-quality early learning and care.

My name is Pyper Davis, and I am the executive director of Educare of Washington, D.C., a nonprofit just across the Anacostia River serving children and families living in poverty with a high-quality early childhood education program.

For context about me, I grew up in Michigan, earned an M.B.A. from Harvard Business School, and worked in the private sector for 15 years both on Wall Street and in the television industry. In

2003, I decided to leave the private sector and harness my business experience to work on improving education outcomes for low-income children. This is what brings me here today.

Educare D.C. opened nearly 5 years ago and offers full-day, year-round, high-quality early childhood education services to children as young as 6 weeks old through age 5. The ounce of prevention, which includes the First Five Years Fund, opened the first Educare in Chicago in 2000. Today Educare D.C. is a part of a 21-school high-quality research-based network across the country, a network which includes two Educare programs in your home State of Oklahoma, Chairman Cole, one in Wisconsin, and one in California as well.

All Educare schools braid together Federal Head Start and child care grants with State, local, and philanthropic dollars to create true public/private partnerships. Private funds account for about one-third of Educare D.C.'s funding, and the other two-thirds come from public funding streams that I have mentioned.

Of the 160 children at Educare D.C., 15 percent experienced homelessness in the past year, and 73 percent live in a family with reported annual income of $9,000 or less. We know these risk factors can derail a child's physical, social, emotional and cognitive development. Without intervention, these factors often lead to a lack of school readiness and are linked to illiteracy, teen pregnancy, high dropout rates, and unemployment later in life.

According to Nobel Laureate economist, James Heckman, every dollar invested in high-quality early learning for disadvantaged children provides a 13 percent yearly return on investment. As brain science and multiple longitudinal studies show, investing these dollars in our youngest children is smart policy and smart economics.

I would like to share just one example of success from the programs that you support. A few years ago, one of our teen moms was encouraged to enroll her infant in Educare so that she could finish high school. Last June, not only did mom complete high school, but she graduated as valedictorian, and she is now a full-time college student. Mom told me that she was able to focus on her own education because she knew that her daughter was safe, healthy, and learning at Educare. This is just one real illustration of that 13 percent return on investment, with two generations, both child and parent transformed.

Educare is able to serve these families because of the funding we receive, especially from the Federal government. More and more Federal investments in high-quality early childhood education programs are being matched by governors and legislatures in blue and red States alike. But States and private investors cannot do it alone. This is hard work, and only by having nationally coordinated efforts and national talent helping to lead can we continue to make progress.

We appreciate the bipartisan support that you have shown these programs, and we hope that will continue as you wrap up Fiscal Year 2017 and work on Fiscal Year 2018, because access to high quality early learning programs can close the achievement gaps. I am requesting that the subcommittee continue to increase support for early childhood programs for Fiscal Year 2018.

Specifically, it took bipartisan support to reauthorize the Child Care Development Block Grant, and it will take bipartisan efforts to fund the reforms that the new law requires. Implementing this law without reducing slots for children will require an increase of $1,200,000,000, and I ask that you increase the appropriation in line with this need.

Head Start and Early Head Start are only able to serve 41 percent of eligible 3- and 4-year-olds and 4 percent of eligible infants and toddlers. I urge the subcommittee to support funding for Head Start above current levels to ensure that the new outcomes-driven Head Start performance standards are implemented with fidelity.

Additionally, I request that the subcommittee help put Early Head Start on a path to reach 10 percent of eligible children over 4 years, starting with an increase of $500,000,000 in Fiscal Year 2018 to expand Early Head Start and Early Head Start child care partnerships.

The Every Student Succeeds Act authorizes a new preschool development grant program within HHS. I request that you provide sufficient funding to allow for new preschool development grant competition. These grants will improve collaboration and coordination at the State and local level.

Parts B and C of the IDEA make early intervention services available to children with disabilities. Thanks to Part B, 753,000 children with disabilities were able to access necessary services in Fiscal Year 2015. I request that you consider increase in funding for both Part B and Part C to ensure that all young children with disabilities have access to vital services.

Access to high-quality early childhood education helps low-income children enter kindergarten ready to learn, and offers entire families greater opportunities and a pathway out of poverty.

Thank you for the opportunity to testify today. I extend an open invitation to all of you to visit Educare D.C., which is just down the road. Thank you.

[The information follows:]

**United States House of Representatives**
**Appropriations Subcommittee on Labor, Health and Human Services and Education**
**Testimony of Pyper Davis**
**Executive Director, Educare - Washington, D.C.**
**March 8, 2017**

Chairman Cole, Ranking Member DeLauro and members of the Subcommittee, thank you for the opportunity to testify before you today on the critical need for all children, especially low-income children, to have access to affordable, high-quality early learning and care. My name is Pyper Davis. I am the Executive Director of Educare Washington, D.C., a non-profit just across the Anacostia River serving children and families living in poverty with a high-quality, early childhood education program. A little bit about me, I grew up in Michigan. After earning my MBA from Harvard Business School, I worked in the private sector for 15 years. My private sector experience includes working on Wall Street at Morgan Stanley and as an executive in the television industry. In 2003, I decided to leave the private sector and harness my training and business experience to work on improving education outcomes for low-income children. This is what brings me here, today.

Educare DC opened nearly five years ago. It offers full-day, year-round, high-quality early childhood education services to children starting as young as six weeks old through age five. The Ounce of Prevention, which includes the First Five Years Fund, launched the original Educare Chicago in 2000. Today, Educare DC is part of a network of 21 high-quality, research-based, early childhood schools across the country – a network which includes two Educare programs in your home state of Oklahoma, Chairman Cole. All Educare schools braid together federal Head Start grants, federal Child Care and Development Fund dollars, along with state, local, and philanthropic funding to create true public-private partnerships. Private funders

account for about one-third of Educare DC's funding, and the other two-thirds are comprised of federal and local dollars including Head Start, child care and State Pre-K from the Office of the State Superintendent of Education. As brain science, multiple longitudinal studies, and return on investment research all show, investing these dollars in children from their birth is smart policy and smart economics.

Of the 160 children at Educare DC, 15 percent have experienced homelessness in the past year and seventy-three percent live in a family with reported annual income of $9,000 or less. We know these risk factors can derail a child's physical, social, emotional, and cognitive development. Without intervention these factors often lead to a lack of school readiness and are linked to illiteracy, teen pregnancy, high dropout rates, and unemployment later in life.

Recognizing the challenges that disadvantaged children and families face, I want to thank the Subcommittee for your bipartisan efforts to increase the federal investment in early childhood programs for children birth through age five. As Nobel Laureate economist James Heckman has demonstrated, every dollar invested in high quality birth-to-five early learning and care programs for disadvantaged children provides a 13% per year return on investment. This ROI includes improved social and employment outcomes, and reductions in chronic disease, health care costs, and remedial education spending.

I would like to share an example of the success I see emerge regularly from the programs that you support. At Educare, we take a two-generation approach to serving young children. In Educare DC's second year of operation, a 15 year old mother was encouraged to enroll her infant in Educare so she could finish high school. Last June, not only did Mom complete high school, but she graduated as valedictorian of her class, and is now a full-time college student. Mom told me that she was able to focus on her own education because she knew that her daughter was safe,

happy and learning at Educare.

This family's story is a real illustration of that 13% return on investment I mentioned earlier. But more than just numbers, these are real people and families who are transformed. We are able to provide services to these children and families because of the funding we receive, especially from the federal government. More and more, federal investments in high-quality early childhood education programs and systems are being matched by governors and legislatures from red and blue states alike. States, philanthropists and private investors cannot do it alone. There is an appropriate role for the federal government that is not intrusive but highly catalytic and collaborative. This is hard work, and only by having nationally coordinated efforts and talent helping to lead can we continue the progress we have started.

Thank you for having worked together in a bipartisan way that increases support for early learning and care programs. We appreciate the bipartisan support you have shown these programs in the past and we hope that will continue as you wrap up FY2017 and as you work on FY2018. Because access to high-quality early learning programs helps children from low-income families enter kindergarten prepared to learn and closes achievement gaps, I am requesting that the subcommittee continue to increase support for early childhood programs in FY2018.

**Child Care and Development Block Grant (CCDBG)**

CCDBG helps parents work while their children receive care, and the reauthorized law includes reforms aimed at improving quality that stimulates children's physical, emotional and cognitive growth. It took bipartisan support to reauthorize CCDBG, and it will take a bipartisan effort for federal funding to realize the reforms in the law. The cost of implementing the new law, to ensure no children lose slots, will require an increase of $1.2 billion above the current funding level, therefore I ask that you increase the appropriation in line with this need.

**Head Start and Early Head Start**

Head Start and Early Head Start deliver comprehensive early learning, health, nutrition, and family support services to low-income expectant families and children from birth to age five. However, only 41% of eligible 3- and 4-year-olds participate in Head Start, and only 4% of eligible infants and toddlers participate in Early Head Start. I urge the subcommittee to build upon its legacy of being a champion for Head Start, and support robust funding above current levels to ensure the new, outcomes-driven Head Start Program Performance Standards are implemented with fidelity. Additionally, I request that the subcommittee support increases that would put Early Head Start on a path to reaching 10 percent of eligible children over four years, starting with an increase of $500 million in FY 2018 to expand Early Head Start, including through Early Head Start-Child Care Partnerships to expand high-quality early learning for infants and toddlers.

**Preschool Development Grants**

The opportunities present within Every Student Succeeds Act (ESSA) will improve supports for our youngest learners as they transition from early childhood education settings to the elementary school classroom. This is particularly clear in that ESSA authorizes a new Preschool Development Grants (PDG) program within the U.S. Department of Health and Human Services (HHS). The new PDGs provide an opportunity to further engage state and local level initiatives that continue to grow in quality and quantity across the country. I request that you provide sufficient funding to allow for a new PDG competition. These grants will improve collaboration and coordination among early childhood programs at the state and local level. Additionally, this would support quality improvement activities, laying the foundation for states that receive grants to increase access to high-quality early education programs in future years.

**Individuals with Disabilities Education Act (IDEA Parts B and C)**

Under the Grants for Infants and Families program, Part C of IDEA, states implement systems of coordinated, comprehensive, multidisciplinary, interagency programs and make Early Intervention services available to children with disabilities, aged birth through 2, and their families. Part B supports the inclusion of young children age 3 through 5 with disabilities in state and federal early learning programs such as Head Start and CCDBG. Thanks to Part B, 753,000 children with disabilities were able to access necessary services in FY2015. Regarding IDEA Parts B and C, I request that you consider providing an increase in funding for both programs to ensure that all children with disabilities birth through 5 have access to vital early learning and development services.

**CONCLUSION**

Access to a high-quality early childhood education helps low-income children enter kindergarten ready to learn, and offers entire families greater opportunities and a pathway out of poverty. Thank you for the opportunity to testify today.

Pyper Davis

Executive Director, Educare DC

202-741-8656

pdavis@educaredc.org

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

## Witness Disclosure Form

Clause 2(g) of rule XI of the Rules of the House of Representatives requires non-governmental witnesses to disclose to the Committee the following information. A non-governmental witness is any witness appearing on behalf of himself/herself or on behalf of an organization other than a federal agency, or a state, local or tribal government.

Your Name, Business Address, and Telephone Number:
Pyper Davis, Executive Director, Educare DC
640 Anacostia Avenue, NE, Washington, DC 20019
Tel: 202 741 8656

1. Are you appearing on behalf of yourself or a non-governmental organization? Please list organization(s) you are representing.
   Educare DC

2. Have you or any organization you are representing received any Federal grants or contracts (including any subgrants or subcontracts) since October 1, 2012 related to the agencies or programs funded by the Subcommittee?

   (Yes) No

3. Have you or any organization you are representing received any contracts or payments originating with a foreign government since October 1, 2012 related to the agencies or programs funded by the Subcommittee?

   Yes (No)

4. If your response to question #2 and/or #3 is "Yes", please list the amount and source (by agency and program) of each Federal grant (or subgrant thereof) or contract (or subcontract thereof), and/or the amount and country of origin of any payment or contract originating with a foreign government. Please also indicate whether the recipient was you or the organization(s) you are representing.

HHS - Head Start $602,317
HHS - Early Head Start $1,070,785
CCDBG - Child Care $393,392

Signature: _____ Date: 3/3/2017

Mr. COLE [continuing]. Testimony, and I loved the testimony. And my one suggestion would be get one of those Educare centers open someplace in Connecticut, you know. It would probably help us a lot. [Laughter.]

Ms. DAVIS. Happy to. Happy to.

Ms. DELAURO. My further suggestion, Mr. Chairman, is given the prospect both the chairman and I know is very real of serious cuts, make your voices heard loud and clear. This is an institution that responds, especially to something that is successful. But please come to Connecticut.

Ms. DAVIS. Thank you.

Mr. COLE. The gentlelady, as always, is correct.

If we could, we will have our next witness, please. Welcome. Good to have you here. Mr. Ted Cornelius, the executive director of the Tennessee State Alliance of YMCAs. You are recognized for 5 minutes for whatever testimony you care to offer.

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WEDNESDAY, MARCH 8, 2017.

## TENNESSEE STATE ALLIANCE OF YMCAS

### WITNESS

### TED CORNELIUS, EXECUTIVE DIRECTOR, TENNESSEE STATE ALLIANCE OF YMCAS

Mr. CORNELIUS. Thank you. So, thank you, Chairman Cole and Ranking Member Fleischmann of Tennessee, and the rest of the members of the subcommittee. I am very thankful for the opportunity to talk with you today about some of the exciting work that the YMCA is doing.

I am the executive director of the Tennessee State Alliance of YMCAs. And on behalf of the 2,700 YMCAs across the country, I am here to talk about some of the work that the Tennessee YMCAs and also YMCAs across the country are doing to prevent diabetes and also save millions of lives, and also save billions of dollars.

So, I am specifically here to ask for $25,000,000 to go towards the Center for Disease Control and Prevention's National Diabetes Prevention Program. We have supported the priority of Congress placing on the National Institutes of Health to be able to look at investing in medical breakthroughs. And I am here to tell you about an investment that the National Institute of Health made in 1996. That was a clinical research trial, and it actually aimed at delaying the onset of type 2 diabetes through weight loss and also the treatment with the drug Metformin. I am here to tell you that the outcomes were extremely successful. We showed 58 percent lost 5 to 7 percent weight loss, and over 60 years of age reduced by 71 percent.

So immediately, Secretary Tommy Thompson called off the trial and urged the Nation to scale the program immediately. The barrier was that it was expensive, and so we were not able to do that. But fast forward a couple of years, the academic institution that was involved in the trial came to the YMCA. We looked at Indianapolis and the local Y's, and we were able to identify delivering this at a 10 to 20 percent reduction, some of the cost.

So, with that then the United Health Group in 2010 were able to start paying for the program for Y's to scale. So then, fast forward 7 years later, we are now in 1,700 community sites, 47 States. 30 private insurers are covering the program. 10 State employee programs are now covering it as well. And I am here to say that we are extremely confident in this program, and that it works, and that we operate in a pay for performance basis, and receive payment only when outcomes are achieved.

So, I just want to emphasize that we could not do this without the partnership with the Centers for Disease Control. It is a public/private partnership that is absolutely critical to this work.

So, we urge Congress to continue to support the CDC's National Diabetes Prevention Program so more of the community organizations, like the YMCA, can go ahead and continue to scale this extremely important program. We do understand that there are challenging budget times right now. We are urging you to invest in taxpayer dollars where you get the most return.

And I can tell you this has been a proven program. So again, we are asking for support for $25,000,000 into the CDC, and here is why. We are spending $322,000,000,000 annually. In Tennessee specifically, $6,600,000,000 is being spent on this disease. And then $1 out of every $3 is being spent on Medicare spending for the care of diabetes.

So, CDC absolutely needs these resources in order to build capacity with organizations to be able to scale this, to educate the 86 million that are in a pre-diabetic condition who sometimes do not even know that they are in a pre-diabetic condition. And then also to run the CDC Recognition Program.

Fast forward to 2012, the YMCA of the USA had a CMMI Innovation Grant Award with CMS and demonstrated cost savings of $2,650 per Medicare patient as far as a return on investment, and marks the first time in history that a community intervention produced a cost savings from a prevention service. Then fast forward to November 2016, CMS finalized a rule enabling scale of program for Medicare with pre-diabetes, which really includes half of all seniors nationwide. So, this benefit will be available starting January 1 of 2018.

So, for the many community organizations like the Y and the CDC Recognition is essential and another reason why funding the Center for Disease Control's Diabetes Prevention Program is so critically important. So, we urge Congress to support a robust investment in diabetes, in chronic disease prevention at the CDC. Thank you.

[The information follows:]

FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

**Remarks of Ted Cornelius,**
**Executive Director, Tennessee State Alliance of YMCAs**

**Testimony before the United States House of Representatives Committee on Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies**

**March 8, 2017**

Good morning. Thank you, Chairman Cole, Ranking Member DeLauro, Rep. Fleischmann of Tennessee and all members of the subcommittee. I'm Ted Cornelius, and I am the Executive Director of the Tennessee State Alliance of YMCAs. On behalf of 2700 YMCAs, I want to thank you for the opportunity to share the work that Ys in TN and across the country are doing to prevent diabetes and potentially save millions of lives and billions of dollars. **I am specifically here to support $25 million for the Centers for Disease Control and Prevention's National Diabetes Prevention Program.**

We support the priority that Congress places on NIH to develop scientific and medical breakthroughs. However, you may be surprised to

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know that a very successful NIH discovery in diabetes is actually being implemented in an extremely cost-effective program by local YMCA's in our communities, rather than a more expensive medical setting.

In 1996, Congress made an enormous investment in the National Institutes of Health for a randomized controlled trial called the Diabetes Prevention Program or the DPP. The DPP was a major multicenter clinical research study aimed at discovering A) whether modest weight loss through dietary changes and increased physical activity or B) whether treatment with the drug metformin could prevent or delay the onset of type 2 diabetes in study participants.

The lifestyle arm of the NIH DPP Trial was incredibly successful, in fact the outcomes surpassed the drug intervention by double. It showed that lifestyle changes reduced the incidence of diabetes by 58% for individuals who lost a modest 5-7% of their body weight. And if individuals were over 60 years of age, the intervention reduced the incidence of diabetes by 71%. With these results, Secretary Tommy Thompson called off the trial and urged the nation to scale the program immediately. Unfortunately, largely due to the cost of the program when it's delivered clinically, the national scaling of this intervention did not occur.

Fortunately, a few years later, one of the academic institutions involved in the original NIH trial approached the Y to see if we could try to replicate the trial findings in the Y and do it cheaper. We did just that, in Indianapolis and Louisville, and we did it for approximately 10-20% of the original cost.

In 2010, UnitedHealth Group started paying for the program and said it would do so nationally if the Y could take it to scale. To date, and only seven years later, we are offering the program in 1700 community sites in 47 states. Thirty private insurers are paying for the program and 10 state employee programs cover it. The Y is so confident in our program, we operate on a pay-for-performance basis, only receiving reimbursement when we achieve the outcomes correlated with reductions in diabetes risk, like weight loss.

We could not do this work without our partnership with the CDC's National Diabetes Prevention Program. This public-private partnership with CDC has been critical to our success, and we urge Congress to support CDC's National Diabetes Prevention Program so more community organizations, like Ys, can offer this lifechanging program.

**We know these are challenging budget times, but we urge you to invest taxpayer dollars where you can get the most return on**

**investment. This is now proven. If you want to save health care dollars invest in this. Please support $25 million for the program, the level the House Appropriations Committee supported in its FY2017 appropriations bill. A $25 million investment seems reasonable when diabetes is costing the nation $322 BILLION annually, including $6.6 BILLION in Tennessee. Modest when $1 in $3 Medicare dollars is spent caring for people with diabetes.**

CDC needs these resources to continue to 1) help organizations gain capacity and scale the program 2) educate some of the 86 million American living with prediabetes about the program and 3) run the recognition program with community-based diabetes prevention programs.

Importantly, in 2012, the Y was awarded a Center for Medicare and Medicaid Innovations demonstration project to test whether the YMCA's Diabetes Prevention Program could produce cost savings to Medicare. 17 Ys in 8 states delivered the program to nearly 8000 seniors. The Y not only delivered the weight loss goals among seniors, but the CMS actuary scored the savings for this program at $2650 per senior over 15 months.

This marks the first time in history that a community intervention produces a cost-savings from a preventive service. In November 2016, CMS finalized a rule enabling the scaling of this program for all Medicare

recipients with prediabetes, which turns out to be half of all seniors. This benefit will be available to eligible Medicare beneficiaries starting January 1, 2018.

For the many community-based organizations, like the Y, CDC recognition is essential in their ability to deliver the program to our nation's seniors through Medicare. **This is another reason why funding the CDC's National DPP is so important. We urge Congress to support a robust investment in diabetes and chronic disease prevention programs at the CDC.** Thank you.

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

## Witness Disclosure Form

Clause 2(g) of rule XI of the Rules of the House of Representatives requires non-governmental witnesses to disclose to the Committee the following information. A non-governmental witness is any witness appearing on behalf of himself/herself or on behalf of an organization other than a federal agency, or a state, local or tribal government.

Your Name, Business Address, and Telephone Number:
Ted Cornelius
1000 Church Street
Nashville, TN 37203
615-259-9622

1. Are you appearing on behalf of yourself or a non-governmental organization? Please list organization(s) you are representing.
   Tennessee State Alliance of YMCAs,
   YMCA of the USA

2. Have you or any organization you are representing received any Federal grants or contracts (including any subgrants or subcontracts) since October 1, 2012 related to the agencies or programs funded by the Subcommittee?

   **Yes** No

3. Have you or any organization you are representing received any contracts or payments originating with a foreign government since October I, 2012 related to the agencies or programs funded by the Subcommittee?

   Yes **No**

4. If your response to question #2 and/or #3 is "Yes", please list the amount and source (by agency and program) of each Federal grant (or subgrant thereof) or contract (or subcontract thereof), and/or the amount and country of origin of any payment or contract originating with a foreign government. Please also indicate whether the recipient was you or the organization(s) you are representing.

See following page for grants and amounts.

Signature: [redacted] Date: 3.3.2017

**Tennessee State Alliance of YMCAs:** No federal grants were awarded October 1, 2012 – Present.

**YMCA of the USA:** Awarded federal grants related to the LHHS Subcommittee, October 1, 2012 – Present, are listed below. All grants originated in the U.S. No sub-grants or contracts were awarded during this time period.

| | Oct 1, 2012 - Present Total | Agency | CFDA |
|---|---|---|---|
| Cancer Survivorship | 350,000 | CDC | 93.424 |
| Capacity Building | 20,000 | CDC | 93.524 |
| Community Transformation Grant | 2,600,000 | CDC | 93.531 |
| Diabetes eReferral | 1,000,000 | CDC | 93.524 |
| Diabetes Prevention | 6,059,797 | CDC | 93.739/93.261 |
| Enhanced Fitness | 399,977 | CDC | 93.068 |
| Enhanced Fitness | 1,550,001 | CDC | 93.424 |
| Million Hearts | 435,000 | CDC | 93.424 |
| Million Hearts | 2,793,181 | CDC | 93.524 |
| Moving for Better Balance | 52,000 | CDC | 93.424 |
| Pioneering Healthier Communities | 150,000 | CDC | 93.283 |
| Emergency Preparedness | 300,000 | CDC | 93.424 |
| Promoting Walking | 1,000,000 | CDC | 93.424 |
| REACH | 4,298,179 | CDC | 93.738 |
| Violence Prevention | 75,000 | CDC | 93.283 |
| WISEWOMAN | 1,000,000 | CDC | 93.424 |
| Health Care Innovation Challenge | 11,885,134 | CMMI | 93.610 |
| VISTA | 100,000 | CNCS | 94.013 |
| | **34,068,269** | | |

Mr. COLE. Thank you for your testimony. I understand my friend from California, Ms. Roybal-Allard, has a question or comment.

Ms. ROYBAL-ALLARD. Okay. Thank you very much Mr. Chairman. Mr. Cornelius, thank you for highlighting a program that is prioritizing real proven prevention efforts in the community.

You did not mention that in your testimony, but I recall that the National Diabetes Prevention Program was originally funded by the Prevention and Public Health Fund, and the NDPP was given its own line item within the CDC. Since the Prevention and Public Health now back fills approximately 12 percent of the CDC budget, what would be the impact for the NDPP if that fund is eliminated as part of repealing the ACA?

Mr. CORNELIUS. Thank you for your question. It would be a great impact. So, it would be about 40 percent to the CDC's budget, which is extreme. And I will tell you, chronic disease in our country is one of the number one killers of disease, costs us an extreme amount of money. That is why I would say it is absolutely critical that we continue to keep having appropriations and this investment into the Centers for Disease Control's budget in order for us to continue to keep scaling this program. Thank you for your question.

Mr. COLE. I thank the gentleman for his testimony, and we will certainly take it under advisement. Thank you again.

Mr. CORNELIUS. Thank you.

Mr. COLE. If we could, next witness. Welcome, sir. It is good to have you here.

Mr. MCPHERSON. Yes, sir. Nice to be here.

Mr. COLE. Good.

Mr. MCPHERSON. Mr. Chairman——

Mr. COLE. Peter McPherson, president of the Association of Public and Land Grant Universities. The gentleman is recognized for 5 minutes.

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WEDNESDAY, MARCH 8, 2017.

## ASSOCIATION OF PUBLIC AND LAND-GRANT UNIVERSITIES

### WITNESS

### M. PETER MCPHERSON, PRESIDENT, ASSOCIATION OF PUBLIC AND LAND-GRANT UNIVERSITIES

Mr. MCPHERSON. Good to be here. Thank you.

My association is a group of 194 universities systems around the country representing the universities that are in every one of your States. They educate over 5 million students, $40,000,000,000 research. It is a large public and the land grants around the country.

I am here to talk about Pell and about NIH funding.

A few comments about college and Pell. Since the Great Recession, almost all the jobs, the new jobs, were taken by people that had some college, and some 72 percent of those new jobs went to people with a 4-year degree. It is clear that these are very important degrees to get for our population.

A few comments about Pell, of course. The low-income minority students in our country simply are not getting the degrees any-

where near the percent that higher-income people are. We certainly applaud getting something like 85 percent or more of the top quintile of income in this country get college degrees. But at the lowest quintile, it is like 8 percent, and it gradually moves up. Pell is just so key to make this work.

When you look at who gets the jobs, we cannot have income people not have some post-secondary education, and those 4-year degrees are very important for so many people. Certainly, they are competent to get them when you look at income distribution.

Well, I look at Oklahoma, for example, where Oklahoma, Oklahoma State, and Langston have 12,000 Pell students. University of Connecticut has 4,000. And I could around the room and give the figures for every one of the States here. They are doing impressive work these are public institutions, and we need to support them. We need to have this discretionary mandatory minimum. I hope you can keep it, it if not increase it, realizing that certainly is difficult in these days.

We think that the yea-round Pell is just central. I know every one of you understand year-round Pell, and I really think you would love to do it. I appreciate the chairman when it was included in the markup last year for up 2017. You said, well, maybe it can be worked out in the final agreement. We hope so. And I appreciate the ongoing interest here.

The NIH funding is, of course, very critical, and you have all been so supportive of it. We hope that there can be a $2,000,000,000 increase for 2017. And, of course, we think that you need to continue to build us up. I am struck by how often I say to my wife, you know, when some friend is ill or has a problem, you know, they would not have been able to deal with that a few years ago. When you think about it, it is really true. We just sometimes forget how much medical technology has advanced, and so much of that is NIH founded.

When we think about our economy, we have all had the benefits of this information technology that has changed our lives, but also changed the economy of this country. There are many people who think that the information technology is going to build and expand upon the biotech nature of this. I believe that in 15 years or so, the investment here is just not only key for the health of every one of us actually, but for the growth of this economy.

So, Mr. Chairman, the ranking minority, friends, members, I hope these are helpful to you.

[The information follows:]

ASSOCIATION OF
PUBLIC &
LAND-GRANT
UNIVERSITIES

Testimony of Peter McPherson, President, Association of Public and Land-grant Universities
House Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies
Public Witness Hearing
Wednesday, March 8, 2017

Chairman Cole, Ranking Member DeLauro, and members of the Subcommittee, it is an honor to join you this morning to testify on the critical importance of federal student aid and university-based research to the economic growth, competitiveness, and health and wellbeing of our country. More specifically, I will talk about the need to ensure the strength of the Pell grant program, including through the restoration of year-round Pell grants, and boost funding for the National Institutes of Health by $2 billion.

I am president of the Association of Public and Land-grant Universities, a membership association consisting of 194 public research universities, land-grant institutions, and state university systems across the country. Every member of Congress has an APLU member institution in their congressional district or state. Our U.S. member universities annually enroll 5.2 million undergraduate and graduate students and conduct $40.7 billion in university-based research.

As the United States has emerged slowly from the Great Recession, what has become increasingly clear is that a college degree is even more essential to employment than before. Of the 11.6 million jobs created after the Great Recession, 11.5 million went to people with some college education. The unemployment rate for bachelor's degree holders is just 2.5 percent. Not only are degree holders finding jobs more easily, the jobs are delivering a lifetime of greater benefits to the individual and tremendous

public benefits to the economy and society.

Bachelor's degree holders on average earn nearly $1 million more in their lifetime than high school graduates. College graduates are also considerably less reliant on government programs and services including Medicaid, housing subsidies, nutrition aid, unemployment benefits, and other forms of public assistance. For instance, those who graduated college are 3.5 times less likely to be impoverished and nearly five times less likely to be imprisoned.

Combined with state investment in public higher education, federal student aid is the lynchpin for higher education access. Pell Grants are often the determining factor in whether a low-income student can afford to go to college. For example, at APLU's three Oklahoma member institutions, the University of Oklahoma, Oklahoma State University, and Langston University, more than 12,000 low-income students participate in the Pell program. At the University of Connecticut, nearly four thousand Pell students were enrolled in the 2014-15 academic year.

APLU urges the Subcommittee to support appropriations necessary to maintain the projected increase in the maximum Pell Grant, at a minimum maintain present levels of discretionary appropriations, and protect the Pell surplus for the long-term fiscal health of the program. Congress should also make permanent annual Pell inflation adjustments, which currently expire after 2017.

The Subcommittee also has a great opportunity to improve Pell Grants by restoring year-round Pell. The Senate Fiscal Year 2017 Labor-H bill would critically restore this program. While the House Subcommittee declined to include year-round Pell during its FY17 markup, we appreciate that Chairman Cole noted a final agreement could still include year-round Pell. I urge the Subcommittee not to pass on this opportunity in FY17 or FY18 if necessary. Restoring year-round Pell would greatly contribute to so

many bipartisan higher education goals. By allowing students to use their Pell eligibility over the summer, the subcommittee would help students graduate sooner, with less debt, and enter the workforce more quickly. Numerous studies have shown that uninterrupted academic progress boosts graduation rates. We also know that the single greatest determining factor of whether a student will successfully repay loans is whether they complete their degree. Year-round Pell is just common sense from all standpoints: students who want to stay on a fast track for graduation; their colleges and universities that support student progress; and the federal government, which also has a great interest in their success. Just last week Speaker Ryan joined the chorus of those voicing their support for year-round Pell.

Another top priority for APLU within the jurisdiction of the Subcommittee is robust funding for the National Institutes of Health. For FY18, we join the greater medical research community in requesting that the Subcommittee provide NIH a $2 billion increase over the FY17 appropriated amount.

APLU universities conduct much of the NIH-sponsored research. This research has immediate economic benefits, including providing high quality jobs across the country. According to an analysis by United for Medical Research, NIH research funding in 2015 directly and indirectly supported over 350,000 jobs nationwide and generated $60.171 billion in new economic activity. Seventeen states experienced an economic gain of $1 billion or more in 2015 due to NIH research.

The economic benefits of strong NIH funding play out not only immediately, but also for years to come. It is no secret that a key ingredient to achieving strong economic growth in the U.S. is a consistent and robust investment in science and research.

Of course, we all know that the primary objective for investing in NIH is the long-term advantages of its research. Cures and therapies for diseases and treatments for injuries are priceless. The biomedical

research community continues to move closer to breaking the codes of Alzheimer's, cancer, and other diseases that have taken far too many lives and brought despair to families in every community. Robust funding for NIH is necessary to continue the progress and build on the momentum of the research advances to date.

APLU and our universities greatly appreciate your Subcommittee's support for NIH. The funding increase provided in FY16 was the beginning of what we hope will be a sustained effort to catch up from a decade of stagnant funding for the agency. The FY17 proposals to grow the NIH budget are still pending, and we look forward to a resolution of the current year appropriations bills that will include a $2 billion increase for this premier biomedical research agency. To continue the scientific breakthroughs and achieve the great promises of addressing the health needs of people across the country, this boost must also continue in FY18.

Thank you for this opportunity to share with you a couple of the major priorities APLU has within your Subcommittee's jurisdiction. We reiterate our appeal that Congress complete the FY17 appropriations process with legislation that prioritizes funding for higher education and research -- investments that yield strong economic and societal returns. We are ready to serve as a resource as you move forward with the FY18 process.

**Subcommittee on**
**Labor, Health and Human Services, Education,**
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Your Name, Business Address, and Telephone Number:
Peter McPherson, President, Association of Public and Land-grant Universities
1307 New York Ave. NW, Washington, DC 20005
(202) 478-6040

1. Are you appearing on behalf of yourself or a non-governmental organization? Please list organization(s) you are representing.
   Association of Public and Land-grant Universities

2. Have you or any organization you are representing received any Federal grants or contracts (including any subgrants or subcontracts) since October 1, 2012 related to the agencies or programs funded by the Subcommittee?

   (Yes) No

3. Have you or any organization you are representing received any contracts or payments originating with a foreign government since October I, 2012 related to the agencies or programs funded by the Subcommittee?

   Yes (No)

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   HHS-National Institutes of Health, $871,518.90, Minority Health and Health Disparities (9/20/11-6/30/2017), APLU, AAMC, USU
   HHS-National Institutes of Health, $98,225.61, Holistic Nursing (1/1/16-6/30/17), APLU
   ED-Institute of Education Sciences, $1,619,368, Completion Grants, (1/1/17-12/31/21), APLU, Temple University

Signature: [redacted]

Date: 3-6-2017

Mr. COLE. I appreciate the comments very much, and I know you will help us. If we got the 2017 bill out, I think you would be very happy with some of your requests.

Mr. MCPHERSON. We will work hard. Our members are intensely interested, as you know. They are happy to chat with you and whatever could be helpful. And, more important, members beyond this table I am sure.

Ms. DELAURO. Thank you very much for your testimony. You are spot on. And I would say that, as Connecticut being one of the oldest land grant colleges in the country. So, thanks for all you do.

Mr. MCPHERSON. Well, I know it well.

Ms. DELAURO. Thank you.

Mr. MCPHERSON. I have been up there. It is a strong institution. Susan is doing nice job.

Ms. DELAURO. Right. Thank you for your support of Pell. It makes a difference. Thank you.

Mr. MCPHERSON. You bet.

Mr. COLE. Thank you very much for your testimony.

Our next witness? I believe, Mr. Kingston? Chairman Kingston, are you here? Why do you not come on up to the dais as well?

Mr. KINGSTON. Thank you, Mr. Chairman.

Mr. COLE. Well, as many of you here know, Mr. Kingston is the former chairman of this committee, my good friend and colleague. To all of us here, it is a particular pleasure to have you back, and I know you have got a witness that you would like to speak as well. But I wanted to recognize you for the wonderful work you did here and what a terrific friend you were, and allow you to make any remarks you care to make as you introduce the next witness.

Mr. KINGSTON. Well, thank the chairman for that, and the ranking member, and my friends on the committee. I wanted to say I did have an opportunity to tour the room right after you renovated it, and I looked up and I saw the Native American artwork with the Italian Renaissance influence. [Laughter.]

And I said to the clerk, I said, Ms. Ross, this is obviously the work of Mr. Cole and Ms. DeLauro. And she said, no, it came from the U.S. Capitol. [Laughter.]

But I thought, you know what? I am still right because it still was Italian Renaissance and Native American influence that helped shape that. But the room looks great, and I am glad to be here.

As you know, Job Corps has 50,000 grads a year. 80 percent of them find work. It is focused on really disadvantaged and sometimes troubled youth, dropouts, and so forth, and many times homeless people. They have trained 3 million people, and one of them is here today.

And if the committee will indulge, Thomas Franklin, if you could just stand up. Let them see what a fine young man you are. [Laughter.]

And Thomas is on his way to be a railroad clerk and studying all things transportation, logistics, and railroad.

But the witness who is here today that I am going to introduce is Susan Fallon. And rather than have somebody from the Job Corps to tell you how great they are, I thought it would be more effective to have one of their partners, a business, Monster, Inc.,

who works very closely with them in helping people. And, Ms. Clark, you will recognize where they are located as your hometown.

And so, our witness is Susan Fallon, and I am going to introduce her. She is one of the vice presidents of Monster, Inc. But if the name rings a bell, her father, Bill Fallon, has been a witness. You know Admiral Fallon has testified before many of our committees on appropriations in the Department of Defense for many years.

So, with that, I will yield the floor.

Ms. DELAURO. Mr. Chairman if I might just before the witness comes, I thought that was you in the back row there, Jack, and I said maybe I am not, you know, seeing correctly. But former Congressman Kingston chaired and co-chaired the Ag Committee, and we did the same with Labor-H. And there are always the discussion about how people on both sides of the aisle cannot get along but Jack Kingston I have gotten along for many, many, many years whether it's on the floor of the House or serving in these positions.

It is great to see you here this morning, Jack.

Mr. COLE. See, Jack, you make me feel like the second husband that cannot quite measure up——

[Laughter.]

Ms. DELAURO. We have been through a lot of battles. We were each chair of the Message Committee in the early, early days.

Mr. KINGSTON. We came together over conflict.

Ms. DELAURO. Conflict, right.

Mr. KINGSTON. We bonded, and we horrified both Democrats and Republicans with our lasting friendship.

Ms. DELAURO. And now he is the star of stage, screen, and television. We see him all the time. Thanks, Jack.

Mr. COLE. It is good to——

Mr. KINGSTON. It is great to be with you.

Mr. COLE. Good to see my friend again. Ms. Fallon, if you would come up, we would love to have you. That was a very clever twofer, you know? [Laughter.]

But it is a delight to have you here, and the gentlelady is recognized for 5 minutes to deliver her testimony.

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WEDNESDAY, MARCH 8, 2017.

## MONSTER GOVERNMENT SOLUTIONS

### WITNESS

### SUSAN FALLON, VICE PRESIDENT OF GLOBAL STRATEGY AND BUSINESS DEVELOPMENT, MONSTER GOVERNMENT SOLUTIONS

Ms. FALLON. Great. Thank you, Mr. Chairman, Ranking Member DeLauro, members of the Subcommittee for inviting me to testify.

Monster is headquartered in western Massachusetts, which is located in the district of your subcommittee colleague, Congresswoman Katherine Clark. I am thrilled to see our hometown congresswoman here today. And, of course, thank you, Chairman Kingston for that kind introduction.

I am honored to have the opportunity to speak to you on issues that are of critical importance not only to Monster Government Solutions, but also to millions of employers across the country. And those are the issues of jobs, our youth, and a skilled workforce.

According to the U.S. Chamber of Commerce, there are 5.6 million jobs that remain unfilled because employers simply cannot find workers with the right set of skills. Some estimates show that this skills gap cost our economy $160,000,000 annually. These are essentially lost jobs in our communities that we could easily reclaim through upskilling and investing in workforce development.

At the same time, there are 5.5 million young Americans aged 16 to 24 who are out of work and out of school. These youth are untapped economic assets who could potentially provide returns of as much as $5,000,000,000,000 dollars to our communities in terms of wages and activity, as well as a reduced dependence on taxpayer support. But these young people, many like Thomas, are not just a statistic. They are our future.

We at Monster, like the dozens of national employers participating in the Hundred Thousand Opportunities Initiative, believe it is a critical priority for our Nation to invest in these young men and women. Towards that end, last year we worked with the Job Corps Program to launch an initiative we call Youth Opportunities 2020.

As you know, Job Corps offers training in more than 100 different high demand occupations in 125 rural and urban communities nationwide. In Program Year 2015, nearly 80 percent of students left with an industry-recognized credential. The result: 86 percent of graduates secured jobs or enrolled in higher education. The bottom line? Job Corps works.

We have learned that small business trust Job Corps to meet their talent needs, which is why over 100 local chambers of commerce, from Connecticut to Oklahoma to Washington, have signed letters of support for the program. Building on this interest, Monster worked with Job Corps last year to launch the Youth Opportunities Portal, which provides students with online career tools and resources, and employers with the tools to be matched to thousands of skilled young Americans at no cost.

For example, our data shows that last month in your district, Mr. Chairman, there were 15,131 job openings published. Last month in New Haven, Ranking Member DeLauro, there were more than 22,126 job openings published. Many of these are middle-skilled jobs that require the technical skills, industry-recognized certifications and training that our youth are receiving from the Job Corps Program. These include transportation and material moving occupations, which account for more than a quarter of the job postings in the chairman's district, to nursing and other healthcare related professions that account for the largest share of postings in the ranking member's district.

We at Monster are mission driven to expand employment opportunities for job seekers, and to help employers find the skills- and work-ready employees they need to grow their businesses. We urge the subcommittee, which has provided incredible bipartisan support to Job Corps for more than 50 years, to continue to provide sufficient funding in Fiscal Year 2018, and help as many of these young people and the employers that need their skills as possible.

Thank you.

[The information follows:]

## Written Testimony of Susan Fallon, Vice President of Global Strategy and Business Development, Monster Government Solutions

Thank you Mr. Chairman, Ranking Member DeLauro, and members of the Subcommittee, as well as former Chairman Kingston, for inviting me to testify. I am pleased to have the opportunity to speak on issues that are of critical importance not only to Monster.com but to me personally and to millions of my fellow citizens across the country: and those are the issues of jobs, our youth, and a skilled workforce. In particular, I am writing to encourage the Subcommittee to continue to fully provide funding at the Fiscal Year 2017 level provided in the Senate for the U.S. Department of Labor's Job Corps program to enable it to continue bridging the gap between opportunity youth and jobs in communities across our great nation.

One of the takeaways of the recent election, across both parties and in both rural and urban communities, was a prevalent sense of economic anxiety among the American people – particularly that good jobs are increasingly out of reach. Some of these jobs may have left our communities, but others, particularly in industries such as manufacturing, simply require more or different skills than in the past. According to the U.S. Chamber of Commerce, there are 5.6 million jobs that remain unfilled because employers cannot find workers with the right set of skills.[1]

This disconnect between the skills needed by local employers and skills of the local workforce is commonly referred to as the "skills gap." Some estimate that this 'skills gap' costs

our economy $160 billion annually.[ii] These are essentially lost jobs in our communities that we can reclaim through upskilling and investing in workforce development.

At the same time, there are 5.5 million young Americans age 16-24 who are neither employed nor enrolled in school.[iii] These youth are untapped economic assets in our communities nationwide and have the potential to provide returns of as much as $5 trillion to our economy and our communities both in terms of wages and economic activity as well as reduced dependence on taxpayer support.[iv] These young people are the future of our country and economy and we literally cannot afford to overlook them.

Fortunately, the path to employment and meaningful careers for these youth is not necessarily long. Nearly 50 percent of job openings over the next decade will be 'middle-skill' jobs, or jobs that require more than a high school education but less than a four-year college degree.[v] These are jobs like transportation and material handlers in Oklahoma, insurance sales agents in Connecticut, and nurses and health care support pretty much everywhere.

Warren Buffet recently observed that America's competitive advantage is that "To a better degree than most societies, we have unlocked human potential." We agree that our workers and particularly our young people are America's greatest assets and for that reason Monster Government Solutions has sought to leverage our own technology and resources to expand our impact in workforce development. We believe economic growth is fueled by efficiently and appropriately connecting jobs and people. We are proud of our work in states like Ohio and Washington, where Monster's solutions help foster collaboration between key workforce stakeholders, improve recruitment services for employers, enrich workforce services

for the unemployed and job seekers, promote work-based training, and more. As a result, more people get into the right jobs faster, spurring economic growth, lowering unemployment insurance costs and conserving state budgets.

We are also particularly focused on investing in opportunity youth. Like the dozens of national employers participating in the 100,000 Opportunities Initiative, such as Walmart, JP Morgan, Hilton, Microsoft, we have made it a priority to connect these young people with employment opportunities. Towards that end, last year we worked with the Job Corps program to launch an initiative we call "Youth Opportunities 2020."

As you know, Job Corps is our nation's largest and most comprehensive program aimed at preparing opportunity youth for careers. Job Corps offers training in over 100 different high-demand occupations in 125 communities nationwide, including both rural and urban communities. Job Corps also provides the support services that are necessary to help develop the employability and 21st century skills of collaboration and teamwork, creativity and imagination, critical thinking, and problem solving that employers frequently cite as more critical than technical skills, but lacking in the labor market. Through counseling, contextualized learning, service learning opportunities, work-based learning and internships, Job Corps produces young people who are ready to work.

Most importantly, Job Corps works. A long-term evaluation of Job Corps found it to be the first program to demonstrate long-term impacts on earnings for this population.[vi] In the 20 years since that study was conducted, the program has continued to improve. In program year 2015, the average literacy and numeracy gains made by Job Corps enrollees were greater than

2.5 Test for Adult Basic Education (TABE) grade-level equivalents and nearly 80 percent of students left with an industry-recognized credential.[vii] The result: 86 percent of graduates secured jobs or enrolled in higher education.[viii]

We've learned over time that small and large businesses across the nation trust their Job Corps centers and Job Corps graduates to meet their talent needs as evidence by that fact that over 100 local Chambers of Commerce, from Oklahoma to Connecticut and Florida to Alaska, have signed letters of support for the program. That is why Monster Government Solutions worked with the National Job Corps Foundation for Youth Opportunities to create and launch our Youth Opportunities portal which gives employers nationwide an opportunity to be matched to and connect with thousands of skilled young Americans at no cost, using Monster's award winning technologies. The 50,000 students that participate in Job Corps each year can create their own personal account, search for job titles that match the program's trade offerings and be matched to jobs based on their credentials earned at Job Corps. Our investment in this platform and in these youth, is one that Monster is proud to make. As a global leader in successfully connecting jobs and people, we believe these types of investments are critical to our country's future and we're committed to building upon them.

We at Monster are mission-driven to expand employment opportunities for our most disadvantaged citizens, including opportunity youth, and to ensure employers find the skills and work-ready employees they need to succeed and grow their businesses. In order to help us, employers nationwide, and our nation achieve that goal, we encourage the Subcommittee and the Congress to continue to invest in opportunity youth. Specifically, which we urge the

Subcommittee, which has provided bipartisan support to Job Corps for over 50 years, to continue to do the same and provide the program with sufficient funding to serve as many of these young people as possible in FY 2018.

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[i] Donahue, T. and Hansen, D. *The Conversation About America's Skills Gap is Changing.* U.S. Chamber of Commerce. Retrieved February 13, 2017 from https://www.uschamber.com/above-the-fold/the-conversation-about-americas-skills-gap-changing

[ii] Fisher, Anne. "Unfilled jobs cost the U.S. economy $160 billion a year." Fortune. November 18, 2014. Retrieved February 21, 2017 from http://tech.fortune.cnn.com/2014/11/18/unfilled-jobs-us-economy/

[iii] *The Opportunity Index: Opportunity in America 2011-2015.* Opportunity Nation. Retrieved November 3, 2016 from http://opportunitynation.org/opportunity-index/.

[iv] Belfield, C., Levin, H., and Rosen, R. *The Economic Value of Opportunity Youth.* Civic Enterprises. January 2012. Retrieved February 21, 2017 from: https://www.serve.gov/new-images/council/pdf/econ_value_opportunity_youth.pdf

[v] *United States' Forgotten Middle.* National Skills Coalition. Retrieved March 2, 2017 from http://www.nationalskillscoalition.org/resources/publications/2017-middle-skills-fact-sheets/file/United-States-MiddleSkills.pdf

[vi] Schochet, P.Z.; Burghardt, J.; and McConnell, S. (2008). *Does Job Corps Work? Impact Findings from the National Job Corps Study.* American Economic Review 2008, 98:5, 1864-1886.

[vii] *Outcome Measurement System Center Report Card (OMS-10); Report Period: 7/1/2015 – 6/30/2016.* U.S. Department of Labor. Retrieved February 13, 2017 from http://www.jobcorps.gov/Libraries/Annual%20Reports/OMS10_2016.sflb

[viii] Ibid

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

## Witness Disclosure Form

Clause 2(g) of rule XI of the Rules of the House of Representatives requires non-governmental witnesses to disclose to the Committee the following information. A non-governmental witness is any witness appearing on behalf of himself/herself or on behalf of an organization other than a federal agency, or a state, local or tribal government.

Your Name, Business Address, and Telephone Number:
**Ms. Susan Fallon**
**Monster Government Solutions**
**8280 Greensboro Drive, Suite 900**
**McLean VA 22101**
**(703) 270-7169**

1. Are you appearing on behalf of yourself or a non-governmental organization? Please list organization(s) you are representing.
   **Monster Government Solutions**

2. Have you or any organization you are representing received any Federal grants or contracts (including any subgrants or subcontracts) since October 1, 2012 related to the agencies or programs funded by the Subcommittee?
   (Yes) No

3. Have you or any organization you are representing received any contracts or payments originating with a foreign government since October 1, 2012 related to the agencies or programs funded by the Subcommittee?
   Yes (No)

4. If your response to question #2 and/or #3 is "Yes", please list the amount and source (by agency and program) of each Federal grant (or subgrant thereof) or contract (or subcontract thereof), and/or the amount and country of origin of any payment or contract originating with a foreign government. Please also indicate whether the recipient was you or the organization(s) you are representing.

Signature: [redacted] Date: 03-03-17

(2) Federal contract or grant information for Monster Government Solutions:

U.S. Department of the Interior's National Business Center;

Program: Talent Acquisition System (TAS), Monster Hiring Management
Department of Education: annual system subscription $127K
Department of Labor: annual system subscription $480K

Mr. COLE. The gentlelady from Massachusetts is recognized for her comments.

Ms. CLARK. Thank you, Mr. Chairman, and thank you for being here today. Mr. Chairman, I am glad you noticed the twofer approach. That is how we roll in CD-5. [Laughter.]

Ms. CLARK. And we are just delighted to be here, and thank you for making the connections. Creating jobs, allowing people to have that matched with good employment is the most critical function we can have. And thank you for your work and being here today to underline the importance of this line item.

Ms. FALLON. Thank you, Congresswoman.

Mr. COLE. Thank you very much for your testimony.

Ms. FALLON. Thank you, sir.

Mr. COLE. Next witness, and it is good to have my good friend, Robert Egge, the chief public policy officer for the Alzheimer's Association. In full disclosure, we have done a lot of work together. Appreciate his good work. And the gentleman is recognized for whatever testimony he cares to deliver to the committee.

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WEDNESDAY, MARCH 8, 2017.

## ALZHEIMER'S ASSOCIATION

### WITNESS

### ROBERT EGGE, CHIEF PUBLIC POLICY OFFICER, ALZHEIMER'S ASSOCIATION

Mr. EGGE. Thank you very much. Good morning, Chairman Cole, Ranking Member DeLauro, and members of the Subcommittee. On behalf of the more than 5 million Americans living with Alzheimer's disease and their 15 million caregivers, thank you for the opportunity to testify before you today.

I would like to begin by thanking you for the extremely important leadership the subcommittee demonstrated in addressing Alzheimer's during the 114th Congress. You were integral to delivering a much-needed historic increase in Alzheimer's funding in Fiscal Year 2016. And for Fiscal Year 2017, you completed the work to do so again. On that note, we ask you to continue to pursue this very important Alzheimer's research funding over the coming 2 months.

The Alzheimer's community is very grateful for your work. You have given new hope to Americans that the realities that define this disease today can and will change in the years ahead. As you are well aware, however, today the realities that define this disease remain grim.

Alzheimer's is a terminal disease with no survivors. Recent failures of high-profile Alzheimer's trials underscore that Alzheimer's retains the unacceptable distinction of being the only one of the top 10 causes of death in America without a way to cure, prevent, or even slow progression. It should be no surprise then that Alzheimer's has become a top priority of Americans. In fact, those middle-aged and older identify Alzheimer's by a significant margin as the disease they fear most.

Alzheimer's is also very costly. Another regrettable distinction held by Alzheimer's is that according to the NIH funded study con-

ducted by Rand economists and published in The New England Journal of Medicine, Alzheimer's has grown to become the most expensive disease in America. More than two-thirds of this cost is paid for by Medicare and Medicaid.

As if all this were not enough to justify an urgent response, America's Alzheimer's crisis is set to grow much worse in the years ahead. Because Alzheimer's is predominately a disease associated with aging and America is predominantly an aging society, these numbers will skyrocket between now and 2050. By 2050, those with Alzheimer's will as much as triple, and the associated costs will quadruple to $1,100,000,000,000 per year, unless, that is, we can change the trajectory through the development of effective treatments and a means of prevention.

These facts underscore that America urgently needs this subcommittee's continued decisive leadership. But all these facts make only half a case. We understand that you not only must ensure that you direct limited resources to where the needs are great, but also to where the opportunities are great.

What is more, you need to decide not just whether funds are warranted, but how much funding is warranted. These are important and difficult questions to answer. Fortunately, in the case of Alzheimer's specifically, Congress has put in place a policy framework that has provided you with this exact information for Fiscal Year 2018, and we urge you to rely on it.

In 2011, the bipartisan National Alzheimer's Project Act became law, requiring the creation of a comprehensive national Alzheimer's plan. The U.S. Department of Health and Human Services released this plan in 2012, containing the lead goal to prevent and effectively treat Alzheimer's by 2025.

Then in 2014, Congress enacted the Alzheimer's Accountability Act. This Act requires the National Institutes of Health prepare for Congress and the President an annual professional judgment budget, sometimes called a bypass budget. In this bypass budget for Fiscal Year 2018, NIH director, Francis Collins, has stated that the NIH will require additional $414,000,0000 in funding to remain on track to achieve the plan's 2025 goal. The NIH has done excellent work carefully detailing a plan-based budget to decisively address this disease. We ask you to fund this plan for the coming Fiscal Year.

When coupled with the facts about the burden of this disease that I outlined earlier, we believe that together those arresting facts and this thorough NIH budget do make for a complete and compelling case for this subcommittee to stay the course, a course that has every potential to change the future of Alzheimer's disease.

In sum, on behalf of the Alzheimer's Association and our sister organization, the Alzheimer's Impact Movement, we commend Congress for creating a process that has equipped this subcommittee in an unusually thorough way to answer the question of what to provide for Alzheimer's research in Fiscal Year 2018. Following this process, NIH scientists have indicated to you that they require an increase of $414,000,0000 in Alzheimer's research funding for the coming year. The Alzheimer's Association and the Alzheimer's

Impact Movement are pleased to adopt this determination by the NIH as our request for this subcommittee.

Thank you.

[The information follows:]

Testimony of Robert Egge, Chief Public Policy Officer of the Alzheimer's Association
Fiscal Year 2018 Appropriations for Alzheimer's-related Activities
at the U.S. Department of Health and Human Services

Subcommittee on Labor, Health and Human Services, Education and Related Agencies
Committee on Appropriations
United States House of Representatives

March 8, 2017

The Alzheimer's Association appreciates the opportunity to comment on the Fiscal Year (FY) 2018 appropriations for Alzheimer's research, education, outreach and support at the U.S. Department of Health and Human Services.

Founded in 1980, the Alzheimer's Association is the world's leading voluntary health organization in Alzheimer's care, support and research. Our mission is to eliminate Alzheimer's and other dementias through the advancement of research; to provide and enhance care and support for all affected; and to reduce the risk of dementia through the promotion of brain health. The Alzheimer's Association is the nonprofit with the highest impact in Alzheimer's research worldwide and is committed to accelerating progress of new treatments, preventions and, ultimately, a cure. Through our funded projects and partnerships, we have been part of every major Alzheimer's research advancement over the past 30 years. Likewise, the Association works to enhance care and provide support for all those affected by Alzheimer's and reaches millions of people affected by Alzheimer's and their caregivers. In partnership with its sister organization, the Alzheimer's Impact Movement (AIM), the Alzheimer's Association is committed to creating a world without Alzheimer's.

**Alzheimer's Impact on the American People and the Economy**

The most important reason to address Alzheimer's is because of the human suffering it causes to millions of Americans. Alzheimer's is a progressive brain disorder that damages and eventually destroys

brain cells, leading to a loss of memory, thinking and other brain functions. Ultimately, Alzheimer's is fatal. Currently, Alzheimer's is the sixth leading cause of death in the United States and the only one of the top ten without a means to prevent, cure or slow its progression. Over five million Americans are living with Alzheimer's, with 200,000 under the age of 65.

In addition to the human suffering caused by the disease, however, Alzheimer's is also creating an enormous strain on the health care system, families and federal and state budgets. Alzheimer's is the most expensive disease in America. In fact, a study funded by the National Institutes of Health (NIH) in the *New England Journal of Medicine* confirmed that Alzheimer's is the most costly disease in America, with costs set to skyrocket at unprecedented rates. If nothing is done, as many as 16 million Americans will have Alzheimer's by 2050 and costs will exceed $1.1 trillion (not adjusted for inflation), creating an enormous strain on the health care system, families and federal and state budgets.[1] As the current generation of baby boomers age, near-term costs for caring for those with Alzheimer's will balloon, as Medicare and Medicaid will cover more than two-thirds of the costs for their care.

Caring for people with Alzheimer's will cost all payers - Medicare, Medicaid, individuals, private insurers and HMOs -- $20 trillion over the next 40 years. As noted in the *2017 Alzheimer's Disease Facts and Figures* report released on March 7, 2017, in 2017, America will spend an estimated $259 billion in direct costs for those with Alzheimer's, including $175 billion in costs to Medicare and Medicaid. Average per person Medicare costs for those with Alzheimer's and other dementias are three times higher than those without these conditions. Average per senior Medicaid spending is 23 times higher.[2]

A primary reason for these costs is that Alzheimer's makes treating other diseases more expensive, as most individuals with Alzheimer's have one or more comorbidities that complicate the management of the condition(s) and increase costs. For example, a senior with diabetes and Alzheimer's

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[1] *2017 Alzheimer's Disease Facts and Figures*: http://www.alz.org/facts/downloads/facts_figures_2017.pdf
[2] ibid

costs Medicare 81 percent more than a senior who only has diabetes. Nearly 30 percent of people with Alzheimer's or other dementias who have Medicare also have Medicaid coverage, compared with 11 percent of individuals without Alzheimer's or other dementias. Alzheimer's is also extremely prevalent in nursing homes, where 64 percent of Medicare residents live with the disease.

With Alzheimer's, it is not just those with the disease who suffer - it is also their caregivers and families. In 2016, 15.9 million family members and friends provided unpaid care valued at over $230 billion. Caring for a person with Alzheimer's takes longer, lasts longer, is more personal and intrusive, and takes a heavy toll on the health of the caregivers themselves. Nearly 60 percent of Alzheimer's and dementia caregivers rate the emotional stress of caregiving as high or very high, with nearly 40 percent reporting symptoms of depression. Caregiving may also have a negative impact on health, employment, income and family finances. Due to the physical and emotional toll of caregiving on their own health, Alzheimer's and dementia caregivers had $10.9 billion in additional health costs in 2016.[3]

**Changing the Trajectory of Alzheimer's**

Until recently, there was no federal government strategy to address this looming crisis. In 2010, thanks to bipartisan support in Congress, the National Alzheimer's Project Act (NAPA) (P.L. 111-375) passed unanimously, requiring the creation of an annually-updated strategic National Alzheimer's Plan (National Plan) to help those with the disease and their families today and to change the trajectory of the disease for the future. The National Plan must include an evaluation of all federally-funded efforts in Alzheimer's research, care and services - along with their outcomes. In addition, the National Plan must outline priority actions to reduce the financial impact of Alzheimer's on federal programs and on families; improve health outcomes for all Americans living with Alzheimer's; and improve the prevention, diagnosis, treatment, care, institutional-, home-, and community-based Alzheimer's programs for individuals with

[3] ibid

Alzheimer's and their caregivers. Through its annual review process, NAPA has enabled, for the first time, Congress and the American people to assess whether the nation is meeting the challenges of this disease for families, communities and the economy.

As mandated by NAPA, the Secretary of Health and Human Services, in collaboration with the Advisory Council on Alzheimer's Research, Care and Services, released the first-ever *National Plan to Address Alzheimer's Disease* in May of 2012 and released annual updates, the most recent of which was released in August 2016. The Advisory Council, composed of both federal members and expert non-federal members, is an integral part of the planning process as it advises the Secretary in developing and evaluating the annual National Plan, makes recommendations to the Secretary and Congress, and assists in coordinating the work of federal agencies involved in Alzheimer's research, care and services.

In keeping with the National Plan, NIH convened research summits in 2012 and 2015, which resulted in the development and updating of research milestones and timelines for meeting the goal of effectively treating and preventing Alzheimer's by 2025. Having a plan with measurable outcomes is important. But unless there are resources to implement the plan and the will to abide by it, we cannot hope to make adequate progress.

If we are going to succeed in the fight against Alzheimer's, Congress must continue to provide the resources the scientists need. Understanding this, in 2014, Congress passed the *Consolidated and Further Continuing Appropriations Act of 2015* (P.L. 113-235), which included the *Alzheimer's Accountability Act (S. 2192/H.R. 4351)*. The Alzheimer's Accountability Act requires NIH to develop a professional judgment budget focused on the milestones established by the National Plan. This provides Congress with an account of the resources that NIH believes are needed to reach the critical goal of the National Plan: to effectively treat and prevent Alzheimer's by 2025. The latest professional judgment budget, released in August 2016, calls for an additional $414 million for Alzheimer's research funding in Fiscal Year 2018.

A disease-modifying or preventive therapy would not only save millions of lives but would save billions of dollars in health care costs. Specifically, if a treatment became available in 2025 that delayed onset of Alzheimer's for five years (a treatment similar in effect to anti-cholesterol drugs), savings would be seen almost immediately, with Medicare and Medicaid saving a cumulative $535 billion in the first ten years.[4]

**Consistent with the Alzheimer's Professional Judgment Budget issued by the NIH for FY 2018, the Alzheimer's Association urges Congress to listen to the scientists at the NIH by supporting an additional $414 million for research activities and priorities included in the National Alzheimer's Plan required under P.L. 111-375.**

**Conclusion**

The Alzheimer's Association appreciates the steadfast support of the Subcommittee and its priority setting activities. We look forward to continuing to work with Congress in order to address the Alzheimer's crisis. We ask Congress to address Alzheimer's with the same bipartisan collaboration demonstrated in the passage of the National Alzheimer's Project Act (P.L. 111-375) and enactment of the Alzheimer's Accountability Act (P.L. 113-235) with an additional $414 million for Alzheimer's research activities in FY 2018.

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[4] *Changing the Trajectory of Alzheimer's Disease: How a Treatment by 2025 Saves Lives and Dollars*: http://www.alz.org/documents_custom/trajectory.pdf

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

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Your Name, Business Address, and Telephone Number:
Robert Egge
1212 New York Avenue NW, Suite 800
Washington, DC 20005
202.393.7737

1. Are you appearing on behalf of yourself or a non-governmental organization? Please list organization(s) you are representing.

   Alzheimer's Association

2. Have you or any organization you are representing received any Federal grants or contracts (including any subgrants or subcontracts) since October 1, 2012 related to the agencies or programs funded by the Subcommittee?

   Yes No

3. Have you or any organization you are representing received any contracts or payments originating with a foreign government since October 1, 2012 related to the agencies or programs funded by the Subcommittee?

   Yes No

4. If your response to question #2 and/or #3 is "Yes", please list the amount and source (by agency and program) of each Federal grant (or subgrant thereof) or contract (or subcontract thereof), and/or the amount and country of origin of any payment or contract originating with a foreign government. Please also indicate whether the recipient was you or the organization(s) you are representing.

See attached.

Signature: [redacted] Date: 3/2/17

**Alzheimer's Association**
**SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS**
**Period ended June 30, 2016**

| Federal grantor/pass-through grantor/program title | Federal CFDA number | FY11 Federal expenditures | FY12 Federal expenditures | FY13 Federal expenditures | FY14 Federal expenditures | FY15 Federal expenditures | FY16 Federal expenditures | TOTAL Federal expenditures |
|---|---|---|---|---|---|---|---|---|
| U.S. Department of Health and Human Services | | | | | | | | |
| Administration on Aging - Special Programs for the Aging - Title IV and Title II - Discretionary Projects Alzheimer's National Call Center - American Recovery & Reinvestment Act | 93.048 | $ 987,000 | $ 987,000 | $ 985,135 | $ 929,926 | $ 933,571 | $ 933,571 | $ 5,756,203 |
| Administration for Community Living - Alzheimer's Disease Demonstration Grants to States | 93.051 | - | - | 185,168 | 66,714 | 62,648 | 216,619 | 531,149 |
| Administration for Community Living - National Family Caregiver Caregiver Support, Title III, Part E | 93.052 | - | - | - | 312,415 | 280,930 | 357,260 | 950,605 |
| Alzheimer's Disease Initiative: Specialized Supportive Services Project (ADI-SSS) thru Prevention and Public Health Funds (PPHF) | 93.763 | - | - | - | - | - | 11,355 | 11,355 |
| Centers for Disease Control and Prevention - Investigations and Technical Assistance - To Partner and Implement Public Health Strategies | 93.283 | 635,590 | 649,580 | - | 554,851 | 888,249 | 465,003 | 3,193,273 |
| Centers for Disease Control and Prevention - The Healthy Brain Initiative: Technical Assistance to Implement Public Health Actions related to Cognitive Health, Cognitive Impairment, and Caregiving at the State and Local Levels | 93.334 | - | | - | - | - | 424,563 | 424,563 |
| Centers for Disease Control and Prevention - Investigations and Technical Assistance - To Partner and Implement Public Health Strategies | 93.945 | | - | 889,102 | - | - | - | 889,102 |
| Total U.S. Department of Health and Human Services | | 1,622,590 | 1,636,580 | 2,059,405 | 1,863,906 | 2,165,398 | 2,408,371 | 11,756,250 |
| U.S. Department of Justice | | | | | | | | |
| Office of Juvenile Justice and Delinquency Prevention - Alzheimer's Disease Patient Assistance - National Alzheimer's Patient Alert Program: Wandering & Safety Response Initiative | 16.015 | 179,364 | 203,758 | 245,420 | 608,330 | - | - | 1,236,872 |
| U.S. Department of Transportation | | | | | | | | |
| National Highway Traffic Safety Administration (NHTSA) Discretionary Safety Grants: Older Driver Resources on Caregivers and Dementia | 20.614 | 47,392 | 86,792 | 4,190 | | - | - | 138,374 |
| Total expenditures of federal awards | | $ 1,849,346 | $ 1,927,130 | $ 2,309,015 | $ 2,472,236 | $ 2,165,398 | $ 2,408,371 | $ 13,131,496 |

Mr. COLE. Thank you. I thank the gentleman very much for his testimony, and reiterate two points that he made that I suspect my good friend from Connecticut would also agree with. The first one is we do need to finish up the 2017 bill. And I am very worried that the temptation when we hit the deadline on April 28th will be to simply continue a CR. If that happens, we will lose the opportunity for a significant boost in funding for NIH in general, Alzheimer's in particular.

So, I know you are working hard on this, and so, I do not need to urge you to do it, but I want to thank you for doing it. And this is a really critical thing. We are thinking a lot about 2018, but we need to literally get the work done because both the Senate and the House have agreed to prioritize both the NIH and Alzheimer's funding.

So, if we do not get the 2017 bill and we CR, we will spend exactly the same amount of money. It just will not go to the NIH and Alzheimer's. So, this is something we need to work on together. And, again, I know what my friend has been a tireless advocate on this as well on her side of the aisle.

The second thing is, the 2018 budget, as my friend would point out, and I will agree with her again, only happens if we have, you know, an appropriate allocation level. And, you know, I am all in favor of the defense buildup. I am not critical of that at all. I think it needs to happen.

But this is not the place to fund it in my view because, you know, I did not think it was particularly good policy when President Obama argued that if defense goes up, domestic has to go up exactly the same amount. It is just as bad to say if defense goes up, domestic spending has to go down exactly. We should evaluate each of them independently in my viewpoint, sort of break that chain.

But, again, I thank my friend for making a good case not only for the particular cause, but for the larger case of just the general allocation this committee receives.

Does my friend from Connecticut care to——

Ms. DELAURO. Well, I think this is an institution that has a lot of very well-meaning people on both sides of the aisle to do things, but it really moves when there is external pressure. I will say this to everybody in the audience. You are the external pressure.

And, you know, I think Chairman is right. We would do well if we did 2017. There would be an increase, and then we are both very concerned about 2018 and what this might mean. And it would be, to say the least, devastating to your interests and others here as well.

So, you need to go back to your groups and associations, people who hear from you.

Mr. EGGE. We will do so.

Ms. DELAURO. Thank you.

Mr. COLE. Again, appreciate the gentleman's testimony. And with that, we will move to the next witness.

Welcome. It is good to have you here.

Mr. LONGMIRE. Good to be here.

Mr. COLE. Mr. Joseph Longmire. He is a student with the Council for Opportunity in Education, better known around here as

TRIO. There is no cause that has probably been more bipartisan on this committee than that. We have worked hard on this program, and we appreciate you very much being here to testify.

The gentleman is recognized for 5 minutes.

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WEDNESDAY, MARCH 8, 2017.

## COUNCIL FOR OPPORTUNITY IN EDUCATION

### WITNESS

### JOSEPH LONGMIRE, JR., STUDENT, COUNCIL FOR OPPORTUNITY IN EDUCATION

Mr. LONGMIRE. I want to start by thanking Chairman Cole and all of the members of the subcommittee for the opportunity to be here today to discuss TRIO. I would be remiss if I did not also acknowledge my congresswoman, Representative Martha Roby, and express my thanks for her support.

I am a witness to the fact that TRIO is making a huge difference in shaping the future of students like me across the 2nd District of Alabama. TRIO has led so many firsts for me, including this visit to Washington, D.C., which marks my first experience flying on an airplane and my first time visiting the Nation's Capital.

I grew up in Greenville, Alabama as the oldest of four children ranging from ages 8 to 20. My parents have always worked extremely hard to provide for my siblings and me. My father maintains several jobs, including full time as an order filler at the Walmart Mart Distribution Center, as well as a barber, mechanic, and handyman. My mother works at a childcare center. My parents always encourage my siblings and me to achieve as much education as possible.

Despite their enduring love and support, I had to look beyond my immediate family for help in pursuing my higher education goals. This is where TRIO stepped in and became like another family for me.

In order to save money, I decided to begin my college career at Lurleen B. Wallace Community College. During my early days as a student there, I met with the counseling services provided by the college, but found that I needed more consistent and personalized support. Thankfully, I stumbled upon a flyer inviting students to come to an orientation for the TRIO Student Support Services Program.

I did not realize it at the time, but that first meeting was my welcome to an educational family that would push me to excel. My first year in TRIO was amazing. The director, staff, and fellow students consistently proved to be reliable sources for help. TRIO's tutoring services were especially critical. Even though they performed well academically in high school, I struggled with several of my college courses and, at times, fear that I would receive failing grades. This was especially true of my English class. However, because of the academic assistance provided by TRIO, I not only passed these classes, but I also earned a few A's along the way.

As my graduation from community college approached, I found myself frustrated about what I wanted to do next. While I knew I wanted to be an occupational therapist, I did not know how to

get there. Once again, it was my TRIO family that helped me find my way. The program director and the staff helped me navigate the complicated process of transferring to a 4-year institution. From deciding where to go to waiving my application fees, they were there every step of the way. Without their help. I would have found myself among the 72 percentage of low-income first generation community college students who failed to transfer without additional support.

Nationally, TRIO Student Support Services participants chance or at a rate that is 46 percent higher. Thanks to the assistance of the TRIO Program at Lurleen B. Wallace Community College, last fall I enrolled as a junior at Alabama State University where I majored in health rehabilitation. The change to a 4-year institution has been dramatic. Coming into a situation where I did not know anyone, I felt like a guppy in a huge ocean of fish.

On my first day of classes, I found the TRIO office, and I felt like a weight was lifted off my shoulders. I knew that I had found my life support for the rest of my college career.

Today, the TRIO Program at Alabama State continues to give me the academic and social support I need in order to succeed. This support system has been extremely critical for me as I must juggle both my studies and my finances. In addition to benefiting from TRIO, I am also a Pell Grant recipient. However, financial aid alone does not fully meet my needs.

So, my course load as a student, I work 30 hours a week as an office clerk at Super Foods Grocery Store and as a merchandiser for a magazine retailer. While my schedule can be overwhelming at times, I know that these years of struggle and sacrifice will be worth it. When I graduate, I will be the first person in my family to earn a bachelor's degree. However, I know with certainty that I will not be the last.

Because TRIO played such a big role in my college life, I made sure that my younger brother, who is now a freshman at Lurleen B. Wallace, also got involved with the TRIO Program on campus. I can truly say that becoming part of TRIO is one of the best decisions that I have made while attending college.

I would enthusiastically recommend participation in TRIO to every college student. It can truly be the difference between failing or passing classes, dropping out or persevering to see another semester, succumbing to overwhelming pressures or learning to thrive amidst adversity.

I hope this subcommittee will do everything possible to increase funding for TRIO so that more students like me will have the opportunity to achieve their college dreams.

Thank you again for the opportunity to testify here today.

[Applause.]

[The information follows:]

**Labor Health and Human Services, Education, and Related Agencies**
**Public Witnesses Hearing**
**Wednesday, March 8, 2017 Hearing**

**Testimony of Mr. Joseph Longmire, Jr.**
Junior, Alabama State University
Representing the Council for Opportunity in Education

I would like to start my testimony by thanking Chairman Cole, Vice Chairman Womack, Ranking Member DeLauro and all of the Members of the Subcommittee for the opportunity to be here today to discuss the impact of the Federal TRIO Programs on my life. I would be remiss if I did not also acknowledge my own Congresswoman, Representative Martha Roby, and express my thanks for her support. I am a witness to the fact that TRIO is making a huge difference in shaping the futures of students like me across the Second District of Alabama. TRIO has led to many "firsts" for me, including this visit to Washington, DC, which marks my first experience flying on an airplane and my first time visiting the nation's capital.

I grew up in a traditional, first-generation household in Greenville, Alabama as the oldest of four children. My parents have always worked extremely hard to provide for my siblings and me. My father maintains several jobs. In addition to working full-time job as an Order Filler at the Wal-Mart Distribution Center, my father also works as a barber, mechanic, and handyman. Meanwhile my mother provides childcare at a local daycare facility. Despite their enduring love and support, I had to look beyond my immediate family for help in pursuing my higher education goals. This is where TRIO stepped in and became like another family for me.

I began my college career at Lurleen B. Wallace Community College. During my early days as a student there, I stumbled upon a flyer inviting students to come to an orientation for the TRIO

Student Support Services program. I didn't realize it at the time, but that first meeting was my welcome to an educational family that would push me to excel in every endeavor. My first year in TRIO was an amazing experience. The Director, staff, and fellow students consistently proved to be reliable sources for help. TRIO's tutoring services were especially critical as I struggled with several of my courses and, at times, feared that I would receive failing grades. This was particularly true of my English Class. However, because of the academic assistance provided by TRIO, I not only passed these classes, but I also earned a few A's along the way.

As my graduation from community college approached, I found myself frustrated as I was completely unsure as to what I wanted to do next. Once again, it was my TRIO family that helped me find my way. The program director and staff helped me navigate the complicated process of transferring to a four-year institution. No matter where I landed, one thing was certain. I knew that I had to become a member of the TRIO Student Support Services at whatever university I attended. Without their help, I don't know if I would have found myself among that handful of low-income, first-generation community college students who manage to successfully transfer to four-year institutions without additional support. Nationally, only 28% of such students manage to transfer; however, TRIO participants transfer at the much higher rate of 41%.

Thanks to the assistance of the TRIO program at Lurleen B. Wallace Community College, last fall I enrolled as a junior at Alabama State University, a historically-black college, where I major in Health Rehabilitation. The change to a four-year institution has been dramatic. Coming into a situation where I didn't know anyone, I felt like a guppie in a huge ocean of fish. On my first day of classes, I knew that I had to find out where the Student Support Services office was located.

When I found the door marked "TRIO," I felt as though a weight was taken off of my shoulders because I knew that I had found my life support for the rest of my college career. Today, the TRIO program at ASU continues to give me the academic and social support I need in order to succeed.

This support system has been extremely critical for me as I must juggle both my studies and my finances. In addition to benefiting from TRIO, I am also a Pell Grant recipient; however, financial aid alone does not fully meet my needs. So, besides my course load as a full-time student, I maintain two part-time jobs that total about 30 hours per week. More specifically, I work as an office clerk at SuperFoods grocery store and as well as a merchandiser for retailer TNG. I recently added substitute teaching to my work schedule in order to allow me to meet my financial goals.

While my schedule can be overwhelming at times, I know that these years of struggle and sacrifice will be worth it. When I graduate in 2018, I will be the first person in my family to earn a bachelor's degree. However, I know with certainty that I won't be the last. Because TRIO played such a big role in my college life, I made sure that my younger brother, who is now a freshman at Lurleen B. Wallace, also got involved with the TRIO program on campus.

When I reflect on my experience, I can truly say that becoming part of TRIO is one of the best decisions that I have made while attending college. I would enthusiastically recommend participation in TRIO Student Support Services to every college student. It can truly be the difference between failing or passing classes; dropping out or persevering to see another semester; succumbing to overwhelming pressures or learning to thrive amidst adversity. I hope

that this Subcommittee will do everything possible to increase funding for TRIO so that more students like me will have the opportunity to achieve their college dreams. Thank you, again, for the opportunity to testify here today.

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

## Witness Disclosure Form

Clause 2(g) of rule XI of the Rules of the House of Representatives requires non-governmental witnesses to disclose to the Committee the following information. A non-governmental witness is any witness appearing on behalf of himself/herself or on behalf of an organization other than a federal agency, or a state, local or tribal government.

Your Name, Business Address, and Telephone Number:

Joseph Longmire, Jr. c/o Council for Opportunity in Education, 1025 Vermont Avenue NW, Suite 900, Washington, DC 200005. 202.347.7430

1. Are you appearing on behalf of yourself or a non-governmental organization? Please list organization(s) you are representing.

   I am representing the Council for Opportunity in Education.

2. Have you or any organization you are representing received any Federal grants or contracts (including any subgrants or subcontracts) since October 1, 2012 related to the agencies or programs funded by the Subcommittee?

   **Yes**

3. Have you or any organization you are representing received any contracts or payments originating with a foreign government since October I, 2012 related to the agencies or programs funded by the Subcommittee?

   No

4. If your response to question #2 and/or #3 is "Yes", please list the amount and source (by agency and program) of each Federal grant (or subgrant thereof) or contract (or subcontract thereof), and/or the amount and country of origin of any payment or contract originating with a foreign government. Please also indicate whether the recipient was you or the organization(s) you are representing.

Please see the attached. All grants were awarded to the Council for Opportunity in Education

Signature: [redacted] Date: March 5, 2017

**Council for Opportunity in Education**

**Listing of Federal Grants**

**October 1, 2012 to September 30, 2017**

| Program Title | Recipient | Federal CFDA Number | Year | Grant/Contract No. | | Amount |
|---|---|---|---|---|---|---|
| **US Department of Education:** | | | | | | |
| Investing in Innovation (i3) - ARRA Funds | Council for Opportunity in Education | 84.396B | 10/1/2012-2/28/2017 | U396B100289 | $ | **15,103,290** |
| Higher Education-TRIO Staff Training Program (Priority 4) | Council for Opportunity in Education | 84-103A | 10/1/2012-9/30/2014 | P103A120014 | $ | **243,462** |
| Higher Education-TRIO Staff Training Program (Priority 2) | Council for Opportunity in Education | 84-103A | 10/1/2012-9/30/2014 | P103A120019 | $ | **486,925** |
| Higher Education-TRIO Staff Training Program (Priority 1) | Council for Opportunity in Education | 84-103A | 10/1/2014-9/30/2016 | P103A140025 | $ | **250,000** |
| Higher Education-TRIO Staff Training Program (Priority 1) | Council for Opportunity in Education | 84-103A | 10/1/2016-9/30/2017 | P103A160044 | $ | **257,500** |
| Higher Education-TRIO Staff Training Program (Priority 2) | Council for Opportunity in Education | 84-103A | 10/1/2016-9/30/2017 | P103A160023 | $ | **128,750** |
| Higher Education-TRIO Staff Training Program (Priority 4) | Council for Opportunity in Education | 84-103A | 10/1/2016-9/30/2017 | P103A160026 | $ | **257,500** |
| **National Science Foundation:** | | | | | | |
| BP: Computing Beyond the Double Bind: Women of Color in Computing Education and Careers | Council for Opportunity in Education | CNS - 1240768 | 10/1/2012-9/30/2014 | | $ | **101,033** |

Mr. COLE. We want to thank the gentleman for his testimony, welcome him to Washington for his first trip up here. I certainly hope it is not his last. And just make the point, which I know this committee knows well, but since its inception, TRIO has produced over 5 million college graduates. And I would suggest that is one terrific investment for the United States of America to have made because I can assure you, those 5 million grads have paid a lot more taxes than we have ever spent on Trio.

This is a program that has a great return for us. Thank you for offering such compelling personal testimony for the difference it has made in your life, and through you and your family's life. It is a very powerful reinforcement for a very important program.

Ms. DELAURO. I would just say thank you very, very much, Joseph. What you do is to provide for us and for everyone here the veracity that the Federal government has a role in people's lives, that it can create, help to create opportunity. And that is why this institution of the United States Congress exists. And we need to continue to provide opportunity so that we can have just remarkable young men like yourself, who will work hard not only for yourself, but for your family as well.

Our congratulations to you, and thank you for being such a great role model. Thank you.

Mr. COLE. Thank you very much. The gentleman is excused. If we could have our next witness.

Welcome. Good to have you here.

Ms. CAMPBELL. Thank you. Thank you for——

Mr. COLE. You bet. This is Ms. Autumn Campbell, a former caregiver, speaking on behalf of the Older Americans Act. The gentlelady is recognized for 5 minutes.

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WEDNESDAY, MARCH 8, 2017.

## OLDER AMERICANS ACT

### WITNESS

### AUTUMN CAMPBELL, FORMER CAREGIVER, ON BEHALF OF THE OLDER AMERICANS ACT

Ms. CAMPBELL. Great. Thank you, Chairman Cole, Ranking Member DeLauro, and members of the committee. My name is Autumn Campbell, and I sincerely appreciate the opportunity to discuss my support for the Older Americans Act.

I am here today to share my experience as a caregiver for my mother and the importance of OAA services in helping me keep her at home. However, I should note that my caregiving experience also deepened the passion for aging issues, and I currently work for the National Association of Area Agencies on Aging, on behalf of local aging agencies that coordinate and deliver OAA programs across the country.

So, I always knew that at some point I was going to take care of my mom. I am an only child, and she was a single parent for most of my life. As she approached her 60s on a teacher's salary, I knew that she did not have the financial resources to live out her retirement independently, and that I would eventually have to

meet her care needs. However, I never thought that would come when I was 32.

Unfortunately, shortly after my mom turned 60, she developed a quickly progressing and devastating neurodegenerative disorder that robbed her of her physical and cognitive capacities. This diagnosis also sent me scrambling to figure out how to take care of her. After moving her in with me and securing Social Security Disability support, I knew that I was ultimately facing a choice of quitting my job to care for her or putting her in institutional care under Medicaid.

I called on the local area Agency on Aging, funded in part through the Older Americans Act, and they connected me to a number of services that helped me keep my mom at home and allowed me to continue working full time. For example, 3 days a week I dropped my mom off at an adult daycare center where I knew she would be loved, fed, entertained, and cared for while I went to work.

The local Aging Agency also provided caregiver respite when I desperately needed a break. When my mom's needs became too severe to take her to adult daycare, the Aging Agency helped me navigate the complicated world of Medicaid, and the local ombudsman office, also funded by the Older Americans Act, ensured that her application for a Medicaid home and community-based services waiver was shepherded through the cumbersome approval process so that she was not facing institutional placement. I could not have navigated my caregiver role without Older Americans Act services and the local aging agency. There is no doubt that without them I would have left the workforce to care for my mom or put her in institutional care funded by Medicaid.

My mom passed away in late 2015, but I am forever grateful that I was able to be there for her when she needed me, and that OAA programs made this possible. But my story is just one of millions about how critical Federal Older Americans Act programs are to seniors and caregivers. These essential programs help us as a country keep our promises to previous generations and care for the people who cared for us.

OAA is the cornerstone of the Nation's non-Medicaid Home and Community-Based Services System. There are dozens of OAA-funded services that enable seniors to age at home and in the community, and a few examples that show the range of the help that OAA provides are: in-home care to help with bathing and dressing; home delivered meals and congregate meals that prevent malnutrition and social isolation; transportation such as rides the doctor or the grocery store, information or referral assistance; case management and care coordination assistance; adult day care to relieve family caregivers; legal services to prevent abuse and exploitation; and support and training for often overwhelmed family caregivers such as myself.

These services are in high demand nationally, but they have very limited Federal resources. Meanwhile, we're facing an unprecedented demographic shift as the Nation's baby boomers age at a historic pace. Every day 10,000 people turn 65, and by 2030, 73 million people, or 1 in 5 Americans, will be 65 or older.

For years, funding for Older Americans Act programs has not kept pace with annual inflation, let alone a growing need. This rapid erosion of funding coupled with this growing need has made it increasingly difficult, or even impossible, for local agencies to even maintain existing services. As a result, local waiting lists are long and they are growing longer.

This dire situation only intensifies the need for Federal investment, especially considering that OAA programs help offset future mandatory spending. When seniors are healthier, Medicare saves money. When frail older adults get the in-home services and support that prevent or delay nursing home admission, Medicaid saves money. Why would we not invest in flexible, targeted, cost-effective, person-centered care on the front end to avoid greater longer-term costs among a growing population?

So, I urge appropriators to carry out the promise that your colleagues on both sides of the aisle made last year by reauthorizing OAA, and ensure that OAA programs are protected from brutal funding cuts. Specifically, I ask that you focus on restoring funding to critical programs, such as OAA Title 3(b), Supportive Services, and Title 3(e), National Family Caregiver Support Program, which have had little to no relief from previous cuts despite recent budget deals.

So, on behalf of the millions of older Americans and their caregivers in every community, on behalf of the hundreds of local agencies coordinating and delivering services, on behalf of one daughter trying to do her best to care for her mother, I urge you to protect investments in the Older Americans Act that are in the best interests of a rapidly aging population and our fiscal health as a country.

Thank you.

[The information follows:]

**Testimony of Autumn Campbell re: Older Americans Act (OAA) Programs**
**House Committee on Appropriations**
**Subcommittee on Labor, Health and Human Services, Education and Related Agencies**
**March 8, 2017**

Thank you Chairman Cole, Ranking Member DeLauro and Members of the Committee. My name is Autumn Campbell and I sincerely appreciate the opportunity to discuss my strong and continued support for protecting funding for the Older Americans Act (OAA).

I am here today to speak on behalf of my own experiences as a former caregiver for my mother, and the importance of OAA services in enabling me to keep her at home. However, I should note that my experiences also deepened a passion for aging issues, and I currently serve as the Director of Public Policy and Advocacy for the National Association of Area Agencies on Aging (n4a), where I have the privilege of advocating on behalf of local Area Agencies on Aging and Title VI Native American aging programs that deliver OAA programs in nearly every community across the country.

I always knew that at some point, I was going to be taking care of my mother. I am an only child and she was a single parent for most of my life. As she approached her sixties on a teacher's salary, I knew that she wouldn't have the financial resources to live out her retirement solely independently, and that I would have a big part in ensuring she was adequately cared for and happy in her later years.

However, I never thought that time would arrive when I was 32. Unfortunately, shortly after she turned 60, she developed a very quickly progressing and devastating neurodegenerative disorder that, over two short years, robbed her of all physical and cognitive capacities. This diagnosis also sent me scrambling to figure out how to provide care for my mother as her abilities declined and she could no longer care for herself. After moving her in with me, securing Social Security Disability support, and working with my very understanding employer on a

flexible schedule to accommodate multiple doctor's appointments, I knew that I was ultimately facing the choice of either quitting my job to care for her, or putting her in institutional care under Medicaid. I called on the local Area Agency on Aging, funded in part through the Older Americans Act, and they connected me to a number of services that helped me keep my mom at home, where we both wanted her to be, and also allowed me to continue working full time.

For example, three days a week I dropped my mom off at an adult day center where I knew she would be loved, fed, entertained and cared for while I went to work. The local aging agency then referred me to private-pay home care options I could afford and that could fill in gaps when she wasn't at adult day care. They also provided caregiver respite when I desperately needed just a couple of days out of town to recharge. When my mom's needs became too severe to take her to adult day care anymore, the aging agency helped me navigate the complicated world of publicly funded home care options for her through Medicaid, and the local ombudsman office (also funded through OAA) ensured that her application for a Medicaid home and community-based services waiver was fast-tracked through an often cumbersome approval process. Her caregiving needs were so severe that we simply didn't have time to wait for the system to run its normal course and the local aging agency was instrumental in moving things along. I could not have navigated this caregiver role without the assistance of these services funded through the Older Americans Act and delivered by the local aging agency, and there is no doubt in my mind that without them I would have quit my job and left the workforce to care for her, or she would have ended up in institutional care funded by Medicaid.

But my story is just one of millions of stories of how critical federal Older Americans Act (OAA) services are to millions of seniors and caregivers in every community in the country. These essential programs help us, as a country, keep our promise to previous generations and

care for the people who cared for us. I urge you to protect and promote investments in the Older Americans Act.

OAA is the cornerstone of the nation's non-Medicaid home and community-based services system, providing seniors and caregivers supports that they need to age at home and in the community for as long as possible.

There are dozens of programs and services funded by OAA, but here are just a few of the most common to show the range of help that OAA provides:

- in-home care, such as help with bathing and dressing;
- home-delivered meals and congregate meals served in local community or senior centers to prevent malnutrition and social isolation;
- transportation, such as rides to the doctor, grocery store or church;
- information and referral assistance so consumers can find the help they need locally;
- case management for those who need help coordinating their care;
- adult day care to relieve family caregivers;
- legal services to protect seniors from being exploited; and
- support for family caregivers who are doing their part to help loved ones age with dignity and independence.

As you can imagine, these services are in high demand in every community, but they have very limited federal resources. Meanwhile, we are facing an unprecedented demographic shift as the nation's baby boomers age at a pace unseen in history. Every day 10,000 people turn 65. In just the next four years, 15 million people will reach traditional retirement age. By 2030, over 73 million people, or one-fifth of the country's population, will be 65 or older.

For years, funding for Older Americans Act programs that support this growing

population has not even kept pace with annual inflation—let alone the population growth. This rapid erosion of funding coupled with a growing need has made it increasingly difficult, or even impossible for local providers to even maintain existing services. As a result, local waiting lists for many essential services are long and growing longer.

This dire situation only intensifies the need for federal investment, both in the short and long-term, especially considering that these vital discretionary programs help offset future mandatory spending—when seniors are healthier, Medicare saves money; when frail older adults receive in-home services that prevent or delay nursing home admission, Medicaid saves money.

Given OAA's 50-year history of providing flexible, targeted, cost-effective and person-centered care to keep seniors healthy, why would we not invest in these essential programs on the front end to avoid much greater long-term costs among a growing population?

This is why I'm here today, joined by a chorus of national and local aging advocates, urging you, as appropriators, to carry out the promise that your colleagues on both sides of the aisle made last year by reauthorizing OAA, and ensure that OAA programs are protected from brutal funding cuts that could directly prevent seniors from getting the ride to the doctor, the meal, or in my case, the adult day care and caregiver support services they need.

I know you face very tough choices about funding priorities this year. However, cutting OAA services will be a penny-wise, pound-foolish strategy and these cuts will end up costing taxpayers much more money in the long-run, and more importantly will threaten the health and dignity of millions of older Americans.

**Specifically, I urge you to support funding for OAA programs that, at a minimum, meets the levels that received bipartisan support in the 2016 reauthorization. I also ask that you focus on restoring funding to critical programs such as OAA Title III B Supportive**

**Services and the Title III E National Family Caregiver Support Program, which have had little to no relief from sequestration cuts despite recent budget deals.**

On behalf of the millions of older Americans and their caregivers in every community across the country, on behalf of the hundreds of local agencies coordinating and delivering services in nearly every community, and on behalf of one daughter caring for her mother, I urge you to protect investments in OAA that are in the best interests of a rapidly aging population and the financial health of the nation as a whole.

Thank you.

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

## Witness Disclosure Form

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Your Name, Business Address, and Telephone Number:
Autumn Campbell
1730 Rhode Island Ave., NW
Suite 1200
Washington, DC 20036

1. Are you appearing on behalf of yourself or a non-governmental organization? Please list organization(s) you are representing.

   Myself as a former caregiver for my mother.

2. Have you or any organization you are representing received any Federal grants or contracts (including any subgrants or subcontracts) since October 1, 2012 related to the agencies or programs funded by the Subcommittee?

   No

3. Have you or any organization you are representing received any contracts or payments originating with a foreign government since October I, 2012 related to the agencies or programs funded by the Subcommittee?

   No

4. If your response to question #2 and/or #3 is "Yes", please list the amount and source (by agency and program) of each Federal grant (or subgrant thereof) or contract (or subcontract thereof), and/or the amount and country of origin of any payment or contract originating with a foreign government. Please also indicate whether the recipient was you or the organization(s) you are representing.

Signature: [redacted]

Date: March 7, 2017

Mr. COLE. I thank the gentlelady for her compelling personal testimony as well as the very persuasive case she makes. Thank you for being here and testifying today.

Ms. CAMPBELL. Thank you.

Mr. COLE. I will call on our next witness, please.

Welcome. Good to have you here. I hope I do not butcher the name. It is Ms. Victoria, is it Kitchyan?

Ms. KITCHYAN. Kitchyan.

Mr. COLE. Kitchyan. Thank you. Great, and actually for me that was pretty good, though. That was not bad. [Laughter.]

Great Plains Area Board of Representative of the National Indian Health Board. The gentlelady is recognized for 5 minutes for testimony.

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WEDNESDAY, MARCH 8, 2017.

## NATIONAL INDIAN HEALTH BOARD

### WITNESS

### VICTORIA KITCHYAN, GREAT PLAINS AREA BOARD REPRESENTATIVE, NATIONAL INDIAN HEALTH BOARD

Ms. KITCHYAN. Good morning, Chairman Cole, Ranking Member DeLauro, and members of the subcommittee. Thank you. On behalf the National Indian Health Board, thank you for allowing me to testify on the Fiscal Year 2018 Health and Human Services budget. My name is Victoria Kitchyan, and I am a member of the Winnebago Tribe in Nebraska, and I am also a tribal council member. I serve as Treasurer.

First, I would like to thank the subcommittee for the great work that it has done to increase the profile of American Indian and Alaska Natives health issues over the last several years. Your commitment to these issues has been enormously helpful to the tribes, and it has allowed us to work directly with the agencies and have some of these hard discussions. So, we thank you for that.

As you are aware, a Federal promise was to provide Indian Health Service was made long ago. Our ancestors entered into these treaties and agreements, and part of these treatment agreements were to provide health service in exchange for tribal land and peace. The land and peace was given by the Federal government has yet to live up to its trust responsibility.

Our people live sicker. We die younger, on average, 4.5 five years earlier, and, in some States, up to 20 years younger. So, the time has long since passed to address some of these shortcomings.

Though the Indian Health Service continues to serve as the primary health provider for American Indians and Alaska Natives, funding for that Agency has always been far below the need. Additionally, IHS was never designed to be a public health system; rather, direct primary care. So, agencies like the Center for Disease Control and Prevention, Substance Abuse and Mental Health Services Administration, and Centers for Medicare and Medicaid Services, all play a crucial and critical role in this trust responsibility, and should offer a complementary role to Indian Health Service to uphold that trust responsibility.

Public health infrastructure in Indian country is one of the most severely underfunded and underdeveloped areas. Like States and territorial governments, tribes have both the rights and responsibilities to offer vital public health services for the communities. Currently tribes are regularly left out of these opportunities. State-run health programs simultaneously were left and overlooked at the Federal level when agencies have opportunities. So, these health initiatives are needed and not funded or overlooked.

One example of this in my tribe is with the Community Health Representative Training Program. We are very thankful to have that opportunity and to have that funding, but the program is driven by the State of Nebraska. It is not tribal priorities. So, the grant supports one position where in our community we know that cohorts are more successful. Cohorts work better, yet we have one position. So, the tribe and other tribal have to supplement that where they can and if they can to be successful and increase those positions.

So essentially, we are trying to fit into someone else's program, and it is just not working for Indian Country. So rather, we would like programs to be designed for the tribe. Government should respond to the local needs, and this means empowering tribes to have the ability to make their own funding decisions on programs like this CHR one I am talking about.

One way we could do this and help support public health infrastructure is supporting direct funding from CDC. NIHB requests on behalf of all tribes that in Fiscal Year 2018 Congress create base funding for tribal communities through the Public Health and Health Service Block Grant by allocating at least 5 percent directly to tribes. This will enable the public health systems in Indian Country to develop consistent, sustainable healthcare infrastructure dollars that are driven by the tribal interests and the tribal parties, and what communities know best are their needs, and not so much an opportunity that we try to navigate through, and fit into, just for funding purposes. It does not work.

So, it is well time that tribal communities catch up to other Americans when it is the expectation of public health. Nowhere is the lack of solid infrastructure and support more acute than when it comes to the Mental and Behavioral Health Service. American Indians and Alaska Natives grapple with complex behavioral health issues. Restructured Federal policy through the years, changing political climate, unresponsive or harmful human services systems have created unresolved historical trauma, intergenerational trauma.

These wounds created by kill the Indian, save the man, these things have left scars, and without the proper resources or flexibility to design the programs that we need, we are just going to continue to perpetuate this problem and never achieve healthier outcomes.

Tribes request that automatic direct funding go to the Mental Health Service Grant and the Substance Abuse Grant. At the very minimum, we would like statutory requirements that would require the States to consult with the tribes, and also show how that is going to roll out and benefit our communities.

We also request they give priority to Circles of Care Program and tribal behavioral health programs. These are some of the only ones that are going to tribes, so we would also like to protect those and ensure that those continue.

And last but not least, I would like to touch on CMS and the over 40 years the acknowledgment to support tribes with CMS, within CMS. So, we need to authorize Medicaid reimbursement at IHs and the tribally-operated facilities, and to help these facilities continue to provide that 100 FMAP where available. And we are pleased to see that this week the House healthcare reform legislation included that, so we appreciate that, and we look forward to, you know, those continue discussions.

However, with Medicaid given more authority, we also want to ensure that the committee has oversight over CMS so that any of the applications submitted, waivers are consulted with the tribes, and that any of the barriers, like, work, life, time limits, or work requirements do not affect the American Indians and Alaska Natives, because these barriers only force a bigger burden on the Indian Health Service that I also said was underfunded.

So, in conclusion I would just like to reiterate our appreciation for the bipartisan commitment. Chairman Cole is very active in our issues. And I just want to say that the National Indian Health Board believes that with a few dedicated resources and a few targeted investments, we can begin to address this persistent disparity that is prevalent in Indian Country.

Thank you.

[The information follows:]

National Indian
Health Board

**TESTIMONY OF THE NATIONAL INDIAN HEALTH BOARD**
**VICTORIA KITCHEYAN, GREAT PLAINS AREA REPRESENTATIVE**
**HOUSE APPROPRIATIONS COMMITTEE - SUBCOMMITTEE ON LABOR, HHS, EDUCATION AND RELATED AGENCIES**
**FY 2018 APPROPRIATIONS TESTIMONY – MARCH 8, 2017**

Chairman Cole, Ranking Member DeLauro and Members of the Subcommittee, thank you for the opportunity to offer this testimony. On behalf of the National Indian Health Board (NIHB) and the 567 Tribal Nations we serve, I submit this testimony on FY 2018 budget for the Department of Health and Human Services (HHS).

The federal promise to provide Indian health services was made long ago. Since the earliest days of the Republic, all branches of the federal government have acknowledged the nation's obligations to the Tribes and the special trust relationship between the United States and Tribes. The United States assumed this responsibility through a series of treaties with Tribes, exchanging compensation and benefits for Tribal land and peace.[1] In 2010, as part of the Indian Health Care Improvement Act, Congress reaffirmed the duty of the federal government to American Indians and Alaska Natives (AI/ANs), 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 urban Indians and to provide all resources necessary to effect that policy." [2]

Today, however, the federal government has not done its part to live up to the responsibility to provide adequate health services to AI/ANs. Though the Indian Health Service (IHS) was founded in 1955 to help the federal government fulfill the trust responsibility for health, Congress has never provided IHS with enough funding to meet the needs of Indian Country. As a result of this underfunding, historical trauma, and a federal-state centric public health system, AI/ANs suffer some of the worst health disparities. AI/ANs live 4.5 years less than other Americans, but in some states life expectancy is 20 years less. Suicide rates for AI/ANs are four times higher than the national average and suicide is the second leading cause of death for Tribal youth between the ages of 15 to 24.[3] AI/AN populations are also approximately twice as likely to die of alcohol-related causes than the general population.[4] According to CDC data, 45.4 percent of Native women experience intimate partner violence, the highest rate of any ethnic group in the United States. American Indian / Alaska Native children have an average of six decayed teeth, when other US children have only one.[5]

But, the obligation to provide healthcare to AI/ANs does not extend only to the IHS. The federal trust responsibility is the responsibility of all government agencies, including others within HHS.

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[1] The Snyder Act of 1921 (25 U.S.C. 13) legislatively affirmed this trust responsibility.

[2] 25 U.S.C. 1602

[3] United States. Department of Health and Human Services, Indian Health Service. (n.d.). Trends in Indian health, 2002-2003. Rockville, MD: Indian Health Service

[4] Centers for Disease Control and Prevention. (2008). Alcohol-attributable deaths and years of potential life lost among American Indians and Alaska Natives—United States, 2001-2005. MMWR. Morbidity and Mortality Weekly Reports. Available online at: https://www.cdc.gov/mmwr/preview/mmwrhtml/mm5734a3.htm

[5] Indian Health Service FY 2016 Budget Request to Congress, p. 78.

Agencies like the Centers for Disease Control and Prevention (CDC); Substance Abuse and Mental Health Services Administration (SAMHSA); and Centers for Medicare and Medicaid Services (CMS) all must play a crucial role in ensuring that Indian Country receives both preventative and direct access to health services.

NIHB would first like to thank the subcommittee for the work it has done to increase the profile of AI/AN issues over the last several years. Addressing AI/AN concerns directly with agency leaders and including Indian-specific report language to the FY 2017 committee report have been enormously helpful as we work with the agencies to improve the health status of AI/ANs. For example, NIHB has long-advocated for a Hepatitis C program targeted at Indian country and we were pleased to see that as a priority last year. We are also very encouraged by the continuous direction to CDC to provide a more comprehensive public health infrastructure in Tribal communities. Commitment to improving mental health services in Tribal communities through Tribal Behavioral Health Grants, Garrett Lee Smith Grants and the Zero Suicide Prevention Initiative is critical in ensuring that that AI/ANs receive access to these services. Again, thank you for your steadfast commitment to these issues.

However, there is much work to be done so that AI/ANs can enjoy the same type of public health system and services available to other Americans. Generally speaking, Tribal health systems are simply left out of many funding streams within HHS for a variety of reasons. Federal block grants flow to states, leaving little opportunity for Tribal governments to receive this funding. Tribes are eligible to apply for many other federal grants that address public health and other issues, however, many of these programs have little penetration into Indian Country because Tribes have difficulty meeting the service population requirements, match requirements, or are under resourced to apply for the grants.

**Centers for Disease Control and Prevention**

*Preventive Health and Health Services (PHHS) Block Grant:* Public health infrastructure in Indian Country is one of the most severely underfunded and under developed areas of the health service delivery system. Like state and territorial governments, Tribes have both the rights and responsibilities to provide vital public health services for their communities. To do this, they must also have the tools to carry out these functions. Currently, Tribes are regularly left out of state- run public health programs and simultaneously, are routinely overlooked by federal agencies during funding decisions for public health initiatives. Tribal governments do not operate within the state regulatory structure, and often must compete with their own state governments for resources. Without a local tax base and with little outside funding, Tribal communities are often the most in need of public health dollars.

During the country's establishment of its public health infrastructure, Tribes and Tribal communities were largely left behind. Most of the health disparities Tribal communities currently face—such as obesity, diabetes, heart disease, and cancer—are largely preventable chronic conditions. Treating these chronic health conditions imposes unnecessary challenges on Tribal health systems and the Indian Health Service (IHS). For example, a 2012 study indicated that the 10.9% of AI/ANs with diabetes accounted for 37.0% of all adult treatment costs for IHS.[1] Investing

[1] Joan M. O'Connell, Charlton Wilson, Spero M. Manson, Kelly J. Acton

in Tribal public health improves the potential for healthy AI/AN communities and reduces the prevalence of chronic health conditions, which results in significant cost savings. Federal investments in Tribal public health also furthers the federal government's fulfillment of its trust responsibility to Tribes.

Establishing Tribal-specific funding streams, scaled for impact, will allow Tribes to secure needed funding and design and implement public health programs that meet the specific needs of their Tribal citizens. In cases where federal funding is restricted to states, those federal funding agencies should require states to report out their efforts to meaningfully engage with Tribes before and after funding is awarded, to ensure that the intended benefits reach Tribal populations. Therefore, NIHB requests that, in FY 2018, ***Congress create base funding for Tribal communities through the PHHS grant program by allocating at least 5 percent to Indian Tribes directly, annually.*** This will enable public health systems in Indian Country to access consistent, sustainable, public health infrastructure dollars so that Tribal communities can begin to catch up to other Americans when it comes to public health.

*Public Health Emergency Preparedness*: The Public Health Emergency Preparedness (PHEP) Cooperative Agreements at CDC provide base funding to states, territories and major cities to upgrade their ability to respond to a public health crises. But again, Tribal communities do not receive this funding directly, and few, if any, see any support from their state programs. Many Tribal reservations reach across state boundaries, and some occupy land areas larger than many states. Without federally-supported infrastructure support for prevention and response to natural disasters or pandemics in Indian Country, the impacts on American Indians and Alaska Natives (and others) could be enormous. Furthermore, failure to fund Tribal communities and reservations could mean that large land areas of this country are not covered for emergency infrastructure support, causing a domino effect throughout the rest of the nation when it comes to pandemics or natural disasters. ***NIHB requests that Congress direct 5% of PHEP funds to Tribes so that they can develop comprehensive and achievable response plans for public health crises.***

**Substance Abuse and Mental Health Services Administration**

Nowhere is the issue of lack of solid infrastructure support more acute than when it comes to mental and behavioral health services. AI/AN children and communities grapple with complex behavioral health issues at higher rates than any other population. Destructive federal Indian policies and unresponsive or harmful human service systems have left AI/AN communities with unresolved historical and generational trauma, leading to contemporary trauma.[6] Where Tribal reclamation of these systems has been possible, it has led to effective service systems designed and implemented, by and for AI/AN people, to promote cultural strength and healing. These Tribal systems have already begun to resolve the trauma left behind by federal policies and systems. But access to behavioral health services is limited. In a study of 514 IHS and Tribal facilities, 82% report providing some type of mental health service such as psychiatric services, behavioral health services, substance abuse treatment, or traditional healing practices, and to improve access 17% (87) have implemented telemedicine for mental health services.[7] However, none provide inpatient

Am J Public Health. 2012 Feb; 102(2): 301–308. Published online 2012 Feb. doi: 10.2105/AJPH.2011.300332

[6] Braveheart, M. Y. A., & DeBruyn, l. M. (1998). The American Indian Holocaust: healing historical unresolved grief. *American Indian and Alaska Native Mental Health Research, 8*(2).

[7] Urban Indian Health Institute. (2012). Addressing depression among American Indians and Alaska Natives: A literature review. Seattle, WA: Urban Indian Health Institute.

psychiatric services.[8] Without access to care, persons in psychiatric distress often end up at the hospital emergency room.[9]

*Mental Health Service Block Grant:* Access to behavioral health services for AI/ANs would be improved if Tribes had access to the Mental Health Service Block Grant. Without this critical funding, comprehensive mental health services are not reaching Tribal communities, though states are awarded these funds. IHS has limited mental health funding, but has always been underfunded to provide sustained mental health infrastructure. ***Congress should dedicate funding to Tribes directly for the Mental Health Services Block Grant.***

*Tribal Behavioral Health Grants and Zero Suicide:* At SAMHSA, several programs specifically target Tribal communities. NIHB was pleased to see that Tribal Behavioral Health Grants (TBHG) received a substantive increase in recent years. This critical program is designed to address the high incidence of substance use and suicide among AI/AN populations and it is a vital component of ensuring that behavioral health challenges are addressed across Indian Country. In FY 2018, NIHB requests ***funding of $50 million for the TBHG program.*** We also request ***funds to be appropriated for specific issues:*** namely, suicide interventions, expansion of mental health counseling capacity and infrastructure, and surveillance of and mediation for increasing levels of domestic violence.

*Circles of Care*: The SAMHSA Circles of Care Program offers three-year infrastructure/planning grants and seeks to eliminate mental health disparities by providing AI/AN communities with tools and resources to design and sustain their own culturally competent system of care approach for children. ***In FY 2018, we recommend increasing Circles of Care funding to $8.5 million.***

*Substance Abuse Block Grant*: The purpose of the SAMHSA Substance Abuse Block Grant (SABG) is to implement activities to treat and prevent substance abuse throughout the country. Few places are more seriously in need than Indian Country when it comes to these issues. Many reservations have been profoundly impacted by drug and alcohol use and in some cases hope seems elusive. Access to overdose prevention medication such as Naloxone, and medication assisted treatments (MAT) such as buprenorphine and methadone is a huge challenge for Tribes. While IHS operates Youth Regional Treatment Centers in each service delivery region, there are few inpatient centers for adults and those in treatment are often taken far from their families where support is nonexistent. However, SABG is operated by state governments, which means that Tribal communities are often left out. We recommend that the Committee allocate specific funding for SABG directly to Tribal communities so that there can be continuous, sustained funding to help address long-term substance abuse issues in Tribal communities. At the very least, Congress should require that SAMHSA require all SABG state grantees to consult directly with Tribes within their borders as a condition of participation, and prove that they are allocating funds to Tribal communities.

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[8] Indian Health Service. (2011). *Inpatient mental health assessment.* Retrieved from http://www.ihs.gov/newsroom/includes/themes/newihstheme/display_objects/documents/FINAL_IHCIA_InpatientMH_Assessment_Final.pdf

[9] *Ibid*

More generally, NIHB requests that Congress provide direction to SAMHSA that would include Tribal consultation during the development of grants to ensure deliverables are culturally competent and trauma-informed. In addition, traditional healing practices should be considered fundable activities for programs administered by the agency. Traditional healing practices for behavioral health issues are critical in ensuring long-term change for AI/ANs.

**Centers for Medicare and Medicaid Services**

*Medicaid Services for AI/ANs:* While most of the appropriations for CMS move through mandatory funding, as Congress debates potential changes to the Medicaid system, it is critical that AI/ANs are protected. Over 40 years ago, Congress amended the Social Security Act to authorize Medicare and Medicaid reimbursement for services provided in IHS and Tribally operated facilities to supplement inadequate IHS funding and as part of the federal trust responsibility to provide healthcare to American Indians and Alaska Natives. At the same time, Congress acted to ensure that States would be reimbursed at a 100 percent federal medical assistance percentage (FMAP) for Medicaid services provided to American Indians and Alaska Natives that are received through the Indian health system and that Medicaid payments to the Indian health care system are not subject to a block grant or per capita cap.

Congress must also preserve AI/AN protections, including freedom from premiums and cost sharing, prohibition of classifying trust lands and cultural and religious items as resources for eligibility purposes, and other protections. Congress must also ensure that States do not create any barriers to access to Medicaid for American Indians and Alaska Natives, such as work requirements, time limits, co-pays or usage caps. These barriers to care do not help reduce program costs, but only force AI/ANs to rely on the already underfunded IHS system meaning that they will have less access to both primary and preventative care. Furthermore, we request that the Committee provide oversight on CMS to ensure that any Medicaid waiver applications submitted are developed with significant Tribal consultation and have the full consent and approval of the Tribes in that state.

**Expansion of Self-Governance at HHS**

For over a decade, Tribes have been advocating for expanding self-governance authority to programs in the Department of Health and Human Services (HHS). Self-governance represents efficiency, accountability and best practices in managing and operating Tribal programs and administering Federal funds at the local level. This proposal was deemed feasible by a Tribal/federal HHS workgroup in 2011. Therefore, we request that the Appropriations Committee direct HHS to enter into pilot projects for self-governance at the agency in FY 2018.

**Conclusion:**

Thank you again for the opportunity to offer to participate in the Public Witness Hearing for FY 2018. As noted above, the federal trust responsibility for health extends beyond the IHS to all agencies of the federal government. We thank the committee for the efforts it has put forward to prioritize this issues at the Department of Health and Human Services. While Tribes have made important gains in recent years in terms of funding, consultation and increased awareness throughout all of HHS, there is still a long way to go before health systems in Indian Country are on par with those enjoyed by other Americans. Please do not hesitate to contact our offices directly if you have any questions or if you require additional information.

Mr. COLE. I want to thank the gentlelady for her testimony. As she knows, this is something I care very deeply about, and we have made significant progress on. But we are so far behind that we could make progress for a lot of years and not catch up.

You know, the direct funding, even though it is administered by HHS, comes out of the Interior Subcommittee for many of these programs, a great majority, Indian Health Service in particular, and they have exactly the same challenge we do. If we have the kind of allocation for non-defense discretionary, they are going to face the same sort of pressure in the Interior Committee where I sit as a member. And Chairman Calvert, who has been very supportive of these issues is there, and our ranking member, Betty McCollum, also is very supportive.

So, your testimony is very timely. The problems are terrific. We made a little progress, not enough. And I would say it is at risk if we do not do the right thing. So, I appreciate the gentlelady's work. I certainly appreciate my friends at the Indian Health Board, including my former staffer, Catrons, back there who worked for me and has gone on to bigger and greater things, but has continued to advance important issues in an effective way. With that, I would recognize my friend.

Ms. DELAURO. Thank you very much, Mr. Chairman. And thank you so much for your testimony. And the chairman, this is an issue that is near and dear to his heart, and I think you know that. But there is also bipartisan support for these efforts.

And I think one of the other areas that you need to take a hard look at is, and I do not know the numbers and I would like to know the numbers, of folks who are dependent on Medicaid in the community, because I think there is going to be a serious challenge with regard to Medicaid as we see with, at least the early stage of the healthcare proposal, both to the Medicaid Expansion Program, but overall to Medicaid. And if we are not careful in that regard, if you are going to shift those funds or those responsibilities to our States, and I know that people talk about the flexibility of States, but oftentimes what the results can be is a rationing of care with regard to this effort.

And so, I think we have to be very, very careful in looking at that. And I know you will do that because the need is so great in the community that you represent. And we should not go back on some of the gains that have been made, but only try to move forward.

So, thank you for your commitment. Appreciate it.

Mr. COLE. Again, thank you for your testimony. The next witness please.

Hi. It is great to have you here. This is Jazmin Goodwin, a GEAR UP alumni and Howard University student, National Council for Community and Education Partnership. The gentlelady is welcome and is recognized for 5 minutes to deliver whatever testimony she cares to give to the committee.

WEDNESDAY, MARCH 8, 2017.

## NATIONAL COUNCIL FOR COMMUNITY AND EDUCATION PARTNERSHIPS

### WITNESS

### JAZMIN GOODWIN, GEAR UP ALUMNUS AND HOWARD UNIVERSITY STUDENT, NATIONAL COUNCIL FOR COMMUNITY AND EDUCATION PARTNERSHIPS

Mr. GOODWIN. Chairman Cole, Ranking Member DeLauro, and distinguished members of the subcommittee, thank you for inviting me to testify on the Gaining Early Awareness and Readiness for Undergraduate Programs, or GEAR UP Initiative. I am honored to be able to share how GEAR UP transformed my life.

GEAR UP is a competitive grant program administered by the U.S. Department of Education that serves 635,000 students 2,800 low-income schools across 46 States. GEAR UP empowers local and State leaders from K–12, higher education, and community organizations to develop partnerships to increase the number of low-income students who are prepared to enter and succeed in higher education.

In a nutshell GEAR UP provides students with academic interventions, supports families along the complex path to college and career, and builds the capacity of schools to strengthen the quality of instruction and counseling.

GEAR UP begins early in the 7th grade, then follows entire classes of students through high school graduation and often through the first year of post-secondary education. Most importantly, the GEAR UP is succeeding. 77.3 percent of the GEAR UP class of 2014 enrolled in a post-secondary immediately following high school graduation, a rate nearly 32 percentage points higher than low-income students nationally.

My parents were in the U.S. Army. I was born on a base in Germany, and my family eventually settled at Fort Jackson in Columbia, South Carolina. My mother and grandmother valued education, and they made it clear that an education beyond high school was critical. My mom even went back to school while raising me and working full time, becoming the first in our family to earn a college degree.

Yet, in school not everyone was perceived as college material, myself included. I struggled to find my footing in middle school and had a very low GPA in 9th grade. The idea of higher education seemed out of reach. Yet the GEAR UP staff helped change the culture of our schools. They helped me discover my talents and interests, challenged me to reach for goals I would not have thought possible, and provided me with tutoring, mentoring, and support to help me and my family make my goals a reality.

Looking back, GEAR UP changed my trajectory. In the 10th grade, my future came into focus when I met admissions officers from Howard University through GEAR UP. I made my mind up that Howard was my goal, but my path there was not a clear one. Were it not for that in-school, after school, and summer programs that GEAR UP offered, I likely would not have had the academic

qualifications to be admitted or to even know how to finance my education.

With GEAR UP, I turned my grades around and made it to Howard University where I applied my GEAR UP mindset to pursue every opportunity I can. I have earned $31,000 in academic scholarships this year, and I am planning on attending law school following my graduation in 2018. I remain active in the GEAR UP community and met GEAR UP alumni from nearly all the States represented by this distinguished committee.

I have learned that my story is not the exception. GEAR UP is improving outcomes in rural and urban communities alike. GEAR UP truly works everywhere.

As students, we frequently hear from policymakers that we need to prepare more young people for the complex skills and knowledge required by employers. We know that this requires education beyond high school, and, frankly, we are ready to rise to the challenge. GEAR UP is closing the opportunity, preparation, and attainment gap. At an annual investment of $505 per student served, GEAR UP pays huge dividends.

I urge the subcommittee to consider a modest increase for GEAR UP to $350,000,000 for Fiscal Year 2018. This will bring 54,000 new students into the program, continue transforming the lives of students and families, and help ensure that our great Nation is better prepared for the demands of tomorrow.

Thank you for the opportunity to speak with you this morning.

[The information follows:]

**Jazmin Goodwin, GEAR UP Alumni Leader and Howard University Student**

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

**Public Witness Hearing**

**March 8, 2017**

Chairman Cole, Ranking Member DeLauro, and distinguished Members of the Subcommittee, thank you for inviting me to testify on the Gaining Early Awareness and Readiness for Undergraduate Programs (GEAR UP) initiative. GEAR UP is a highly-competitive discretionary grant program housed at the U.S. Department of Education designed to substantially increase the number of low-income students who are prepared to enter and succeed in postsecondary education. It is an honor to represent the GEAR UP community and the 635,000 students served across nearly 2,800 secondary schools. The return on investment of GEAR UP is extraordinary, and I urge the committee to appropriate $350,000,000 for Fiscal Year 2018 to this critical program so that an additional 54,000 students across our great nation may realize their college and career goals.

My name is Jazmin Goodwin and I want to share with you how GEAR UP fundamentally changed my life from middle school to the present day. Even after high school graduation, I have remained active in supporting the work of GEAR UP as an alumni leader, contributing to my hometown GEAR UP program and the national work of GEAR UP across 46 states.

As you know, GEAR UP provides 6- or 7-year grants to states or partnerships comprised of K-12, higher education, and community-based organizations that strengthen the pathways to college and careers in low-income communities. GEAR UP identifies whole classes of 7$^{th}$ graders

and exposes them, their families, and their schools to comprehensive interventions that follow them through high school graduation and optionally through the first year of postsecondary education. GEAR UP uses early and sustained interventions to ensure that students are successful in rigorous courses, are knowledgeable about the steps necessary to prepare for life beyond high school, and ultimately enroll in a high-quality certificate, associates', or bachelors' degree program that suits their goals.

The results of GEAR UP have been remarkable. The U.S. Department of Education reports that the program is meeting or exceeding performance targets related to the percentage of students taking critical gateway courses in mathematics, the percentage of GEAR UP students completing high school, and most importantly, the percentage of GEAR UP students enrolling in higher education. The Department reports that 77.3% of the GEAR UP class of 2014 enrolled in a postsecondary institution immediately following high school graduation[1]. Considering that nationally only 45.5% of low-income students did the same over the prior year, GEAR UP is clearly a catalyst for results. Achieving these outcomes at a modest annual federal investment of $505 per GEAR UP student speaks to the power of these highly flexible, locally-led programs. Keep in mind that for each federal dollar a state or partnership receives, it is matched with a local, non-federal dollar, subsequently doubling our national investment in our GEAR UP students, families, and schools.

My mother and father were in the United States Army, and I was born on a military base in Germany. My early years were spent at Fort Bragg in North Carolina before my family settled in Fort Jackson in Columbia, South Carolina. Columbia is known for being a tight-knit and patriotic community, but it is an economically diverse one as well. The importance of education

beyond high school was not universally appreciated like in many higher-income communities. The schools I attended generally viewed students as either "college material" or "not college material," early on in ways that did not always seem fair.

I was quite lucky to have a different perspective. My grandmother—who raised me when my parents were away for long deployments—made sure I knew that education was my passport to a rewarding career and self-sufficiency. My mother, who worked full-time, led by example and went to college as I grew up, becoming the first in our family to earn a college degree. Seeing her, I knew early on that having a high school degree was not enough, and most of my fellow students knew it too. We knew intuitively what the research has long supported. Most jobs in this country will require some form of postsecondary training, and despite perceptions, most low-income students want to go to college[2]. We just have a more challenging path to get there.

Despite the encouragement I had at home, higher education seemed out of reach. The GEAR UP staff at my middle school saw the potential in students that others may have missed. GEAR UP changed the culture of our school by raising expectations and providing a wealth of academic programs to support us.

I needed GEAR UP the most during my freshman year of high school. I was experiencing a tumultuous time at home; my parents separated, my father was deployed abroad, and my mother typically worked twelve hour days at her military post. Because of her schedule, I would arrive to school an hour and a half early, and would have to wait three hours or so before I could get picked up. I was adrift, and my grade point average suffered: it was 1.9 on a 4.0 scale. The GEAR UP staff went to extraordinary lengths to help me find my purpose by making me

aware of opportunities that I did not know existed. Most importantly, they gave me and my peers the tools we needed to take advantage of those opportunities. I heard a speaker once say that, "GEAR UP isn't a hand out, it's a hand up," and I could not agree more. The GEAR UP team challenged me each day to do my absolute best, and I started to see dramatic improvements in my grades.

It was at a GEAR UP college and career fair that my future came into focus. I met admissions staff from Howard University in Washington, D.C. and I made my mind up then and there that Howard was the university for me. Given my grades, I had a long way to go, but my GEAR UP team helped me set a path to attend Howard. They provided me with after-school and weekend tutoring, mentored me, sent me to summer academic programs, helped me prepare for the SAT and ACT, and guided my family through the college application and financial aid processes. GEAR UP was a life-line to my classmates, and the overall impact the program had on our school was profound.

As you can surmise, I achieved my goal and am now a junior at Howard University where I have a 3.78 GPA and am majoring in Media, Journalism, and Film and plan to attend law school after graduation. Financing my postsecondary education is a challenge every year, but using the skills I learned in GEAR UP, I apply for every scholarship possible. This year, I have earned $31,000 in academic scholarships. When I graduate next year, it will be an extraordinary event for both my paternal family and my GEAR UP family.

I could not have made it this far without GEAR UP. When they met me in the 7$^{th}$ grade, my life could have proceeded down several routes, but they made sure I was ready for the life I dreamed of. I do not want you to think that GEAR UP only worked for me, because I am just one

of the millions of students who have seen their prospects improve because of GEAR UP. The program reflects the communities it serves. GEAR UP works in rural Oklahoma, the urban schools of Connecticut, and in every state represented by this distinguished subcommittee. GEAR UP can succeed anywhere that K-12, higher education, and community leaders have a commitment to improving college and career readiness for students like me.

Given that the workforce of today *and* tomorrow requires an education beyond high school[3], I hear frequently from our national leaders that we need to do more to prepare students—especially those from low-income and working class backgrounds—for that reality. My fellow students and I agree wholeheartedly and believe that GEAR UP is an important part of the solution. Yet the demand for the program far exceeds the available resources. As you take on the hard work of preparing the Fiscal Year 2018 appropriation, our community urges you to consider a modest increase for the GEAR UP program to $350,000,000, an increase of $27.2 million over the prior year, so that 54,000 new students can benefit from the program as I did.

Thank you for the opportunity to speak with you this morning and I will be happy to respond to any questions.

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[1] U.S. Department of Education. (2016). FY 2017 Department of Education Justifications of Appropriation Estimates to the Congress: Higher Education (Volume II). Retrieved from https://www2.ed.gov/about/overview/budget/budget17/justifications/index.html

[2] Roderick, M., Nagaoka, J., & Coca, V. (2009). College readiness for all: The challenge for urban high schools. The Future of Children, 19(1), 185–210.

[3] Carnevale, A., Smith, N., & Strohl, J. (2010). Help wanted: Projections of jobs and education requirements through 2018. Georgetown University, Center on Education and the Workforce. Washington, DC.

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

## Witness Disclosure Form

Clause 2(g) of rule XI of the Rules of the House of Representatives requires non-governmental witnesses to disclose to the Committee the following information. A non-governmental witness is any witness appearing on behalf of himself/herself or on behalf of an organization other than a federal agency, or a state, local or tribal government.

Your Name, Business Address, and Telephone Number:

Jazmin Goodwin; 509 Rose Creek Lane, Columbia, SC, 29229; 803-569-5422

1. Are you appearing on behalf of yourself or a non-governmental organization? Please list organization(s) you are representing.

   National Council for Community and Education Partnerships

2. Have you or any organization you are representing received any Federal grants or contracts (including any subgrants or subcontracts) since October 1, 2012 related to the agencies or programs funded by the Subcommittee?

   (Yes) No

3. Have you or any organization you are representing received any contracts or payments originating with a foreign government since October 1, 2012 related to the agencies or programs funded by the Subcommittee?

   (Yes) No

4. If your response to question #2 and/or #3 is "Yes", please list the amount and source (by agency and program) of each Federal grant (or subgrant thereof) or contract (or subcontract thereof), and/or the amount and country of origin of any payment or contract originating with a foreign government. Please also indicate whether the recipient was you or the organization(s) you are representing.

Jazmin Goodwin has not received any federal grants, contracts or payments.

The National Council for Community and Education Partnerships has received the following subcontracts from grantees funded under the U.S. Department of Education's Gaining Early Awareness and Readiness for Undergraduate Programs (GEAR UP) (CFDA Numbers 84.334A and 84.334S) during the current calendar year. In all cases, the country of origin is the United States of America.

4. (Continued)

The National Council for Community and Education Partnerships serves as the managing director of the GEAR UP College and Career Readiness Evaluation Consortium, a multi-state collaborative designed to evaluate the impact of program interventions on secondary and postsecondary education outcomes. Annual membership contributions from GEAR UP grantees participating in the consortium during the current calendar year is $18,915 from each of the following 13 GEAR UP grantee fiscal agents: Northern Arizona University; Idaho State Department of Education; Kentucky Council on Postsecondary Education; Minnesota Office of Higher Education; Montana University System; University of North Carolina; New Mexico Higher Education Department; Nevada Department of Education; Oklahoma State Regents for Higher Education; Tennessee Higher Education Commission; Utah Valley University; Washington Student Achievement Council; and the University of Wyoming.

The National Council for Community and Education Partnership also receives subcontracts to provide evaluation and professional development services to the following GEAR UP fiscal agents during the current calendar year:

- Iowa College Student Aid Commission; $28,000
- Eastern Oklahoma State College; $35,000
- Vermont Student Assistance Corporation Foundation; $10,208
- SYNTIRO/GEAR UP Maine; $11,666
- Region One Education Service Center (TX); $45,434

In addition, the National Council for Community and Education Partnership serves as the third-party project evaluator for the U.S. Department of Education's First in the World program (CFDA Numbers 84.116F and 84.116X) at Delaware State University. The evaluation subcontract totals $56,250 for the current calendar year.

Signature: [redacted] Date: 03/06/17

Mr. COLE. Well, I want to begin by thanking you. Judging from your testimony, you are going to be a pretty formidable lawyer someday. [Laughter.]

It is great to have you here. This is a program where we did in 2016 increase the investment, and if we can get that 2017 bill, there will be another increased investment. And then, obviously 2018 depends on the overall allocation.

But you are exactly right. I have seen this program in action. It is very heavily involved in my State, and has delivered tremendous gains for students, frankly, that absent this would not have had the preparation, the opportunity to pursue a degree. So, again it is a wonderful, wonderful program, and you are a terrific example of the kind of people that come out of this program.

So, the committee very much appreciates your testimony.

Ms. DELAURO. I would just say what he said to Joseph, Mr. Chairman. You know, some days we wonder what we do here. I am serious. And the TRIO Program and the GEAR UP Program really allow for people to realize their dreams. So, that is a noble goal of the Federal government to help to realize people's dreams.

Thanks for being here.

Mr. COLE. And speaking only for myself, I wonder what I am doing here every day. [Laughter.]

It is not just some days. But, again, thank you very much for your testimony.

Our next witness, please. Thank you very much. Good to have you here.

Mr. WEBB. Good morning.

Mr. COLE. You bet. This is Mr. Edwin Webb, the associate executive director of the American College of Clinical Pharmacy. The gentleman is recognized for 5 minutes to deliver whatever testimony he cares to the committee.

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WEDNESDAY, MARCH 8, 2017.

## AMERICAN COLLEGE OF CLINICAL PHARMACY

### WITNESS

### C. EDWIN WEBB, ASSOCIATE EXECUTIVE DIRECTOR, AMERICAN COLLEGE OF CLINICAL PHARMACY

Mr. WEBB. Thank you, Chairman Cole, Ranking Member DeLauro, members of the Subcommittee for this opportunity to address the subcommittee.

In my statement and written testimony, we urge your continued support of funding for the Agency for Healthcare Research and Quality. In addition, I wanted to discuss briefly how the comprehensive medication management services of the Nation's clinical pharmacists will help Federal healthcare programs, such as Medicare and others, deliver better value and quality for patients and for our healthcare system. These, of course, are goals that we all share.

ACCP is the professional society for the Nation's leading clinical pharmacists. We are the professional home for clinical pharmacy practitioners, residents, scientists, and others practicing in more

than 60 countries. Like our members, we are committed to excellence in clinical pharmacy practice and patient pharmacotherapy.

Unlike pharmacists with which you are likely most familiar, clinical pharmacists generally do not engage in the dispensing of medications. While the safe and efficient distribution of medications is an important component of pharmacy practice, clinical pharmacists' practice commonly occurs directly with physicians and other health professionals on the patient's healthcare team to ensure that the medications prescribed for those patients actually achieve the best possible clinical outcomes.

To prepare for this practice, clinical pharmacists are educated and trained in team-based direct patient care environments. They are frequently granted patient care privileges by collaborating physicians and health systems. These privileges allow them to perform a full range of medication decision making functions and management functions for their patients. These privileges are granted on the basis of demonstrated knowledge of medication therapy and clinical experience gained through post-graduate residency training and specialist board certification, both of which are expected in addition to standard training for pharmacist licensure.

An important word about the Agency for Healthcare Research and Quality. ACCP strongly supports the mission and goals of AHRQ. We urge the subcommittee to protect the AHRQ budget by providing at least $334,000,000 in budget authority consistent at least with current Fiscal Year levels.

AHRQ is the only Federal agency with the sole purpose of evaluating and disseminating research that determines how to make care as effective, efficient, and affordable as possible. The work of AHRQ is vital to the work of clinical pharmacists and their colleagues, in hospitals, clinical practices, and other health care delivery settings.

Our members are dedicated to helping transform healthcare delivery in America by adopting patient-centered, collaborative healthcare approaches that deliver better care, smarter spending, and healthier people. AHRQ supports research and communication programs that help reinforce the value of that approach. Therefore, we urge you to support AHRQ and its mission through adequate funding.

As this subcommittee and all of Congress consider ways to strengthen and improve the Nation's healthcare system, ACCP also urges support for comprehensive medication management services. It is practiced by clinical pharmacists as members of inter-professional teams. It is a collaborative process that helps ensure that all medications taken by the patient are effectively coordinated, achieve their intended clinical goals, and improve patient outcomes. In short, CMM helps get the medications right.

Top healthcare experts recognize CMM as a significant advance in quality of care. It is fully supported by the Patient-Center Primary Care Collaborative. It is emerging as a standard of care for integrated private sector health systems, like the Cleveland Clinic, Geisinger Health System, Kaiser Permanente, and others. And it is also recognized within important Federal programs, such as the Public Health Service, State Medicaid programs, and the VA.

It can be effectively operationalized under collaborative drug therapy management agreements that have been duly authorized in 49 States, or through credentialing and privileging systems established by individual health systems.

We believe that coverage for CMM and Medicare is a key part of helping move all of healthcare to a more value-based, collaborative, and efficient system. We fully understand that the Medicare statutes are not within the subcommittee's specific jurisdiction, but we know that you are vitally interested as a committee and a subcommittee on efficiency and value in our Federal healthcare programs. We, therefore, urge your support for the dialogue that is beginning two floors down today and going forward to advance this notion of quality of care.

Congress has focused many years on addressing problems associated with suboptimal and inefficient medication use. We believe the time is opportune to truly help patients get their medications right by making sure that team-based and patient-centered care around their medications is part of the care that they are being offered.

Thank you so much for this opportunity.

[The information follows:]

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Department of Government & Professional Affairs

**Testimony of the American College of Clinical Pharmacy to the House Committee on Appropriations Subcommittee on Labor, Health and Human Services, Education and Related Agencies Hearing for Outside Witnesses**

**Submitted for the Record on March 3, 2017**

**Contact: C. Edwin Webb, Pharm.D., M.P.H.**

**Associate Executive Director,** ewebb@accp.com

Chairman Cole, Ranking Member DeLauro and distinguished members of the Subcommittee. On behalf of the American College of Clinical Pharmacy (ACCP) we appreciate your leadership over these vital components of our nation's health funding. As the subcommittee considers important spending priorities for fiscal year 2018, we urge you to carefully consider both the needs of existing healthcare programs as well as opportunities to create greater value within our healthcare system. Our testimony therefore focuses on funding needs for the Agency for Healthcare Research and Quality (AHRQ) and also on a progressive clinical practice delivered by members of our profession that demonstrably improve the quality and clinical outcomes of medication use in both public and private sector health care systems.

By way of background, ACCP is the professional society for clinical pharmacists in the United States and around the world. We provide education, advocacy and resources that enable our members to achieve excellence in practice and research, making us the professional home for clinical pharmacy practitioners, scientists, educators, administrators, students, residents and fellows from more than 60 countries. Like our members, we are committed to excellence in clinical pharmacy practice and patient-centered pharmacotherapy.

Unlike many of our pharmacist colleagues, our members' practice activities generally do not include the dispensing of medications. While the safe and efficient distribution of medications is clearly an important component of patient care – and our members are educated and licensed to offer this service – clinical pharmacists most commonly practice directly with physicians, other health professionals and patients in interprofessional health care settings to ensure that patients' medication regimens are effective, safe, and appropriate for their medical conditions.

To facilitate this practice, clinical pharmacists are frequently granted patient care privileges by collaborating physicians and health systems, allowing them to assume full responsibility for a range of medication decision-making functions as part of the patient's health care team, including the initiation, modification, monitoring, and discontinuation of treatment.

These privileges are granted on the basis of the clinical pharmacist's demonstrated knowledge of medication therapy and record of clinical experience. This specialized knowledge and clinical experience is usually gained through post-graduate residency training and specialist board certification, which is expected in addition to the education required for pharmacist licensure.

**Funding for the Agency for Healthcare Research and Quality (AHRQ)**

As a professional and scientific society dedicated to enabling clinical pharmacists to achieve excellence in patient care practice, ACCP urges the subcommittee to prioritize the budget of the Agency for Healthcare Research and Quality (AHRQ) for FY 2018 by providing the agency at least $334 million in budget authority, consistent with current levels.

AHRQ is the only federal agency with the sole purpose of generating and disseminating research that demonstrates how to make care as effective, efficient, affordable, equitable, and safe as possible. The health services research, quality improvement protocols, datasets, and tools supported by AHRQ are not only vital to the work of clinical pharmacists but are also used in hospitals, medical centers, physician and other clinician practices, nursing facilities, clinics, and public health departments in communities across the nation to improve the quality, access, and value of health care services and programs.

In order to advance this overarching goal of improving health care delivery in America, it is also necessary to continue to support the ongoing transformation of both payment structures and delivery systems that reward (1) quality outcomes from the care being provided, not the quantity of services, (2) value of care rather than volume of care and, most importantly, (3) patient-centered care through the support of the patient's entire health care team – with patients and their caregivers fully included in the team.

**Full Integration of Clinical Pharmacists into Federal Health Programs**

In order to improve the efficiency and enhance the value of care under federal healthcare programs, including Medicare, policymakers should take actions across all of these programs to integrate and utilize clinical pharmacists to the full capacity of their training and education.

Clinical pharmacists are highly trained medication experts who graduate with a Doctor of Pharmacy degree and have commonly completed up to two years of postgraduate residency training. In addition, many clinical pharmacists go on to achieve certification in a pharmacy practice specialty recognized by the Board of Pharmacy Specialties (BPS). BPS currently recognizes ten areas of specialty practice including ambulatory care pharmacy, oncology pharmacy, pharmacotherapy and critical care pharmacy.

Clinical pharmacists practice in a range of health care settings, including integrated private sector delivery systems, hospitals and outpatient clinics, emergency departments, community pharmacies, physicians' offices, community-based clinics, nursing homes and managed care organizations.

Clinical pharmacists commonly deliver care under formal collaborative drug therapy management (CDTM) agreements or through credentialing and privileging processes of the institution or its medical staff. They work alongside physicians and other health professionals as full members of interprofessional teams. As such, each day they assess the status of patient problems, evaluate the effectiveness of the patient medications and determine whether the prescribed medications are optimally meeting patient needs and goals of care.

Specifically, clinical pharmacists:

- Identify and document medication-related problems of concern to the patient and all members of the care team, using a consistent care process that assures medication appropriateness, effectiveness and safety;
- Initiate, modify, monitor, and discontinue drug therapy to resolve the identified problems and achieve medication-related outcomes that are aligned with the overall care plan and goals of therapy; and
- Engage and educate patients and families in fully understanding their medication regimen, supporting active patient engagement in the successful use of their medicines to achieve desired health outcomes.

This direct patient care service is known as "comprehensive medication management" (CMM) and is increasingly recognized within emerging patient-centered medical homes (PCMH), accountable care organizations (ACO) and many private sector delivery systems. It is recognized as a core strategy to achieve better clinical outcomes and quality by many health care leadership groups. The Patient-Centered Primary Care Collaborative (PCPCC) supports the practice of team-based CMM and has published a resource guide to assist with the integration of this service into clinical practice in the PCMH.

The practice of CMM helps reduce medication mismanagement that can result in either under treatment or preventable adverse events; inappropriate, ineffective, or unnecessarily costly medication choices for the established goals of care; duplicative or interacting medications; avoidable side effects; and inconsistent adherence or other patient challenges or issues that directly reduce treatment success.

In short, CMM helps "get the medications right" as part of an overall effort to improve the quality and affordability of the services provided patients. In "getting the medications right," CMM also contributes to enhanced productivity for the entire health care team. By fully utilizing the qualified clinical pharmacist's skills and training to coordinate the medication use process as an integral team member, physicians and other providers are essentially freed to maintain focus on respective patient care activities that align with professional responsibilities as defined by scope of practice that reflect their particular area of expertise.

CMM is an increasingly valued component of care and benefit design in a variety of health delivery structures and payer programs, including private integrated care systems such as Kaiser

Permanente and the Geisinger Health System, state Medicaid programs including North Carolina and Minnesota, and the Veterans Health Administration.

However, coverage of CMM does not exist within the Medicare program to support a coordinated medication management service for beneficiaries delivered by an effective inter-professional health care team.

This is particularly troubling due to the central role that medications play in the care and treatment of the nation's seniors. Sixty-six percent of Medicare beneficiaries have two or more chronic diseases; 40% have four or more and 60% of seniors are taking 3 or more discrete prescription or non-prescription medications at any point in time. Drug therapy problems occur all too frequently and add substantial costs to the health care system. Drug-related morbidity and mortality costs exceed $200 billion annually in the U.S., exceeding the amount spent on the medications themselves. Medicare beneficiaries with multiple chronic diseases account for 76% of all hospital admissions, and are 100 times more likely to have a preventable hospitalization than those with no chronic conditions.

When combined with the continuing growth in the number and categories of medications -- and greater understanding of the genetic and physiologic differences in how people respond to their medications -- the current system consistently fails to deliver the full promise medications can offer. In short, the current medication use "non-system" fails to get the medications right far too often. This is not just the case in Medicare, but in other healthcare programs as well.

With the federal government responsible for more than $1 trillion per year in health care spending, and mandatory programs projected to overwhelm the entire federal budget, it is vital that we as a nation provide adequate resources to ensure that health care delivery organizations, health providers, policymakers, and the people they serve make informed choices about how to obtain the best care while addressing costs and protecting patient safety.

As part of this effort ACCP urges policymakers to address the imperative for improved medication use quality and safety by promoting and advancing coverage for CMM services delivered under collaborative, patient-centered payment and delivery structures. We would welcome the opportunity to provide further information, data, and connections with successful practices that provide CMM services to help further inform the Subcommittee as you consider spending priorities.

Thank you for the opportunity to provide this testimony and for your consideration of this statement.

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

## Witness Disclosure Form

Clause 2(g) of rule XI of the Rules of the House of Representatives requires non-governmental witnesses to disclose to the Committee the following information. A non-governmental witness is any witness appearing on behalf of himself/herself or on behalf of an organization other than a federal agency, or a state, local or tribal government.

Your Name, Business Address, and Telephone Number:
C. Edwin Webb
1455 Pennsylvania Ave., NW Suite 400
Washington, DC 20004-1017
202.621.1820

1. Are you appearing on behalf of yourself or a non-governmental organization? Please list organization(s) you are representing.

   American College of Clinical Pharmacy

2. Have you or any organization you are representing received any Federal grants or contracts (including any subgrants or subcontracts) since October 1, 2012 related to the agencies or programs funded by the Subcommittee?

   Yes No

3. Have you or any organization you are representing received any contracts or payments originating with a foreign government since October I, 2012 related to the agencies or programs funded by the Subcommittee?

   Yes No

4. If your response to question #2 and/or #3 is "Yes", please list the amount and source (by agency and program) of each Federal grant (or subgrant thereof) or contract (or subcontract thereof), and/or the amount and country of origin of any payment or contract originating with a foreign government. Please also indicate whether the recipient was you or the organization(s) you are representing.

Signature: [redacted] Date: 3/3/2017

Mr. COLE. I thank the gentleman very much for his testimony and being very patient. You have been here from the very beginning, so thank you very much.

I would be remiss, I want to take a point of personal privilege. I see in the back room my good friend, Arnold Mitchem, who is the president and founder of the, what is it, Council for Economic Opportunity.

Dr. MITCHEM. Council for Opportunity in Education.

Mr. COLE. There you go. And nobody has done more to help create these TRIO graduates that you have seen around here that gave such compelling testimony earlier today than the gentleman in the back of the room. So, it is a pleasure to have my friend here.

With that, thank you very much. Next witness?

Welcome.

Ms. ARTIGA. Good morning.

Mr. COLE. Good to have you here.

Ms. ARTIGA. It is an honor to be here. Thank you for having me.

Mr. COLE. It is an honor to have you. Ms. Samantha, is it Artiga?

Ms. ARTIGA. Artiga.

Mr. COLE. Artiga, okay. Very good. I would like to take credit, but my capable clerk corrected my mispronunciation immediately. Ms. Artiga is director of Disparities Policy Project at the Henry J. Kaiser Family Foundation. The gentlelady is welcome and recognized for 5 minutes to deliver her testimony.

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WEDNESDAY, MARCH 8, 2017.

## THE HENRY J. KAISER FAMILY FOUNDATION

### WITNESS

### SAMANTHA ARTIGA, DIRECTOR, DISPARITIES PROJECT, THE HENRY J. KAISER FAMILY FOUNDATION

Ms. ARTIGA. Chairman Cole, Ranking Member DeLauro, thank you so much for having me here and for the opportunity to testify.

The Kaiser Family Foundation is a nonprofit health policy organization, so I am not taking the advocacy position or requesting any specific funding. But I did want to use this as an opportunity to emphasize the importance of continuing to support efforts to address health and healthcare disparities in our Nation. This is a particularly important and timely issue to address given the transformation of healthcare in recent years under the Affordable Care Act and the changes being considered to healthcare right now by this Congress.

Health and healthcare disparities are differences between groups in their health status and their ability to obtain the medical care that they need, which are rooted in historic economic, social, and racial disadvantages. Addressing disparities is not only important from a social justice standpoint, but also for improving our overall Nation's health, and for reducing unnecessary healthcare costs. With the projections estimating that we will be a majority/minority nation by 2044, it is increasingly important that we address these disparities.

Today many groups face disparities. People of color and low income individuals face more barriers to obtaining the care they need

and experience poor health outcomes compared to whites and those with higher incomes. As an example, blacks have higher rates of chronic disease, like asthma and diabetes, and their infant mortality rate is more than twice as high as the rate for whites. Although disparities are often viewed through the lenses of race and income, they also occur across other dimensions, including language, location, and sexual orientation.

In recent years, there have been advancements in reducing disparities that reflect an increased Federal focus on disparities as well as provisions within the Affordable Care Act. Specifically, ACA investments through discretionary programs to support public health and prevention services and enhance the healthcare workforce and delivery system supported reduction of disparities. For example, the ACA boosted funding for community health centers, included initiatives to increase the number of providers, and created the Prevention and Public Health Fund, which I believe was already mentioned this morning.

In addition, the Affordable Care Act's Medicaid and marketplace health coverage expansions led to large gains in health insurance among low-income individuals and people of color which helped to narrow the longstanding disparities they face in health coverage. If maintained, coverage gains will help reduce disparities in access to care as well as health outcomes over the longer term.

Despite this progress, challenges remain. Differing state decisions to implement the ACA Medicaid expansion to low-income adults widen geographic disparities in coverage. States that have expanded have experienced larger gains in coverage and more improved access to care than the States that have not. And those States that have not expanded are largely concentrated in the South, a region home to many people of color that has high rates of chronic disease and poor health.

Moreover, although disparities in coverage by race and income have narrowed, low-income people and people of color remain significantly more likely to be uninsured, and these disparities persist among our Nation's children. For example, Hispanic children are twice as likely as white children to be uninsured, and the uninsured rate among American Indian and Alaskan Native children is nearly 5 times as high as the rate for white children.

As we look forward, there is much at stake for health and healthcare disparities as this Congress considers future funding decisions and broader healthcare reforms. The newly released American Health Care Act would likely erode recent progress and have significant negative effects on disparities. The changes to Medicaid would disproportionately affect people of color and low-income people for whom the program is a central source of coverage. Notably, more than half of all our Nation's children of color rely on Medicaid.

Its proposal to cap Federal Medicaid financing would lead to a fundamental shift in the Federal commitment to States to support care for individuals with the greatest health needs and lowest incomes. The cap would limit growth to a pre-set amount, and if State costs exceed capped amounts, they would need to increase State spending or make program cutbacks. Capped funding would also lock in historic differences across States and benefits and

spending. Moreover, the elimination of the enhanced Federal funding for the expansion would likely result in eligibility reductions and losses in coverage that would disproportionately affect low-income people on people of color.

Reductions in health coverage would also increase strains on other parts of the healthcare system, including community health centers and public health programs. However, the act would also eliminate funding for the Prevention and Public Health Fund, which several governors have cited as a key component to support their public health and prevention activities.

Amid this uncertainty to changes in health insurance, coverage support for public health and prevention services, and a healthcare workforce and delivery system that can adequately meet the needs of our increasingly diverse population, is more important than ever.

Thank you again for this opportunity. I hope you find these remarks useful for your future deliberations and work.

[The information follows:]

**Testimony submitted by**
**Samantha Artiga, Director, Disparities Policy Project,**
**The Henry J. Kaiser Family Foundation**
**for the House Subcommittee on Labor, Health, and Human Services, Education, and Related Agencies**
**March 8, 2017**

Chairman Cole, Ranking Member DeLauro, and other members of the subcommittee, thank you for this opportunity to testify on the status of health and health care disparities in our nation. It is a timely and important issue given the transformation of health care in recent years under the Affordable Care Act (ACA) and the changes being considered to health care by this Congress. In my comments today, I will address the following key points:

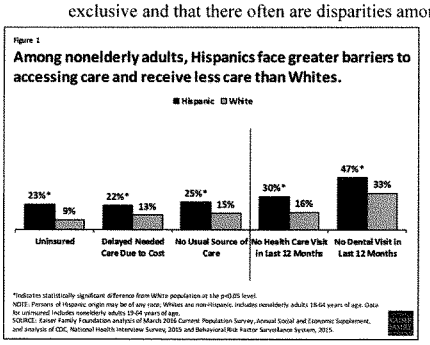
- **It is increasingly important to address disparities given our nation's growing diversity.** Health and health care disparities, which are differences between groups in their health status and their ability to access and use needed care, remain a persistent issue in the United States. Addressing disparities is not only important from a social justice standpoint, but also for improving our nation's health and reducing unnecessary costs.
- **Today, many groups face significant disparities in their health and health care.** People of color and low-income individuals face large disparities in access to and use of health care as well as health outcomes. Disparities also occur across other dimensions including language, location, and sexual orientation.
- **Maintaining gains in health insurance and support for public health and prevention, the health care workforce, and the delivery system are key for continuing advancements in reducing disparities.** The ACA health insurance expansions and investments in public health and prevention, the health care workforce, and the delivery system supported reductions of disparities. Changes being considered to repeal the ACA and restructure Medicaid, including capping federal financing, would disproportionately affect low-income individuals and people of color and negatively affect disparities.

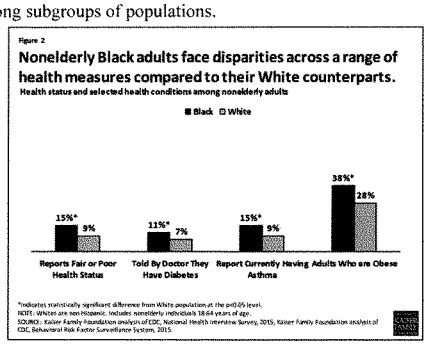
**Health and health care disparities in the United States are a longstanding and persistent issue.** Health and health care disparities refer to differences between groups in their health status and in their access to and use of needed health care.[1] While some health differences reflect genetics, disparities often refer to unnecessary differences that are driven by factors rooted in historic economic, social, and racial disadvantages. Research increasingly shows that race, class, and zip code play a larger role in determining health than genetics.[2] Although disparities have been documented for decades and there have been overall improvements in our nation's health, many disparities have persisted and, in some cases, widened over time.[3]

**Addressing disparities is not only important from a social justice standpoint, but also for improving our nation's health and reducing unnecessary costs.** Disparities in health and health care not only affect the groups facing disparities, but limit overall improvements in our nation's health. They also result in increased costs due to unnecessary medical expenditures and indirect costs associated with lost work productivity and premature death.[4] As our nation becomes increasingly diverse, with projections estimating that people of color will make up more than half of the population by 2044, it is increasingly important to address disparities.[5]

**Today, many groups face significant disparities in their ability to access and use needed health care as well as in their health status and outcomes.** There remain large disparities by race and ethnicity.[6] For example, Hispanics fare worse than Whites across measures of health access and use (Figure 1), and Blacks fare worse across a range of health measures compared to Whites (Figure 2).[7] There also are disparities by income, with lower income people facing greater barriers to accessing and using care and reporting worse health status than those with higher incomes.[8] Although disparities are often viewed through the frames of race and income, they also occur across other dimensions. For example, research shows increased barriers for

LGBT individuals, people with limited English proficiency, and individuals living in rural and inner city areas.[9] Further, it is important to recognize that these groups are not mutually exclusive and that there often are disparities among subgroups of populations.

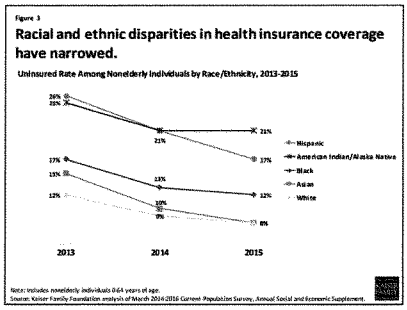



**There has been an elevated federal focus on eliminating disparities in recent years.** In 2011, the Department of Health and Human Services (HHS) developed its first action plan to eliminate racial and ethnic disparities.[10] The plan builds on organizational changes made within HHS under the ACA to prioritize and better coordinate efforts to reduce disparities. The ACA also strengthened data collection and research efforts to allow for improved measurement and monitoring of disparities and provided new protections from discrimination in health care.

**ACA initiatives and investments through discretionary programs to strengthen public health and prevention, the health care workforce, and the delivery system support reduction of disparities.** For example, the ACA boosted funding for community health centers, which are a key source of care for low-income individuals and people of color.[11] It also contains provisions to increase the number of providers, particularly in underserved areas.[12] Moreover, it provided funding for and expanded initiatives to strengthen the public health workforce and infrastructure and prevention services, including the new Prevention and Public Health Fund.[13]

**The ACA's broad health insurance coverage expansions through Medicaid and the Marketplaces also have played a central role in reducing health care disparities.** Since implementation of these expansions, there have been large gains in coverage for low-income individuals and people of color, which helped narrow disparities in coverage (Figure 3).[14] The Medicaid expansion played a particularly important role in these coverage gains.




**These coverage gains are expected to reduce disparities in access to and use of health care as well as health outcomes over the long-term.** Research shows that health insurance makes a key difference in whether and when people get medical care, where they get their care, and ultimately how healthy they are.[15] There also has been growing recognition that, although health insurance is key to health, social and environmental factors also influence health. An increasing number of initiatives within the health care system have emerged to address broader social determinants of health.[16] Further, there has been increased recognition of the need to increase diversity within the health care workforce, enhance providers' ability to deliver culturally and linguistically appropriate care, and increase provider access within rural and underserved areas.[17]

**Despite nationwide gains in health insurance, differing state decisions to implement the ACA Medicaid expansion to low-income adults have widened disparities in coverage.** In states that expanded, parents and childless adults with incomes up to 138% of the federal poverty level (FPL), which is about $28,200 for a family of three, are eligible for Medicaid. In contrast, among the 19 largely Southern states that have not expanded, the median Medicaid eligibility

limit for parents is 44% FPL, or less than $9,000 per year for a family of three, and other adults generally are not eligible. As a result of these eligibility differences, Medicaid expansion states have realized larger gains in coverage and access to care than states that have not expanded.[18] In particular, there are widening gaps between the South, which is home to many people of color and has high rates of chronic disease and poor health, and the rest of the nation.[19]

**Further, although disparities in coverage have narrowed, low-income people and people of color still are more likely to be uninsured than those with higher incomes and Whites.[20]** Hispanics and American Indians and Alaska Natives (AI/ANs) have the highest uninsured rates among racial and ethnic groups, and these disparities persist among children.[21] In 2015, Hispanic children were nearly twice as likely as White children to be uninsured (7% vs. 4%), and AI/AN children were nearly five times as likely as White children to be uninsured (19% vs. 4%).[22]

**Maintaining gains in health insurance and support for public health and prevention, the health care workforce, and the delivery system are key for continuing advancements in reducing disparities.** Changes being considered to health insurance through repeal of the ACA and restructuring of Medicaid, including capping federal financing, could have significant negative effects on disparities. People of color and low-income individuals would be disproportionately impacted by these changes since they had large coverage gains under the ACA and Medicaid is a central source of coverage for them. Reductions in health insurance and funding also would increase strains on other parts of the health care system, including community health centers and public health programs, which already face funding constraints and uncertainty regarding their future funding. Amid potential changes to health insurance, support for public health and prevention services and a health care workforce and delivery system that meets the needs of our increasingly diverse population is particularly important.

[1] Department of Health and Human Services, *HHS Action Plan to Reduce Racial and Ethnic Health Disparities*, (Washington, DC: Department of Health and Human Services, April 2011), http://minorityhealth.hhs.gov/npa/files/plans/hhs/hhs_plan_complete.pdf.

[2] Harry J Heiman and Samantha Artiga, *Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity,* (Washington, DC: Kaiser Family Foundation, November 2015), http://kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/.

[3] Agency for Healthcare Research and Quality, *2015 National Healthcare Quality and Disparities Report and 5th Anniversary Update on the National Quality Strategy*, (Rockville, MD: Agency for Healthcare Research and Quality, May 2015), https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqrdr/nhqdr15/2015nhqdr.pdf.

[4] Thomas LaVeist, Darrell Gaskin, and Patrick Richard, *The Economic Burden of Health Inequalities in the United States*, (Washington, DC: Joint Center for Political and Economic Studies, September 2009), http://www.hhnmag.com/ext/resources/inc-hhn/pdfs/resources/Burden_Of_Health_FINAL_0.pdf.

[5] Sandra L. Colby and Jennifer M. Ortman, Projections of the Size and Composition of the U.S. Population: 2014 to 2060, (Washington, D.C., U.S. Census Bureau, March 2015), https://www.census.gov/content/dam/Census/library/publications/2015/demo/p25-1143.pdf.

[6] Agency for Healthcare Research and Quality, *2015 National Healthcare Quality and Disparities Report and 5th Anniversary Update on the National Quality Strategy*, op cit. and Samantha Artiga et. al., *Key Facts on Health and Health Care by Race and Ethnicity,* (Washington, DC: Kaiser Family Foundation, June 2016), http://files.kff.org/attachment/Chartpack-Key-Facts-on-Health-and-Health-Care-by-Race-and-Ethnicity.

[7] Samantha Artiga et. al., *Key Facts on Health and Health Care by Race and Ethnicity,* op cit.

[8] Agency for Healthcare Research and Quality, *2015 National Healthcare Quality and Disparities Report and 5th Anniversary Update on the National Quality Strategy*, op cit.

[9] Kaiser Family Foundation, *Health and Access to Care and Coverage for Lesbian, Gay, Bisexual, and Transgender Individuals in the U.S.*, (Washington, DC: Kaiser Family Foundation, June 2016), http://kff.org/disparities-policy/issue-brief/health-and-access-to-care-and-coverage-for-lesbian-gay-bisexual-and-transgender-individuals-in-the-u-s/; Kaiser Commission on Medicaid and the Uninsured, *Overview of Health Coverage for Individuals with Limited English Proficiency*, (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, August 2012), http://www.kff.org/uninsured/8343.cfm; and Agency for Healthcare Research and Quality, *2013 National Healthcare Disparities Report,* (Rockville, MD: Agency for Healthcare Research and Quality, May 2014), https://www.ahrq.gov/sites/default/files/publications/files/2013nhdr.pdf.

[10] Department of Health and Human Services, *HHS Action Plan to Reduce Racial and Ethnic Health Disparities*, op cit.

[11] Kaiser Family Foundation, *Summary of the Affordable Care Act,* (Washington, DC: Kaiser Family Foundation, April 2013), http://kff.org/health-reform/fact-sheet/summary-of-the-affordable-care-act/.

[12] Ibid.

[13] Ibid.

[14] Samantha Artiga, et. al., *Health Coverage by Race and Ethnicity: Examining Changes Under the ACA and the Remaining Uninsured,* (Washington, DC: Kaiser Family Foundation, November 2016), http://kff.org/disparities-policy/issue-brief/health-coverage-by-race-and-ethnicity-examining-changes-under-the-aca-and-the-remaining-uninsured/ and Rachel Garfield, et. al., *The Uninsured: A Primer – Key Facts about Health Insurance and the Uninsured in the Wake of National Health Reform,* (Washington, Kaiser Commission on Medicaid and the Uninsured, November 2016), http://kff.org/uninsured/report/the-uninsured-a-primer-key-facts-about-health-insurance-and-the-uninsured-in-the-wake-of-national-health-reform/.

[15] Kaiser Commission on Medicaid and the Uninsured, *Key Facts About the Uninsured Population, (Washington, DC: Kaiser Family Foundation, September 2016),* http://kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/.

[16] Harry J Heiman and Samantha Artiga, *Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity,* op cit.

[17] Office of Minority Health, *National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care: A Blueprint for Advancing and Sustaining CLAS Policy and Practice,* (Washington, DC: U.S. Department of Health and Human Services, April 2013),

https://www.thinkculturalhealth.hhs.gov/pdfs/EnhancedCLASStandardsBlueprint.pdf and The Commonwealth Fund, *State and Federal Efforts to Enhance Access to Basic Health Care*, (New York, NY: The Commonwealth Fund, March 2010), http://www.commonwealthfund.org/publications/newsletters/states-in-action/2010/mar/march-april-2010/feature/feature.

[18] Larisa Antonisse, et. al., *The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review*, (Washington, DC: Kaiser Family Foundation, February 2017), http://kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review/.

[19] Samantha Artiga and Anthony Damico, *Health and Health Coverage in the South: A Data Update, (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, February 2016)*, *http://kff.org/disparities-policy/issue-brief/health-and-health-coverage-in-the-south-a-data-update/*.

[20] Michael E Martinez, Emily P Zammitti, and Roben A Cohen, *Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, January-September 2016, (Hyattsville, MD: National Center for Health Statistics, February 2017)*, https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201702.pdf.

[21] Samantha Artiga, et. al., *Health Coverage by Race and Ethnicity: Examining Changes Under the ACA and the Remaining Uninsured,* op cit.

[22] Ibid.

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

## Witness Disclosure Form

Clause 2(g) of rule XI of the Rules of the House of Representatives requires non-governmental witnesses to disclose to the Committee the following information. A non-governmental witness is any witness appearing on behalf of himself/herself or on behalf of an organization other than a federal agency, or a state, local or tribal government.

Your Name, Business Address, and Telephone Number:
Samantha Artiga
1330 G Street, NW
Washington, DC 20005
202-347-5270

1. Are you appearing on behalf of yourself or a non-governmental organization? Please list organization(s) you are representing.

   On behalf of myself

2. Have you or any organization you are representing received any Federal grants or contracts (including any subgrants or subcontracts) since October 1, 2012 related to the agencies or programs funded by the Subcommittee?

   Yes (No)

3. Have you or any organization you are representing received any contracts or payments originating with a foreign government since October I, 2012 related to the agencies or programs funded by the Subcommittee?

   Yes (No)

4. If your response to question #2 and/or #3 is "Yes", please list the amount and source (by agency and program) of each Federal grant (or subgrant thereof) or contract (or subcontract thereof), and/or the amount and country of origin of any payment or contract originating with a foreign government. Please also indicate whether the recipient was you or the organization(s) you are representing.

Signature: [redacted]

Date: 3/6/17

Mr. COLE. I thank the gentlelady very much for coming and testifying before the committee. We do not often get people to come and do not ask for money. [Laughter.]

Mr. COLE. You know, you are a delightful witness to have.

Ms. DELAURO. And I just wanted to just add, thank you for the information and the data. Oftentimes we speak anecdotally, and we cannot where it really will affect the healthcare people in this Nation and what the elimination of the Prevention Fund would do, and, again, I mentioned earlier what the cutbacks in Medicaid would do. But that is based on sound data and research, and that is the basis on which we can proceed.

So, I very much thank you.

Ms. ARTIGA. And that is the business of our foundation is data.

Ms. DELAURO. Thank you very, very much.

Ms. ARTIGA. So, if we can ever be of assistance, please let us know.

Ms. DELAURO. Thank you. Appreciate it.

Ms. ARTIGA. Thank you.

Mr. COLE. Thank you. Thank you for your testimony. Next witness please?

Our order has changed. Mr. William Kohlhepp, president of the Physician Assistant Education Association. I hope I did not butcher your name too bad.

Dr. KOHLHEPP. Very nicely done.

Mr. COLE. Okay, I appreciate that. You have already scored points with the chair, whether it is true or not. The gentleman is recognized for 5 minutes for whatever testimony he cares to deliver to the committee.

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WEDNESDAY, MARCH 8, 2017.

## PHYSICIAN ASSISTANT EDUCATION ASSOCIATION

### WITNESS

### WILLIAM KOHLHEPP, M.D., PRESIDENT, PHYSICIAN ASSISTANT EDUCATION PROGRAM

Dr. KOHLHEPP. Great. Chairman Cole, Ranking Member DeLauro, and members of the subcommittee, thank you for the opportunity to speak to you today and to ask for your continued support of Title 7 primary care training and enhancement grants. These grants provide funding for curricular innovations, faculty development, access to care for underserved areas, and workforce diversity in the physician assistant profession, which I will refer to as PA.

I am also here today to inform the committee about a critical situation that PA education programs face in accessing sufficient clinical education sites to train our students with patients.

My name is Dr. William Kohlhepp, and I am president of the Physician Assistant Education Association, PAEA, and dean of the School of Health Sciences at Quinnipiac University. I speak to you today to underscore the importance of PA education and how PAs enhance inter-professional teams in our evolving healthcare system. We recommend $12,000,000 in funding to support PA education in Fiscal Year 2018 to enhance program innovation and the

recruitment, training, and development of students and faculty at PA programs nationwide.

The PA Program was created 50 years ago in response to a shortage of primary care physicians. PAs are educated as generalists, and we have a unique flexibility to fill gaps in both primary care and in specialties. PAs spend 2,000 hours in clinical training, second only to our physician colleagues in time devoted to training with patients. PAs enter primary care more than any other specialty.

Increasing demand for PAs has meant rapid growth of the profession. We have grown from three graduates to more than 110,000. PAs are now licensed to practice medicine, including prescriptive authority, in every State and D.C. The pipeline to our profession is strong with the Bureau of Labor Statistics projecting a 30 percent increase in the number of PA positions between 2014 and 2024.

PA programs are well positioned to continue increasing our output of PAs who can help meet the changing healthcare needs of the nation. However, efforts to increase the number of PA graduates must contend with one major barrier: the critical shortage of clinical training sites. We are trapped in somewhat of a vicious cycle. Projected shortages of clinicians have led to health professions to try to increase numbers of clinicians they graduate, which in turn increases pressure on clinical sites. At the same time, clinicians are facing new demands for increased productivity and implementation of new electronic health records, which has forced many potential preceptors to reduce their commitment to education.

Finally, supply and demand pressures have led some programs to pay for clinical sites. More than a third of programs report paying for some or all sites, an increase of 14 percentage points since 2012. Surveys indicate that 95 percent of program directors are concerned about clinical site opportunities, and that nearly half report that the payment trend has negatively affected plans to increase enrollment.

Federal investments can help break this cycle. Title 7 funds help improve clinical education and help programs to recruit applicants from disadvantaged and minority backgrounds. But Federal funding has not kept pace with program growth. Today there are 218 PA programs, yet the most recent training and primary care program competition funded only 13 programs out of that 218.

PAEA's request for $12,000,000 to expand the capacity of PA education is an investment in improving access to primary care, which can reduce future healthcare costs. Federal incentives to encourage clinicians to precept PA and other students are a promising strategy for relieving the clinical site crisis, and would also promote inter-professional education.

PAEA welcomes the opportunity to work with you to explore policies that will create a supportive environment for preceptors and lower barriers to accepting students into their practices. The number of PA programs in the congressional districts represented by this subcommittee total 55 out of the 218. This committee has a real interest in PA program education. We invite you to see those programs in person.

Regardless of how healthcare reform plays out, the Nation's need for highly-trained will remain. Thank you for the opportunity to testify today.

[The information follows:]

**CODE RED–CRITICAL: Clinical Education Site Shortage Threatens PA Health Workforce**

*Submitted for the Record to the House Appropriations Subcommittee on Labor, Health and Human Services, Education and Related Agencies – March 8, 2017*
*Testimony of William Kohlhepp, DHSc, PA-C, President, Physician Assistant Education Association (PAEA)*

On behalf of the Physician Assistant Education Association (PAEA), which represents the 218 accredited PA programs in the United States, I am pleased to submit testimony on the FY 2018 appropriations for physician assistant (PA) education programs authorized through Title VII of the Public Health Service Act. PAEA supports funding of at least $580 million in FY 2018 for health professions education programs under Title VII. PAEA also requests $12 million of that funding to support PA programs through the HRSA Primary Care Training and Enhancement Grants Program. Title VII is the only designated federal source for PA education and is crucial to the PA education system's ability to graduate highly skilled PAs, ready to enter the workforce.

**CODE RED–Critical: Clinical Site Shortages**

The PA profession has played a key role in the U.S. health care system for 50 years. Responding to demand, the profession has grown rapidly, with more than 100,000 graduates now practicing in every medical surgical specialty and setting. The PA profession stands ready to help fill projected shortages of clinicians. However, efforts to increase numbers of PA graduates must contend with a shortage of clinical training sites, a phenomenon experienced throughout the health professions and particularly acute in primary care disciplines.

The shortage of clinical sites is a direct result of the projected shortages of providers in recent years. As the health professions education system has moved to increase the numbers of graduates, the rising numbers of clinicians in training put pressure on available clinical sites.

Simultaneously, practicing clinicians faced new productivity and documentation demands, forcing some to reduce their commitment to education.

Competition for clinical sites has also led to a new and compounding issue—PA programs paying for sites. More than a third (35.4%) of PA programs now report paying for some or all sites, an increase of 14 percentage points since 2012.[1] PAEA data also show that an astounding 94.8% of program directors are moderately or very concerned about clinical site opportunities, and that almost half of them (46.7%) reported that the need to pay for sites has negatively affected their plans to increase enrollment.[2]

Payments for supervised clinical rotations also increases costs for students — through new fees and increased tuition. Federal assistance can help break this cycle.

**Background on the Profession and Education Model**

PAs are licensed health professionals educated in general medicine who have consistently proven to be effective members of the health care team. PAs provide a broad range of medical and therapeutic services to diverse rural and urban populations and have prescriptive authority in all 50 states.

PA education programs average 27 months in length, comprised of a year of classroom studies and a year or more devoted to clinical rotations. The 2,000 hours of clinical training that PA students undergo is second only to that of physicians in time devoted to training with patients. Their advanced medical training allows PAs to practice with significant autonomy, often serving as the sole medical provider in remote and underserved areas. The PA practice model is, by design, a team-based approach to patient-centered care in which PAs work in

[1] Physician Assistant Education Association. *By the Numbers: Program Report 31*. Washington, DC: PAEA, 2016. doi:10.17538/PS31.2016

[2] Association of American Medical Colleges. *Recruiting and Maintaining U.S. Clinical Training Sites: Joint Report of the 2013 Multi-Discipline Clerkship/Clinical Training Site Survey*. Washington, DC: AAMC; 2013.

partnership with physicians and other health professionals. This model is very attractive to applicants, as reflected in the pronounced growth in the PA applicant pool from 4,669 in 2001 to approximately 27,000 applicants in 2017. Over the past five years alone, there has been a 26% increase in the number of PA program applicants.

**Need for Increased Title VII Funding**

The unmet need for primary care services in the United States is well documented and expected to grow as the population ages. The PA profession was created specifically to address a shortage of primary care physicians 50 years ago, and today's PAs remain ready to address the new challenges our nation faces in primary care and other specialties. However, even with the current output of a little more than 8,000 PA graduates each year, clinician shortages continue to persist, particularly in rural and underserved communities. Title VII, as the single direct funding source for PA programs, plays a crucial role in developing and supporting our members' ability to produce the next generation of PAs.

In academic year 2014-2015, Title VII grantees educated 4,390 PA students. About 29% of PA students reported a disadvantaged background, and 13% came from a rural background. Training sites for this program were primarily located in a medically underserved community (60%), a primary care setting (58%), and/or a rural setting (19%).

More than 2,000 individuals trained alongside PA students while participating in interprofessional team-based care across all training sites affiliated with the grantee program. Grantees implemented 135 courses and training activities to PA students during the academic year as part of efforts to integrate primary care curriculum into PA training. Lastly, 364 PA faculty members were trained through the faculty development activities funded by the program, and 29 faculty members completed structured faculty programs.

Title VII funding enhances clinical training and education, assists PA programs to recruit applicants from disadvantaged and minority backgrounds, and supports innovative programs to ensure a diverse, well-trained health professional team. Title VII was strengthened in 2010 when Congress enacted a 15% allocation in the appropriations process for PA programs. This funding has enhanced capabilities to train future PAs, to creatively expand care to the underserved, and to develop a more diverse PA workforce. For example, one of our PA program uses a HRSA grant to operate a mobile health vehicle to provide health education and initial health screenings to local underserved patients and to increase students' awareness of the importance of cultural competency and health literacy. Another grant allows a program to provide scholarships to incoming PA students who are veterans, and who dedicate their postgraduate careers to a primary care setting.

Finally, federal support of clinicians who precept PAs and other health professionals and is a promising strategy for relieving the clinical site crisis and would have the additional benefit of promoting interprofessional education and practice.

**Enhancing Diversity**

The quality of patient care is enhanced when clinicians reflect America's changing demographics. PA programs are committed to attracting students from underrepresented groups and disadvantaged backgrounds, as well as experienced veterans who aspire to civilian health professions. Studies show that health professionals from underserved areas are three to five times more likely to return to underserved areas.[3,4,5] PA programs continue to explore innovative ways

[3] Phillips RL, Dodoo MS, Petterson S, et al. *Specialty and Geographic Distribution of the Physician Workforce: What Influences Medical Student and Resident Choices?* Washington DC: The Josiah Macy, Jr. Foundation and The Robert Graham Center; 2009.
[4] Hyer RL, Bazemore AW, Bowman RC, Zhang X, Petterson S, Phillips RL. Rural origins and choosing family medicine predict future rural practice. *Am Fam Physician*. 2007;76(2):207.
[5] Talley RC. Graduate medical education and rural health care. *Acad Med*. 1990;65:522-525.

to recruit diverse individuals and sustain them as education leaders. Increased education costs may have a negative impact on the diversity of the PA applicant pool and reduce the number of graduates who practice primary care.

To leverage the efforts of PA programs and increase workforce diversity in the PA profession, PAEA supports funding for the Health Careers Opportunity Program (HCOP) and increased funding for the Scholarships for Disadvantaged Students and the National Health Service Corps (NHSC). These programs are vital to our nation's health and provide a clear path for students who might not otherwise consider a PA career.

**Recommendations on FY 2018 Funding**

The Physician Assistant Education Association, along with our colleagues in the health professions community, requests the committee's support for Title VII health professions programs at a minimum of $580 million for FY 2018. This level of funding is crucial to educate and maintain highly skilled primary care practitioners, particularly those from diverse backgrounds and veterans, who are more likely to practice in medically underserved areas and serve vulnerable populations. For PA education programs, we request funding of $12 million, which will allow support for the expanding number of PA programs expected to begin enrolling students during the next four to five years.

We thank subcommittee members for their support of the PA profession and look forward to your continued commitment to finding solutions to the nation's health workforce shortage and the current challenges we face in securing and maintaining quality clinical education sites.

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

## Witness Disclosure Form

Clause 2(g) of rule XI of the Rules of the House of Representatives requires non-governmental witnesses t o disclose to the Committee the following information. A non-governmental witness is any witness appearing on behalf of himself/herself or on behalf of an organization other than a federal agency, or a state, local or tribal government.

Your Name, Business Address, and Telephone Number:
William Kohlhepp, DHSc, PA-C
Quinnipiac University
School of Health Sciences – Physician Assistant Program
275 Mt. Caramel Avenue
Hamden, CT 06518
(203) 582-5226

1. Are you appearing on behalf of yourself or a non-governmental organization? Please list organization(s) you are representing.
   Physician Assistant Education Association
   Quinnipiac University

2. Have you or any organization you are representing received any Federal grants or contracts (including any subgrants or subcontracts) since October 1, 2012 related to the agencies or programs funded by the Subcommittee?

   Yes No X

3. Have you or any organization you are representing received any contracts or payments originating with a foreign government since October I, 2012 related to the agencies or programs funded by the Subcommittee?

   Yes No X

4. If your response to question #2 and/or #3 is "Yes", please list the amount and source (by agency and program) of each Federal grant (or subgrant thereof) or contract (or subcontract thereof), and/or the amount and country of origin of any payment or contract originating with a foreign government. Please also indicate whether the recipient was you or the organization(s) you are representing.

Signature: [redacted] Date: March 6, 2017

Mr. COLE. I want to thank the gentleman very much for his testimony and for highlighting a really important issue that we have, which is simply the lack of personnel to cover the needs of our population, whatever our system of health care delivery happens to be. Very valuable and very timely.

Dr. KOHLHEPP. Thank you.

Ms. DELAURO. Let me just say thank you to you, Bill, for the work that you do and for the work that Quinnipiac does.

Dr. KOHLHEPP. Thank you, Congresswoman.

Ms. DELAURO. Really are outstanding. And as the Chairman would point out, if we could get the 2017 bill out, we could have the opportunity for some increased or for some, you know, flat funding. But nevertheless, we would have some, you know, some resources there to deal with. But thank you very, very much for your testimony.

Mr. COLE. Well, on a totally unrelated issue, thank you for the polling at Quinnipiac. [Laughter.]

As an old pollster, I love that stuff, and actually one of my friends, Peter Brown, is associated with your program. It is very——

Ms. DELAURO. Mr. Chairman, that program was established many, many, many, many, many years ago by a wonderful individual, whose name was Paul Falcigno. He has since passed on, but he served on the New Haven Board of Alderman with my mom all those years ago. So, I feel very proprietary about Quinnipiac, the polling, and the great work they do here. Thanks.

Dr. KOHLHEPP. Our School of Health Sciences does great work.

Ms. DELAURO. Amen.

Dr. KOHLHEPP. But I will give the prop out to the hockey team and to the poll.

Ms. DELAURO. Amen. Amen.

Dr. KOHLHEPP. Thank you for the opportunity to testify.

Ms. DELAURO. Thank you.

Mr. COLE. Thank you very much. Our next witness please? Welcome.

Ms. RENNER. Good morning.

Mr. COLE. Good. Megan Renner, good to have you here. The executive director of the U.S. Breastfeeding Committee. And the gentlelady is recognized for 5 minutes for whatever testimony she cares to give the committee.

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WEDNESDAY, MARCH 8, 2017.

## U.S. BREASTFEEDING COMMITTEE

### WITNESS

### MEGAN RENNER, EXECUTIVE DIRECTOR, U.S. BREASTFEEDING COMMITTEE

Ms. RENNER. Thank you. Chairman Cole, Ranking Member DeLauro, and members alert and members of the subcommittee, thank you for the invitation to present public witness testimony today. My name is Megan Renner, and I am the executive director of the U.S. Breastfeeding Committee, an independent, nonprofit coalition of more than 50 national organizations, with a network of

State and local coalitions in all 50 States working collaboratively to create a landscape of support for breastfeeding families across our Nation.

Breastfeeding is a proven primary prevention strategy, and the first food of breast milk builds a foundation for lifelong health and wellness. The evidence for the value of breastfeeding to children's and women's health is scientific, solid, and continually being reaffirmed by new research. Compared with formula fed infants, we know that those who are breast fed have a reduced risk of several acute illnesses in infancy as well as of SIDS and the debilitating disease of necrotizing enterocolitis that preemies can suffer from.

In the longer term, mothers and children have a reduced risk of several chronic diseases, including obesity, diabetes, and asthma in children, and diabetes, cardiovascular disease, and breast and ovarian cancers in women. Yet these impacts beyond families, of course, also benefiting our Nation's employers and our economy.

An updated and consolidated study just published in 2016 of both the maternal and pediatric health outcomes and associated costs showed that if 90 percent of our Nation's infants were breastfed according to medical recommendations, annually we would prevent 3,340 deaths, $3,000,000,000 in medical costs, and $14,200,000 in the costs of premature death.

Everyone can, of course, agree that the decision to breastfeed is a personal one, and a mother should not be made to feel guilty when she cannot or chooses not to breastfeed. Yet we know the great majority of pregnant women and new mothers want to breastfeed, and 81 percent start out breastfeeding in the hospital. Despite this initial success, however, 6 in 10 breastfeeding mothers stop earlier than they intend. They are unable to reach their own personal goals due to a number of identified key barriers to breastfeeding.

These obstacles, dubbed the booby traps by one of our member organizations, can be addressed through simple cost-effective interventions. And that is why in 2011, Surgeon General Regina Benjamin launched the Surgeon General's Call to Action to support breast feeding, outlining 20 concrete action steps that would have the greatest impact across six different sectors of society.

So, our priority recommendations address several of the surgeon general's 20 action steps by a robust collective action that cuts across multiple sectors. We believe there is great promise in the coordinated and collaborative approaches used by the Centers for Disease Control and Prevention to further cost-effective public health actions to increase healthy eating and physical activity.

So, on behalf of the more than 3 million U.S. families that choose to breastfeed their newborns every year, I respectfully urge the subcommittee to sustain the bipartisan support for effective and innovative initiatives to support breastfeeding families, especially by a continuation of this funding for the CDC's Division of Nutrition, Physical Activity, and Obesity, supporting Breastfeeding Families Program at the original requested amount of $50,000,000 a year. Congress has dedicated funding to this program for more than 5 years, and the impact of these investments has already been substantial with a special emphasis on maternity care practice improvement and continuity of care.

We know the maternity care experience can influence both breastfeeding initiation and later infant feeding behavior, and the CDC collects data every 2 years through a national survey of maternity practices. The results of the 2015 survey showed that on average, U.S. hospitals scored 79 out of a possible 100 points, which is an increase from an overall national score of just 63 in 2007 and 70 in 2011. By another measure over the same period, the percentage of hospitals implementing a majority of the recommended practices has increased from 29 percent in 2007 to 62 percent in 2015.

These current CDC breastfeeding initiatives are also addressing the need to ensure healthcare professionals have sufficient knowledge and skills to increase access to professional and peer lactation support, and to support employers and child care providers to implement breastfeeding supports that have a critical impact when families return to work or school.

Additional recommendations that we would like to put forth include directly funding the HHS Office of Women's Health, breastfeeding support programs, especially the initiatives to provide resources to employers to support nursing mothers in the workplace, and to support and inform breastfeeding mothers via the Your Guide to Breastfeeding, the It's Only Natural Campaign, and the OWH Women's Health Help Line.

We also urge the subcommittee to address obstacles to greater availability of safe banked donor human milk for fragile infants by funding the Agency for Healthcare Research and Quality, to conduct a systematic review of evidence and a study on federal regulation and support of donor milk banks, and by funding the Health Resources and Services Administration to establish evidence-based clinical guidelines.

Finally, we would like to also express support for continued funding of several affiliated programs, and ensuring incorporation and expansion of breastfeeding support within them, including the Reach Program, Racial and Ethnic Approaches to Community Health, the National Early Care and Early Care and Education Collaboratives under CDC, and within HRSA, the Title 5 Maternal and Child Health Block Grant, especially the special projects of regional and national significance, Healthy Start, and the MIECHV Home Visiting Program.

Thank you again for this opportunity to share our recommendations. We are extremely grateful to the subcommittee for your sustained efforts to support these programs. Thank you.

Mr. COLE. Thank you very much, the gentlelady, for her testimony. Next witness please.

Welcome.

Dr. DALAL. Thank you.

Mr. COLE. Good to have you here.

Dr. DALAL. Nice to be here.

Mr. COLE. You will have to bear with me. Dr., is it Mehul Dellah?

Dr. DALAL. Dr. Mehul Dalal.

Mr. COLE. Mehul Dalal. Well, thank you very much for your indulgence, and it is great to have you here as a witness. The gentleman is the president of the National Association of Chronic Dis-

ease Directors. The gentleman is recognized for 5 minutes for whatever testimony he cares to present to the committee.

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WEDNESDAY, MARCH 8, 2017.

## NATIONAL ASSOCIATION OF CHRONIC DISEASE DIRECTORS

### WITNESS

### MEHUL DALAL, M.D., PRESIDENT, NATIONAL ASSOCIATION OF CHRONIC DISEASE DIRECTORS

Dr. DALAL. Thank you, Chairman Cole, Ranking Member DeLauro, and members of the committee for allowing me to testify on behalf of the National Association of Chronic Disease Directors, which I will refer to NACDD.

My name is Mehul Dalal. I am currently serving my term as the president of board of directors for NACDD, and I am the State chronic disease director in Connecticut. Specifically, I want to express our strong support for increased funding for key chronic disease programs at CDC. Simply put out the grant and support of the CDC, most States would have an extremely limited ability to address these critical public health issues.

These investments, as detailed in our written testimony, work to prevent disease in the first place, which in turn contributes to the economic productivity of the workforce, educational outcomes for children, and fitness levels for military recruits, and helps counteract the skyrocketing healthcare costs.

NACDD is a nonprofit public health organization that serves chronic disease program directors of each State and U.S. jurisdiction, and connects more than 6,000 chronic disease practitioners across the country. We represent a core sector of governmental public health, and we work closely with our executive and State territorial health agency leaders as well, as our governors and state legislatures.

Poor health of the population can exert a tremendous force, unemployment rates, interest costs, and other tangible factors that ultimately affect our ability to maintain a strong global economic position. The primary driver of costs in healthcare is chronic disease. According to the CDC, chronic disease accounts for approximately 75 percent of the Nation aggregate healthcare spending, or an estimated $5,300 for every individual in the U.S.

Treatment of chronic disease constitutes an even larger portion of spending, 96 cents per dollar for Medicare and 83 cents per dollar for Medicaid. As the American population ages, more people are categorized as high risk for multiple chronic diseases, and these health care costs are projected to continue their rise.

State public health chronic disease prevention and control programs are key in improving the Nation's health and counteracting the rise in healthcare costs. States are implementing diverse and cost-effective strategies that worked to prevent diabetes, reduce heart disease and stroke, and promote fitness and nutrition in order to reduce the disability and costs associated with these conditions. As an example, in the New Haven area, CDC resources have supported us to work with community health centers and identify

over 16,000 at-risk patients, and implement programs in the clinics and in the communities that educate and empower hundreds of patients to take charge of their own conditions.

In one instance, a community health worker identified a 55-year-old woman with diabetes who did not have a primary care physician. In addition to linking her to a primary care doctor, our program provided her with a gym membership and health coaching services. And with this support, she herself developed her own individualized fitness plan where she focused on Zumba and weightlifting. Over time she reduced her need for diabetes medications pills from six pills a day to a half a pill a day, and she dropped in size from a size 12 to a size four. And from the physician's standpoint, what I am interested in, she reduced her blood pressure by 10 percent, blood cholesterol by 23 percent, and her blood sugar by 31 percent. Her family was so impressed by the success that she now is a source of encouragement and advice to her brother, her sister, her sister-in-law, who have all gone on to adopt healthy life changes.

Multiply these examples by the tens of thousands across the Nation, and you can see how by working with large groups of people outside of the more expensive medical settings of clinics and doctors' offices, we are a good investment that saves healthcare dollars for Medicaid and Medicare and the entire health care system. Many of our program's approaches were developed by this committee's investments in NIH and the CDC, and without the work of my colleagues some of the wonderful findings of Federal research would sit on the shelf and never realize its full potential to improve health.

The Prevention and Public Health Fund, also known as the Prevention Fund authorized on the Affordable Care Act, supplies more than 12 percent of the CDC budget, providing essential funds to help States keep communities healthy and safe. The Prevention Fund supports programs like the 317 Immunization Program, chronic disease prevention programs, and the entire Preventive Health Block Grant, which is the only source of flexible funding for the States and U.S. territories to American Indian tribes and the District of Columbia to tailor preventive and health promotion programs to their population's specific needs.

Today only a small fraction of the United States governmental health investment supports prevention and health promotion. Substantial investment in the CDC and the state health departments are necessary for a real impact to be made. These programs must include increased resources for every State to address State-specific public health challenges, diabetes prevention and control, heart disease prevention, and improving physical activity and nutrition.

Public health programs work to improve care, prevent disease, and prevent complications of disease. An investment in chronic disease prevention and control programs saves lives, improves the quality of life, and saves healthcare dollars.

Thank you for allowing me this opportunity to appear before you.

[The information follows:]

**Mehul Dalal, MD, MSc, MHS**
**National Association of Chronic Disease Directors**
**Testimony—House Subcommittee on Labor-HHS-Education and Related Agencies**

**Introduction**

Thank you, Chairman Cole, Ranking Member DeLauro, and Members of the committee, for allowing me to testify on behalf of the National Association of Chronic Disease Directors (NACDD). Specifically, I want to express our strong support for increased funding for the key chronic disease programs which are administered under the National Center for Chronic Disease Prevention and Health Promotion at the CDC. Simply put, without the grant support and work of this important Center at CDC as well as the Office for State, Tribal, Local and Territorial Support, most states would have an extremely limited effort to address these critical public health issues – or none at all.

NACDD is a non-profit public health organization that serves the chronic disease program directors of each state and U.S. jurisdiction, and connects the more than 6,500 chronic disease practitioners across the country. As such, we represent a core sector of governmental public health. Together with a network of affiliated state organizations, we are the executive state and territorial health agency leaders that share a common mission to promote and protect the public's health and prevent illness and injury. Guided by our governors and state legislatures for whom we work, our federal partners at CDC help us knit together a coordinated, national approach to addressing our most urgent problems and improving the health of our nation.

**Problem Statement**

As the United States seeks ways to regain our economic footing and rebuild prosperity, we must remember that poor health of the population can exert tremendous force on employment rates, interest costs, and other tangible factors that ultimately affect our ability to maintain a strong global economic position. The primary driver of cost in healthcare is chronic disease. According

to the Centers for Disease Control and Prevention (CDC), chronic disease accounts for approximately 75 percent of the nation's aggregate health care spending - or an estimated $5,300 per person in the U.S. annually, and much of this is preventable. In terms of public insurance, treatment of chronic disease constitutes an even larger portion of spending - 96 cents per dollar for Medicare and 83 cents per dollar for Medicaid. Public health chronic disease prevention and control, which is managed by state health departments, focuses on risk factors and diseases, links the clinical and community sectors, and is the key to addressing this epidemic.

As the American population ages and more people are categorized as "high risk" for multiple chronic diseases, it is important to recognize that an individual's choices, as well as where they live, attend school, and work, have an impact. Risky behaviors such as poor diet, lack of physical activity, use of tobacco, and ignoring known risks, like family history, result in a dramatic increase in chronic conditions. When individuals make poor choices about their health, the result is poor collective health quality in a country that spends much more on healthcare than anywhere else in the world.

**Programs**

State Public Health Chronic Disease Prevention and Control Programs are key in improving our nation's health. Today, only a small fraction of the United States' governmental healthcare investment supports prevention and health promotion. States are implementing diverse, cost effective strategies that work for prevention and control of diabetes, reduction of heart disease and stroke, and promotion of fitness and nutrition in order to reduce the disability associated with chronic conditions. How exactly do we do that? We work in your communities to bring evidence-based approaches to people in the workplace, in schools, in community centers and other places. We provide accurate information about the leading risks to their health, and basic

actions that they can take to prevent and manage disease. We take advantage of technology to find at-risk groups, and we use the internet and social media to reduce the cost of our programs and boost their effectiveness. At times we work upstream to keep people healthy, and before someone at-risk becomes sick and has to see a doctor. We also work with patients to help them self-manage their conditions once diagnosed for illnesses such as diabetes, heart disease, arthritis and many common diseases. By working with large groups outside of the more expensive medical settings of clinics and doctors' offices, we are a good investment that saves healthcare dollars for Medicaid, Medicare, and the entire healthcare system. Many of our program approaches were developed by this committee's long-standing investments in research at NIH and CDC. We are actually part of the implementation of many NIH discoveries, and we bring them to your cities, suburban areas, and especially to rural areas where they are often most needed. In fact, in rural areas, state health agencies are often the primary source of this information and services to your constituents. Without the work of my colleagues, some of the important findings of federal research would sit on the shelf and never realize its full potential to improve health.

The Prevention and Public Health Fund (the Prevention Fund) authorized under the Affordable Care Act supplies more than 12 percent of the Centers for Disease Control and Prevention (CDC) budget, providing essential funds to help states keep communities healthy and safe. The Prevention Fund supports programs like the 317 immunization program, chronic disease prevention, and the entire Preventive Health Block Grant. The Preventive Health Block Grant is the only flexible funding for states, U.S. territories, 2 American Indian tribes, and the District of Columbia to tailor preventive and health promotion programs to their population's specific public health needs. Examples of current funding areas include chronic disease prevention and

control, emergency medical services, environmental health, infectious disease prevention and control, community-based education, injury prevention and control, and disease and risk factor surveillance. Funding prevention not only saves lives but it saves money. A comprehensive study of evidence-based prevention programs found that every dollar invested in preventative health yields $5.60 in savings. Investing in prevention through the Prevention Fund counteracts the much larger bill--$3.2 trillion and growing—that we pay every year as a country to treat illness and disease.

Healthcare costs for a person with diabetes are about 2.3 times higher than expenditures for individuals without diabetes. However, diabetes is preventable and controllable. Blood sugar control reduces the risk for eye disease, kidney disease, and nerve disease by 40% in people with type 1 or type 2 diabetes, and blood pressure control reduces the risk of heart disease and stroke among people with diabetes by at least 33%. Public Health Diabetes Prevention and Control Programs contribute substantially to the prevention and effective management of diabetes, which can significantly reduce the financial burden to individuals and communities.

Heart disease and stroke are the first and fifth leading causes of death in the United States. The total direct and indirect cost of cardiovascular disease and stroke in the United States was estimated to be $320 billion in 2011, while the total annual costs associated with high blood pressure were estimated to be over $46 billion. With aggressive professional education, early risk identification, risk reduction and treatment, these events are often preventable.

Despite the proven health benefits of physical activity, only half of American adults and a quarter of adolescents get enough aerobic physical activity to maintain good health and avoid

disease. Additionally, 76% of Americans one year and older do not consume the recommended amounts of fruit and 87% do not consume the recommended amount of vegetables. The cost of obesity in the U.S. is oppressive, reaching approximately $270 billion in 2009. Physical activity saves lives, saves money and protects health. If Americans met the recommended physical activity levels, one in nine premature deaths could be prevented. Public health programs that promote physical activity and healthy eating provide the venues and opportunities to help make the healthy choice the natural choice, and provide reinforcement for healthy messages provided in the course of clinical care.

Today only a small fraction of the United States' governmental healthcare investment supports prevention and health promotion. A substantial investment in the CDC, State Health Departments, and other HHS agencies is necessary for a real impact to be made. These programs must include increased resources for every state to address:

- State-specific public health challenges
- Diabetes Prevention and Control
- Heart Disease and Stroke Prevention
- Improving Physical Activity and Nutrition

Public health programs work to improve care, prevent disease, and prevent complications of disease. An investment in chronic disease prevention and control programs saves lives, improves quality of life and saves healthcare dollars.

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

## Witness Disclosure Form

Clause 2(g) of rule XI of the Rules of the House of Representatives requires non-governmental witnesses to disclose to the Committee the following information. A non-governmental witness is any witness appearing on behalf of himself/herself or on behalf of an organization other than a federal agency, or a state, local or tribal government.

Your Name, Business Address, and Telephone Number:
National Association of Chronic Disease Directors (NACDD)
2200 Century Parkway, Suite 250
Atlanta, GA 30345
(770)458-7400

1. Are you appearing on behalf of yourself or a non-governmental organization? Please list organization(s) you are representing.
   National Association of Chronic Disease Directors

2. Have you or any organization you are representing received any Federal grants or contracts (including any subgrants or subcontracts) since October 1, 2012 related to the agencies or programs funded by the Subcommittee?

   Yes No

3. Have you or any organization you are representing received any contracts or payments originating with a foreign government since October 1, 2012 related to the agencies or programs funded by the Subcommittee?

   Yes No

4. If your response to question #2 and/or #3 is "Yes", please list the amount and source (by agency and program) of each Federal grant (or subgrant thereof) or contract (or subcontract thereof), and/or the amount and country of origin of any payment or contract originating with a foreign government. Please also indicate whether the recipient was you or the organization(s) you are representing.

4.

| Agency | Program | Awarded Amount | Recipient Status |
|---|---|---|---|
| Centers for Disease Control - NCCDPHP | NACDD National Diabetes Prevention Program Expansion and Sustainability Project | 3,409,797.00 | Organization I am representing |
| Centers for Disease Control - OSTLTS | OSTLTS Partnerships - CBA of the Public Health System | 32,786,851.00 | Organization I am representing |
| Centers for Disease Control - NCCDPHP | National Organization for Chronic Disease Prevention and Health Promotion | 17,458,089.00 | Organization I am representing |
| Centers for Disease Control - NCCDPHP | National Organization for Chronic Disease Prevention and Health Promotion | 5,000,000.00 | Organization I am representing |
| Centers for Disease Control and Prevention | NACDD Partnerships to Create and Implement a national arthritis policy platform | 2,308,710.00 | Organization I am representing |
| Centers for Disease Control and Prevention / Agency for Toxic Substances and Disease Registry (ATSDR) | Advancing Arthritis Public Health Approaches through National Org | 400,000.00 | Organization I am representing |

Signature: [redacted] Date: 3/3/2017

Mr. COLE. I want to thank the gentleman very much for his testimony and particularly for the focus on CDC. We get a lot, and appropriately, a lot of focus on NIH and the splendid work they do. But I always like to say, you know, the CDC is every bit as important in defending the lives of Americans as the Pentagon is, and in some ways more. You are more likely to die in a pandemic than you are in a terrorist attack.

And these long-term contributions of changing lifestyle are really priceless investments. As you pointed out in your testimony, the money saved on the back end in Medicare and Medicaid is just unbelievable. So, I thank the gentleman for his focus on a very important issue for this committee.

Dr. DALAL. Yeah, thank you for your support.

Ms. DELAURO. Thank you, Mr. Chairman, and welcome, Dr. Dalal. Thank you very, very much for the work that you do. I think that the chairman talked about the work of the CDC in this area. And what this is about is the strengthening of our States and their ability to cope with the issue of chronic disease. And it is not situated here, but it is in the States, and providing those funds to the States is critical.

The other point that you make, I think we have to be very, very careful if we are looking at eliminating the Prevention Fund albeit in 2017. And in addition to that, actually the Prevention Fund was a backup and a way in which we could look to provide critical funding in a number of areas which the CDC has laid out over the years. But if we are going to be in the business of cutting back on appropriations, Mr. Chairman, and if we are going to eliminate the Prevention Fund, we are really going to put people at grave risk and not take advantage of the expertise and the dedication of folks who are trying to deal with chronic disease when we know that 70 percent of the population is dealing with a chronic illness.

So, thank you very, very much. Where do you live in New Haven?

Dr. DALAL. In the East Rock neighborhood.

Ms. DELAURO. All right. Okay. Thank you.

Dr. DALAL. I think we are neighbors.

Ms. DELAURO. We are neighbors. Thank you.

Mr. COLE. Next witness, please.

This is Ms. Lynnetta, is it Kopp?

Ms. KOPP. Kopp.

Mr. COLE. Kopp. Thank you for correcting me. President of the National Senior Corps Association. The gentlelady is recognized for 5 minutes to deliver whatever testimony she cares to the subcommittee.

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WEDNESDAY, MARCH 8, 2017.

## THE NATIONAL SENIOR CORPS ASSOCIATION

### WITNESS

### LYNNETTA KOPP, PRESIDENT, THE NATIONAL SENIOR CORPS ASSOCIATION

Ms. KOPP. Thank you. Chairman Cole, Ranking Member DeLauro, members of the subcommittee, thank you for the oppor-

tunity to appear before you today to discuss funding for the three Senior Corps programs administered by the Corporation for National and Community Service. Those programs are the Foster Grandparent Program, the RSVP Program, and the Senior Companion program.

The funding levels we are requesting today are as follows: for the Foster Grandparent Program, $107,702,000; RSVP, $63,000,000; and Senior Companion Program, $45,512,000.

My name is Lynnetta Kopp, and I testified today as president of the National Senior Corps Association, representing the interest of Senior Corps directors, volunteers, and the people and communities we serve. I also bring regards from my colleagues in the leadership of the National Association of Foster Grandparent Directors and the National Association of RSVP directors, who also embrace this request.

Senior Corps is a federally authorized and funded network of National Service programs that provide individuals age 55 and better an opportunity to share their life experience through volunteer service, meeting unmet community needs in our community. I have had the pleasure of being an RSVP director and a foster grandparent director in Lacrosse, Wisconsin for the past 14 years. I come before you today advocating for funding for the continuance of these three Senior Corps programs.

The requested funding would restore the level to 20 percent of the cut, which RSVP lost over 100,000 volunteer positions. This funding would also provide sufficient funding to sustain the Foster Grandparent Program and Senior Companion Programs at their current levels.

The new Administration will be presenting the Fiscal Year 2018 budget shortly, which may eliminate funding for the Corporation of National Community Service. And to coin a phrase, this would be penny wise and pound foolish. Not only have these programs enjoyed bipartisan support from members of Congress, including those of you who are serving on this committee, these programs are incredibly cost-effective. For every $1 spent on volunteer service in our Nation, our communities reap a nearly tenfold return in the Foster Grandparent Program and the Senior Companion Program, and even more so from a return on their investment in the RSVP Program, given the low cost per volunteer for this program.

The two stipend programs, Foster Grandparent and Senior Companion Program, provide low-income seniors with an opportunity to serve. And in the case of the Foster Grandparent program, it allows them to serve at-risk students and disadvantaged youth and homebound and frail seniors through the Senior Companion Program. There is not a day that goes by that our Senior Corps directors do not receive testimonials on the value of the service that this program provides.

RSVP matches individuals' personal interests with those skills and volunteers with opportunities to fill these unmet community needs. As the largest senior volunteer organization in the Nation, RSVP has been improving the lives of their neighbors and friends since 1971, meeting the unmet needs in our communities, whether it is helping prepare tax returns, provide transportation services, offer respite to caregivers, tutor children, repair homes, support

veterans and military families, or assist victims of disaster areas. These are just a few of the things that these programs help to do.

RSVP volunteers served 329,000 veterans through transportation and employment services, referrals and mentored—I am sorry—more than 78,000 children, provided independent living services to 797,000 adults, and primarily those were frail seniors. Also, provided respite services to 20,300 families, engaged 20,100 veterans who serve as RSVP volunteers, and leveraged an additional 18,500 volunteers to support RSVP activities.

All told, roughly $200,000,000, which funds the Senior Corps, provides a $2,300,000,000 return on investment. And according to data compiled by the independent sector, more than 25,000 foster grandparents supported by this request would contribute 24 million hours of service. This is valued at over $565,000,000. This would enhance 62 million hours of service, which is valued at over $1,000,000,460 based on the independent sector data, which averages a volunteer hour at $23.56. And the more than 12,000 senior companions underwritten by this budget would provide 12.2 million hours or service, valued at $287,432,000, helping roughly 61,000,000 older frail seniors in our community.

The Senior Corps has over 45 years of successful performance measurement, and we do have a return on our investment. While great value is derived by the beneficiaries of senior service, the benefit to those who serve is tangible and measurable. By keeping seniors active and involved, Senior Corps keeps older Americans vibrant and in their communities, avoiding the cost of institutionalization, keeping bright the social connections seniors need to remain vital and truly what we define as community in a country too frequently measured by our differences these days than by our commonalities.

Chairman Cole, Ranking Member DeLauro, and members of the committee, the commitment that you have previously given to our programs is indeed appreciated. On behalf of the thousands of volunteers, organizations, and agencies who rely on Senior Corps, we ask you to continue your support and join us in championing our budget request for these vital programs.

But on a more personal note, thank you for your public service, and remember you do not have to be retired to be an RSVP volunteer. Thank you. [Laughter.]

[The information follows:]

**Testimony of Lynnetta Kopp (President, National Senior Corps Association)**

House Subcommittee on Labor, HHS, Education and Related Agencies Appropriations

Chairman Cole, Ranking Member DeLauro, members of the Subcommittee:

Thank you for the opportunity to appear before you to discuss funding for the three Senior Corps programs, which are administered by the Corporation for National and Community Service. Those programs being: The Foster Grandparent Program, Senior Companion Program, and RSVP.

The funding levels we request are as follows:

Foster Grandparent Program: $107,702,000

RSVP: $63,000,000

Senior Companion Program: $ 45,512.000.00

My name is Lynnetta Kopp and I testify today as President of the National Senior Corps Association, representing the interests of Senior Corps directors, volunteers, and the people and communities we serve. (I also bring regards from my colleagues in the leadership of the National Association of Foster Grandparent Program Directors and the National Association of RSVP Directors, whose organizations also embrace this request.)

Senior Corps is a federally authorized and funded network of national service programs that provide older Americans an opportunity to share their life experiences through volunteer service. The Foster Grandparent Program, RSVP, and the Senior Companion Program, are the mechanism through which individuals age 55 and better provide essential services to cost-effectively address un-met critical community needs.

I have had the pleasure of being involved with Senior Corps since 2004 as Executive Director of two Senior Corps program in La Crosse, Wisconsin-RSVP and the Foster Grandparent Program. I come before you today advocating for funding for the continuance of the three Senior Corps programs.

The requested funding will restore the level of support afforded these critical senior volunteer programs to historical levels – still short of the goal of providing every senior who wishes to serve, that opportunity. These levels would reverse the 20% cut to RSVP which led to the loss of 100,000 volunteer positions for seniors seeking to make a positive impact in their communities, through service, and would provide sufficient funding to sustain the Foster Grandparent Program and Senior Companion Program at their current levels.

***The National Senior Corps is the story of many, one of which I share with you now.***

> ***La Crosse, WI…January, 20 below zero., No telephone, no heat, not even a stove, and now a broken water faucet. This senior woman, lived alone…very low income and not sure where to turn for help. Having exhausted all her resources, someone suggested she call RSVP as they had a volunteer Handyman program that may be able to assist. RSVP volunteers answered the call. It was essential for her faucet to be replaced so that she could have running water in her home. The handymen were able to not only repair and replace the faucet, they shared with her more about the services and programs RSVP has. This individual was so moved by the assistance she received and the compassion shown her that she wanted to give back in some way which led her to become an RSVP volunteer tutoring and mentoring students in need of extra help with reading and math skills. This is just a small sample of the myriad ways in which Senior Corps makes a difference in so many lives.***

The new administration will be presenting a fiscal year 2018 budget shortly which **may** eliminate funding for the Corporation for National and Community Service and its programs, including Senior Corps, AmeriCorps and many other worthy opportunities for Americans to serve.

If this is true, the direction is the wrong one. To "coin" a phrase, this move would be "penny wise and pound foolish".

Not only have these programs enjoyed broad bipartisan support from members of Congress, including those of you who serve on this Subcommittee, the programs of the Senior Corps are incredibly cost effective. In fact, for every $1.00 spent on volunteer service by our nation's seniors, communities reap a nearly ten-fold return in the Foster Grandparent and Senior Companion Programs and even more than that amount in the return on investment in RSVP, given the low cost-per-volunteer of the program.

The two stipend programs of the Senior Corps (Foster Grandparent Program and Senior Companion Program) provide seniors who are low income and many who are at or below 200 percent of the poverty line an opportunity to serve their neighbors and in the case of Foster Grandparents serve at risk and disadvantaged youth, and homebound and frail seniors through the Senior Companion Program. In return for their service, the income-qualified volunteers receive a modest stipend.

There isn't a day that goes by without our Senior Corps directors receiving testimonials of the value of the service provided:

*"If not for my Senior Companion Program volunteer, I don't know what I would of done. She's been a life saver. I couldn't have gotten food or meds and probably would have died of loneliness. I have absolutely no help or other family. I'm sure I would have no life without this program. I've very grateful for it and don't even like to think what it would be like without it."*

RSVP provides opportunities for individuals age 55 and better to make a difference in their communities through volunteer service, offering maximum flexibility and choice to its volunteers by matching the personal interests and skills of volunteers with opportunities to fill un-met needs in our communities.

It has been proven time and time again that RSVP volunteers assist in improving the lives of their neighbors and friends every day by meeting the un-met needs of their communities. Whether it is helping prepare their tax returns, provide needed transportation services, offer respite to caregivers, deliver health and nutrition services, support veterans and military families, volunteer in parks, participate in disaster prevention and relief activities, just to name a few. We work collaboratively through such networks as Area Agencies on Aging, city and county governments, social service agencies, and faith-based organizations.

RSVP volunteers served 329,000 veterans through transportation and employment service referrals; mentored more than 78,000 children; provided independent living services to 797,000 adults, primarily frail seniors; provided respite services to nearly 20,300 family or informal caregivers; engaged 20,100 veterans who served as RSVP volunteers and leveraged an additional 18,500 volunteers to support RSVP activities such as delivering meals to those in need and tutoring at-risk children. RSVP also serves as an important resource in disaster relief efforts.

All told, the roughly $200,000,000 which funds the Senior Corps provides a $2.3 billion dollar return on investment, worth well in excess of this investment. According to data compiled by Independent Sector, the more than 25,000 Foster Grandparents supported by this request would contribute 24,000,000 hours of service valued at $565,440,000. By restoring funding as requested for RSVP, thousands of RSVP volunteers would enhance the 62,000,000 hours of service, valued at $1,460,720,000 based on the Independent Sector's data (which values an hour of volunteer service at $23.56) and the more than 12,000 Senior Companions underwritten by this budget proposal would provide 12.2 million hours of service valued at $287,432,000, helping roughly 61,000 older frail seniors in our communities.

The Senior Corps has over 45 years of successful performance measurement and has provided cost-effective services to Americans who need attention or a helping hand saving this nation millions of dollars. For decades, the Senior Corps has been the cornerstone of National Service and civic engagement. During difficult budget times, senior volunteers are a stabilizing force in communities across our nation by providing the most cost-effective service for those un-met community needs.

While great value is derived by the beneficiaries of senior service, the benefit to those who serve is also tangible and quite measurable. By keeping seniors active and involved, the Senior Corps keeps older Americans vibrant and in their communities, avoiding the cost of institutionalization, keeping bright the social connections that our nation's seniors must maintain to remain vital, and truly defining "community" in a country too frequently measured by our differences these days than by our commonality.

Those who serve are proud to serve and those they serve are grateful.

Chairman Cole, Ranking Member DeLauro, and members of the Subcommittee, the commitment you have continuously provided for our programs is indeed appreciated. I am here today on behalf of the thousands of volunteers, organizations and agencies who rely on Senior Corps, asking you to continue your support and join us in championing our budget request for these vital programs.

On a more personal note, thank you for your public service and remember, one does not have to be retired to be a volunteer in Senior Corps.

Thank you for this opportunity. I am prepared to answer any questions you might have.

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

Witness Disclosure Form

Clause 2(g) of rule XI of the Rules of the House of Representatives requires non-governmental witnesses to disclose to the Committee the following information. A non-governmental witness is any witness appearing on behalf of himself/herself or on behalf of an organization other than a federal agency, or a state, local or tribal government.

Your Name, Business Address, and Telephone Number:
Lynnetta P. Kopp
2920 East Avenue South, Suite 104
La Crosse, WI 54601
608.785.0500

1. Are you appearing on behalf of yourself or a non-governmental organization? Please list organization(s) you are representing.
   National Senior Corps Association (NSCA)
   And as Director of my Senior Corps Program-Coulee Region Retired & Senior Volunteer Program, Inc.

2. Have you or any organization you are representing received any Federal grants or contracts (including any subgrants or subcontracts) since October 1, 2012 related to the agencies or programs funded by the Subcommittee?
   Yes

3. Have you or any organization you are representing received any contracts or payments originating with a foreign government since October I, 2012 related to the agencies or programs funded by the Subcommittee?
   Yes

4. If your response to question #2 and/or #3 is "Yes", please list the amount and source (by agency and program) of each Federal grant (or subgrant thereof) or contract (or subcontract thereof), and/or the amount and country of origin of any payment or contract originating with a foreign government. Please also indicate whether the recipient was you or the organization(s) you are representing.
   Retired & Senior Volunteer Program - $365,823.00 –Corporation for National & Community Service- Coulee Region RSVP, Inc.
   Foster Grandparent Program – (sub-grant)$258,218.00 –WI Dept. Health Services

[redacted] 3.3.17

Signature: Date:

Mr. COLE. Very good. I want to thank the gentlelady for her testimony, and I am sure most members of this committee, probably every member, can testify to the value of these programs.

Ms. DELAURO. Absolutely. Thank you.

Ms. KOPP. Next witness. Welcome. Dr. Jeffrey Shell?

Dr. CHELL. Chell.

Mr. COLE. Chief executive officer of the National Marrow Donor Program and To Be Matched. So, welcome. It is good to have you here. The gentleman is recognized for 5 minutes for her testimony he cares to deliver to the committee.

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WEDNESDAY, MARCH 8, 2017.

## NATIONAL MARROW DONOR PROGRAM/BE THE MATCH

### WITNESS

**JEFFREY W. CHELL, M.D., CEO, NATIONAL MARROW DONOR PROGRAM/BE THE MATCH**

Dr. CHELL. Thank you, Chairman Cole, and other distinguished members of the committee. My name is Jeffrey Chell, and I am proud to serve as the chief executive officer of the National Marrow Donor Program/Be The Match.

We also proudly operate the C.W. Bill Young Cell Transplantation Program through three competitively bid contracts with the Health Resource Service Administration. These contracts include a single point of access and Office of Patient Advocacy, the Bone Marrow Coordinating Center, and the Cord Blood Coordinating Center. Collectively these contracts allow NMBP to operate the National Be The Match Registry and provide lifesaving, unrelated transplants using individual altruistic adult donors and cord blood units. We also work closely with the cord blood banks that receive critically important funding directly through the National Cord Blood Inventory.

I would like to thank Chairman Cole, Ranking Member DeLauro, and all the members of the Committee for inviting me to speak. On behalf of Be The Match and our 565 network partners, we want to thank you for maintaining the congressional commitment to patients fighting blood cancers and other disorders, for the only possible cure is an unrelated transplant.

For each $1,000,000 that Congress adds to the program, 10,000 donors are added to the program. For each million it adds to the NCBI, an additional 667 cord blood units will be collected and stored. As you can see, these dollars go directly to saving lives.

Because our funding has been flat for over a decade, for Fiscal Year 2018, we ask that Congress modestly increase our funding by $5,000,000 for the program. That allows us to replenish the registry as donors age off the registry, and also increase our efforts to add diversity to the registry as patients are most likely to find a donor with someone that they share a common ancestry.

We also ask Congress to increase the NCBI funding by $5,000,000 over previous years, consistent with last year's numbers from this subcommittee, to fund the additional collection of cord blood units. These units have been exceedingly helpful in providing lifesaving transplants for patients who are difficult to match who

are also members of our ethnic minority communities. Congress has authorized both the national registry and NCBI, most recently unanimously for another 5 years, in December of 2015.

As I testify before you today, I am reminded of the foresight that this committee had in the mid-1980s that created the program on which Americans rely today. Through the leadership of late Congressman Bill Young, the Congress decided to establish the national registry where men, women, and children with leukemia and other fatal disorders could find that unrelated donor that could save their lives. Since Congress made this important decision to establish the registry 30 years ago, Be The Match has formed a highly successful public/private partnership and has made tremendous progress. We are honored to continue to serve as the steward of this critical national resource.

Today we remain the single point of access for both cord blood units and adult volunteer donors, and again provide the only hope of cure for 70 different medical conditions, including blood cancers and sickle cell disease. The Be The Match Registry has grown to nearly 16 million donors and more than 238,000 cord blood units, including 93,000 collected through the National Cord Blood Inventory. We have facilitated more than 80,000 transplants since our founding, and currently are track facilitating 60 to 100 transplants per year.

Because we collect data on all of these transplants, we have been able to improve patient outcomes and reduce the complication rates of transplants. During the past 20 years, the 1-year survival rate from these transplants has gone from 40 percent now to over 70 percent.

But there really is so much more that we can do. The need for transplant is increasing, particularly for older Americans, and we are currently only meeting half the need in the United States. New indications, such as curing sickle cell disease, also drive the need for more volunteer donors and cord blood units. With the Federal dollars that you allocate to the program, we continue our efforts to expand the diversity of the registry and increase the number of minority cord blood units listed on the registry.

Federal funding remains critical to continue us to provide access to transplant, and the funds for the program and NCBI continue to allow us to increase the likelihood that each and every American can receive that lifesaving transplant.

We thank you for your ongoing support of the program and the NCBI, and while we understand the very difficult budget situation, we know that any additional funding for these programs will go directly to helping us cure more patients in need.

Thank you very much.

[The information follows:]

**Written Testimony of Dr. Jeffrey W. Chell before**
**the House Appropriations Subcommittee on Labor,**
**Health and Human Services, Education, and Related Agencies**
**March 8, 2017**

Good morning Mr. Chairman, and other distinguished members of the Subcommittee. My name is Dr. Jeffrey Chell and I am the Chief Executive Officer of the National Marrow Donor Program (NMDP)/Be The Match. We operate the C.W. Bill Young Cell Transplantation Program (Program) through three competitively bid contracts with the Health Resources and Services Administration (HRSA). These contracts include the Single Point of Access and Office of Patient Advocacy, the Bone Marrow Coordinating Center, and the Cord Blood Coordinating Center. Collectively, these contracts allow NMDP/Be The Match to operate the national Be The Match Registry and provide life-saving unrelated blood and marrow transplants using individual adult donors and cord blood units. Through our affiliation with the Medical College of Wisconsin, known as the Center for International Blood and Marrow Transplant Research (CIBMTR), of which I am the executive director, NMDP/Be The Match also holds a subcontract for the Stem Cell Therapeutic Outcomes Database. We also work closely with the cord blood banks that receive critically important funding directly through the National Cord Blood Inventory (NCBI) grant program. I would like to thank Chairman Cole, Ranking Member DeLauro, and all of the Members of the Subcommittee for inviting me to speak with you today. On behalf of 565 Network partner organizations and everyone at NMDP/Be The Match, we also want to thank you for maintaining the Congressional commitment to patients fighting blood cancers and other disorders whose only hope for a cure is a bone marrow or cord blood transplant. For each $1 million the Congress adds to the Program, 10,000 donors will be added to the registry. For each $1 million it adds to the NCBI, an additional 667 cord blood units will be collected and stored. As you can see, these dollars go directly to saving lives. Because our funding has been flat for more than a decade, for FY2018, we ask that the Congress modestly increase the funding for the Program by $5 million above last year's amount to allow us to

replenish the registry as volunteers age off and continue our efforts to increase the ethnic diversity of the registry as patients are most likely to find a match within their ethnic group. We also ask that the Congress increase the NCBI funding by $5 million over previous years, consistent with last year's numbers from this Subcommittee, to fund the collection of additional cord blood units. These units have been exceedingly helpful in providing life-saving stem cells for patients who are difficult to match. The Congress has authorized both national registry and NCBI, most recently unanimously for another five years in December 2015.

As I testify before you today, I am reminded that it was the foresight of the House Appropriations Committee in the mid-1980s that created the Program on which Americans rely today. Through the leadership of the late Congressman Bill Young, the Congress decided to establish a national registry where men, women, and children with leukemia and other fatal blood disorders could find an unrelated donor to save their lives. Since the Congress made the important decision to establish the registry 30 years ago, NMDP/Be The Match has formed a highly successful public-private partnership and has made great progress. We are honored to serve as the steward of this critical national resource. Today, the Be The Match Registry remains the single point of access for both cord blood units and adult volunteer donors. This assures that physicians will have access to any potential donor or cord blood unit regardless of where they are located across the globe in order to perform adult stem cell transplants that can cure more than 70 different diseases or conditions, including blood cancers and sickle cell disease. The Be The Match Registry has grown to include nearly 16 million donors and more than 238,000 cord blood units, including 93,000 NCBI units. Through international relationships, NMDP/Be The Match has access to more than 29 million potential donors and 721,000 cord blood units worldwide.

But, the C.W. Bill Young Program is more than the national registry. Through the Office of Patient Advocacy, we assist patients and their families in navigating the complexities of health insurance and help them overcome logistical, psychosocial and informational barriers throughout the transplant continuum. We also work closely with donor and collection centers through the Bone Marrow Coordinating Center to recruit and retain volunteer potential donors, produce a comprehensive plan for donor retention, and identify ways to increase operational efficiencies. This work includes engaging with insurers, employers, and States in striving to ensure that volunteer donors have no out-of-pocket costs when they are chosen to donate. We similarly provide financial and educational support to public cord blood banks as the manager of the Cord Blood Coordinating Center and provide guidance to HRSA in the administration of the NCBI program to determine optimal composition of cord blood inventory. Through the Stem Cell Therapeutic Outcomes Database, we facilitate cutting edge research to improve patient outcomes and find innovative ways bone marrow and cord blood can be used to save lives. We provide patient services, caregiver support, and financial support through the Be The Match Foundation and help patients maintain healthy lives after transplant.

Our focus is on patients for whom cellular therapy is the best hope for curing their diseases and is often the only therapy available with an intent to cure. Today, we are able to treat patients with cancers and pre-cancers, such as leukemia, Myelodysplasia, and lymphomas; bone marrow failure disorders, such as aplastic anemia and immunodeficiency syndromes; and genetic diseases, such as sickle cell disease. To treat these diseases, we infuse bone marrow, peripheral blood stem cells, or cord blood cells into a patient after having eliminated his/her current

irreversibly diseased or damaged bone marrow. These new cells restore the patient's ability to make healthy blood cells and provide a new immune system to attack cancer cells. Finding the best match possible is important because if donor stem cells are not the same HLA type as the recipient they will recognize the recipient as being different and attack, leading to rejection.

Because we collect data on all transplants, we have been able to improve patient outcomes and reduce the complications of transplantation. During the last 20 years, the one-year survival rate for these patients has increased from just over 40 percent to 70 percent. Access to multiple cell sources allows us to find the best match possible for patients. Initially focused only on bone marrow, the Program today also allows physicians to select peripheral blood stem cells and cord blood, as well as bone marrow, as the source of the adult stem cells used in transplant.

However, more can be done. The need for transplants is increasing, especially among Americans 65 years and older. With the growth in knowledge from each transplants, we now are able to successfully transplant patients well into their 70's. The increase in the number of transplants for older Americans, and minority patients significantly increases the need for more volunteer donors and cord blood units. While NMDP/Be The Match facilitated transplants have grown by 200 percent overall and 250 percent for minorities since 2006, there is more work we can do in this area too. Only about half of Americans who could benefit from a transplant get one. With the federal dollars you allocate, we continue our efforts to expand the diversity of the adult volunteer donor registry and increase the number of minority cord blood units on that registry. During the last 5 years cord blood has been the product source for about 21 percent of

all transplants and 37 percent of minority patients who received a transplant relied upon cord blood.

Even though NMDP/Be The Match has improved the ability of those needing a transplant to find a match, there are other barriers that continue to make access difficult. These non-match barriers to access and care have a profound affect on our ability to make transplant therapies accessible to all. Language, literacy, finances, insurance, geography, lack of knowledge, and predisposition by general hematologists and oncologists towards non-transplant therapies all have an impact. NMDP/Be The Match continues to work with patients, physicians, community leaders, and others to address these problems as well.

Federal funding remains critical to continuing to provide access to transplantation. We need to continue to recruit new potential donors both to improve access for minority patients and to renew the current list of donors with younger donors. Grafts from younger donors have shown improved clinical outcomes. The funds for the Program and the NCBI allow us to continue to improve the chances of every American needing a transplant to find a match and provides the critical infrastructure that allows NCBI cord blood units to be used to save lives. We thank you for your ongoing support of the Program and the NCBI. While we understand the difficult budget situation, we also know that any additional funding for these programs will help provide the cure for a patient who has no other options. Thank you again for allowing me to testify before you today.

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

## Witness Disclosure Form

Clause 2(g) of rule XI of the Rules of the House of Representatives requires non-governmental witnesses to disclose to the Committee the following information. A non-governmental witness is any witness appearing on behalf of himself/herself or on behalf of an organization other than a federal agency, or a state, local or tribal government.

Your Name, Business Address, and Telephone Number:
Dr. Jeffrey W. Chell, Chief Executive Officer
National Marrow Donor Program/Be The Match
500 N 5th Street, Minneapolis, MN 55401-1206
Phone: (612) 627-5850

1. Are you appearing on behalf of yourself or a non-governmental organization? Please list organization(s) you are representing.
   - National Marrow Donor Program/Be The Match
   - Center for International Blood and Marrow Transplant Research

   Both organizations are not-for-profit entities that contract with HRSA

2. Have you or any organization you are representing received any Federal grants or contracts (including any subgrants or subcontracts) since October 1, 2012 related to the agencies or programs funded by the Subcommittee?

   Yes X No

3. Have you or any organization you are representing received any contracts or payments originating with a foreign government since October 1, 2012 related to the agencies or programs funded by the Subcommittee?

   Yes No X

4. If your response to question #2 and/or #3 is "Yes", please list the amount and source (by agency and program) of each Federal grant (or subgrant thereof) or contract (or subcontract thereof), and/or the amount and country of origin of any payment or contract originating with a foreign government. Please also indicate whether the recipient was you or the organization(s) you are representing.

See attached

Signature: [redacted] Date: March 6, 2017

House Appropriations Committee Request

| Source | Purpose | FY12 | FY13 | FY14 | FY15 | FY16 | FY17 through Jan | Total |
|---|---|---|---|---|---|---|---|---|
| HRSA | C.W. Bill Young Cell Transplantation | 19,261,482 | 19,285,049 | 18,102,984 | 17,852,173 | 17,707,623 | 6,099,214 | 98,308,525 |
| DOD | Research | 18,816,561 | 19,916,405 | 18,371,641 | 17,965,098 | 18,178,364 | 549,706 | 93,797,776 |
| NIH | Research | 8,182,011 | 6,421,743 | 7,273,309 | 8,153,706 | 5,861,363 | 2,072,630 | 37,964,762 |
| | | 46,260,054 | 45,623,197 | 43,747,934 | 43,970,977 | 41,747,350 | 8,721,550 | 230,071,062 |
| | | | | | | | | 230,071,062 |
| | Audited By | D&T | D&T | Baker Tilly | Baker Tilly | Baker Tilly | Unaudited | |

**Items to note:**

1) Values represent revenue recognized by NMDP by year
2) May not match the amount awarded by the agency that year due to carryover
3) Amounts do match audited schedule of federal awards as well as the respective OMB form filed for each year noted
4) Additional tabs include documentation used for support

Mr. COLE. Thank you. I want to thank you for your very valuable testimony, and thank you particularly for mentioning our late good friend Mr. Young, who, when he left us, was the longest-serving Republican in Congress and, of course, on this committee for many years. Chaired the full committee. He is often known obviously for the extraordinary work he did on defense issues in the capacity of chairing that. But he touched this committee and a lot of different ways over many decades, and this is a worthy legacy for him. So, thank you very much for mentioning his name.

Dr. CHELL. He often shared with me that one of the things he was most proud of in his service was helping develop this program and the 80,000 lives that he has helped to save.

Mr. COLE. He had a lot to be proud of over many decades.

Dr. CHELL. Thank you so much.

Mr. COLE. Thank you. And our last witness of the morning, the early afternoon, but it is early afternoon. We are pretty much on schedule. Welcome. Good to have you here.

Ms. DELAURO. Good afternoon.

Mr. COLE. Susan Ruzenski. I hope I got that right.

Ms. RUZENSKI. Yes.

Mr. COLE. Executive director of the Helen Keller National Center for the Deaf-Blind Youth and Adults. So, welcome to the committee. The gentlelady is recognized for 5 minutes for whatever testimony she cares to give.

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WEDNESDAY, MARCH 8, 2017.

## HELEN KELLER NATIONAL CENTER FOR DEAF-BLIND YOUTH AND ADULTS

### WITNESS

### SUSAN RUZENSKI, EXECUTIVE DIRECTOR, HELEN KELLER NATIONAL CENTER FOR DEAF-BLIND YOUTH AND ADULTS

Ms. RUZENSKI. Thank you, Chairman Cole, and Ranking Member DeLauro, and members of the Subcommittee for providing me with this opportunity to testify on behalf of the Helen Keller National Center. I am Sue Ruzenski. I have been the executive director since 2014, and I am proud to say I have been working with Helen Keller National Center for the last 38 years.

Our mission is to enable each person who is deaf and blind to live, work, and thrive in their community of choice. And my objective this morning is to provide you with clear and specific justification why the Helen Keller National Center is requesting an increase in funding of $4,700,000 in Fiscal Year 2018.

And why is this funding vital for HKNC's ability to meet our five congressional mandates that was set forth 50 years ago this past October, as we were made an act of Congress. Our current annual appropriation is $10,300,000, and the increase is a request that will bring us to $15,000,000 annually in 2018.

The five mandates that were set forth in the HKNC Act are: to provide specialized and intensive services to any deaf-blind person in the United States; to train and support family members; to train professionals and equip them with the competencies to work effectively with individuals who are deaf-blind; to conduct applied re-

search and, with respect to best practices, disseminate those practices throughout the country; and maintain a national registry of individuals who are deaf-blind.

We strive to accomplish our mission through three avenues. We are the only national vocational rehabilitation program that is working exclusively with youth and adults who are deaf-blind. We have 10 regional offices throughout the United States, and we have an information research and professional development department.

Our vision is to solidify a network of qualified service providers nationwide who can address the training needs of people who are deaf-blind in their local areas throughout the United States. The foundation of this national infrastructure has already been established over the past 50 years, but now it is essential for us to secure adequate resource to ensure that the standards of practice of professionals are implemented at a national level, and the collaborative efforts in a coordinated and sustainable national service delivery.

HKNC is ready to lead this charge given the $50,000,000 annual appropriation. Essentially, HKNC has been level funded for 16 years. In 2016, we received a $1,200,000 increase, and for that we are very grateful. The critical need, however, still exists, and the level of funding to commensurate with the scope and the importance of this work remains.

With level of funding spanning over that 16-year period, we had to really make some tough decisions. We had to eliminate and suspend some of our programs. The comprehensive rehabilitation program now serves fewer people on an annual basis, and we have more than a 1-year waiting list for people coming to the program. For a person who has an experience of a sudden change, a loss in vision and hearing, a 1-year waiting period is not acceptable.

I can share with you a story about a gentleman named Carlos. He was an ex-Marine, and this happened to Carlos. He had tumors which caused a sudden change, total loss of vision and hearing. When he arrived at the program, his only way of communicating was the use of block letters printed on his back, and we would spell out the words to him.

Through training over a 2-year period, he was able to learn Braille, tactile sign language, the use of adaptive equipment. He is now living in his own apartment in California and attending college on a part-time basis. The provision of those timely, quality services made a profound difference to Carlos' quality of life.

HKNC has taken steps. Given that increase of 1,200,000 in 2016, we conducted five statewide needs assessments in collaboration with Mississippi State University and the States of Georgia, Arizona, Missouri, Oregon, and New York. And the results became the basis of how we develop modules for an array of professionals, including VR counselors as well as mental health professionals.

We address many of the training priority areas that were identified in adaptive technology, self-advocacy, haptics orientational ability, just to name a few. We also established a National Community of Practice. We have 38 partner agencies, both State and private, who are working with us who are interested in strengthening the vocational rehabilitation options for people who are deaf-blind.

And together we share learning, conduct research, and disseminate and implement best practices.

In 2011, Westat Corporation did a 2-year evaluation of HKNC, and that was on behalf of the Department of Education the Rehabilitation Services Administration. We were identified as the gold standard by those that are familiar with our work. And what this study did reveal, however, is that most States lack services and the resources, reconfirming HKNC's goal to build this national sustainable infrastructure.

The Federal government's 50-year investment has made a tremendous impact. We have touched the lives in the past 10 years of over 16,000 deaf-blind individuals. For those individuals with a desire to work, 51 percent are competitively employed.

In summary, we have a plan. For this $4,700,000, what would we do? We would maximize the effectiveness of this National Community of Practice. We would replicate our community services program in four States. We deploy 20 deaf-blind specialists, two in each region around the country, boots on the ground, working with people who are deaf-blind with our field staff. We provide and coordinate further research to propel this field, and increase the capacity of our ability to offer comprehensive vocational and rehabilitation services to a greater number of individuals on an annual basis.

Congressional leaders 50 years ago shared our commitment and our vision for services for people who are deaf-blind, and the Helen Keller National Center is at a critical moment in their history. The time has come for national service delivery to be created so that all American citizens who are deaf-blind have an equal opportunity to live self-actualized lives and contribute as members of their community.

[The information follows:]

March 8, 2017

**Testimony of Susan Ruzenski**
**Executive Director**
**Helen Keller National Center, Sands Point, NY**

The Helen Keller National Center (HKNC), authorized by the Helen Keller National Center Act (CFDA No. 84.128), is funded by the Department of Education and the Labor/HHS/Education Appropriations Subcommittees in the House and Senate. **The Center requests an increase of $4.7 million from its current $10.3 million to $15 million in funding for FY 2018.**

Authorized by a unanimous vote of Congress in 1967, HKNC's mission is to enable all deaf-blind citizens (totaling more than 2.4 million Americans) to live, work and thrive in his/her community of choice. HKNC operates the only comprehensive national vocational rehabilitation program exclusively serving both youth and adults who are deaf-blind. The Act mandates that the Center will:

(1) Provide specialized intensive services, or any other services, at the Center or anywhere else in the United States necessary to encourage the maximum personal development of any individual who is deaf-blind;
(2) Train family members of individuals who are deaf-blind at the Center or anywhere else in the United States, in order to assist family members in providing and obtaining appropriate services for the deaf-blind individual.
(3) Train professionals and allied personnel at the Center or anywhere else in the United States to provide services to the deaf-blind.
(4) Conduct applied research, development programs, and demonstrations with respect to communication techniques, teaching methods, aids and devices, and delivery of services;
(5) Maintain a national registry of individuals who are Deaf-Blind.

The year 2017 marks HKNC's fiftieth year as a national resource. HKNC is striving to fulfill its congressional mandate by: operating a comprehensive rehabilitation training program at its headquarters in Sands Point, NY; providing technical assistance, information, referral, advocacy, and training to local communities through its ten (10) regional offices and outreach programs; enhancing the ability of service providers to better meet the needs of people who are deaf-blind at the state and local levels by sponsoring research, disseminating information, and offering training to professionals nationwide.

Essentially, HKNC has been level-funded for nearly 16 years. In the FY 2016 appropriations act HKNC was granted an increase of $1.2 million by the Committee for which we are most grateful. But a critical need remains for HKNC to receive an annual appropriation of $15 million in FY 2018 to ensure that American citizens who are deaf-blind are provided with training opportunities that will promote their success, independence and full participation in their communities and for HKNC to fully meet its congressional mandate.

The lack of funding over many years to cover even moderate inflation of costs has affected services and some aspects of national service delivery. Fulfillment of our mission requires an investment by the federal government not only to restore capacity, but to grow and strengthen it to become the national resource it was intended to be. Over the long period of level funding HKNC had to eliminate staff positions supporting the comprehensive vocational rehabilitation program, resulting in a one year waiting list for prospective participants. Fewer people are being served annually and, regrettably, a model program providing employment and life skills training to deaf-blind Americans with intellectual disabilities had to be largely discontinued.

HKNC has been able to take important steps with the increase of 1.2 million dollars in 2016 to strengthen its national impact with expansion of on-line web courses for professionals working with individuals who are deaf-blind and the establishment of a HKNC Deaf-Blind National Community of Practice (NCOP). The NCOP is a national network of thirty- eight partners consisting of state and private agencies interested in strengthening or developing vocational rehabilitation service options for adults and youth who are deaf-blind through shared learning and collaborative research on best practices. In addition, during 2016 HKNC continued

to develop innovative programs such as the Deaf-Blind Immersion Program (DBIS) specifically addressing the needs of individuals who are deaf-blind and have intellectual disabilities and their community service providers. The time has come to provide HKNC with the financial resources to fully meet its mission and congressional mandates that were created 50 years ago when HKNC was established as an Act of Congress.

**Presently there is a serious lack of qualified practitioners to meet the growing needs of all age groups of deaf-blind individuals including transition age youth, working age adults, and the burgeoning population of senior citizens.**

In June of 2011, the WESTAT Corporation completed a two year evaluation of HKNC on behalf of the U.S. Department of Education's Rehabilitation Services Administration. Among its conclusions were that, "*HKNC [is] meeting its mandate to provide services to any deaf-blind individual, family members, and service providers, and conduct applied research and demonstrations*" and that, "*the preponderance of evidence from multiple data sources indicates that HKNC is providing services to address the vocational and independent living needs of deaf-blind individuals, and many stakeholders familiar with HKNC's work consider HKNC to be the 'gold standard' for provision of services to deaf-blind individuals.*" Additionally, the WESTAT evaluation indicated that state VR agencies generally lack services and resources for individuals who are deaf-blind, further reconfirming the necessity of HKNC's goal to build a national infrastructure. With increased funding HKNC can fortify the network of service providers nationwide and establish a sustainable infrastructure leading to exemplary practices and collaborative efforts in services, learning and research.

With the increased FY 2018 funding HKNC has taken steps toward development of an improved process to address the unmet needs of individuals with combined vision and hearing loss, their family members and vocational rehabilitation professionals. The former HKNC national affiliate network was re-invented as the Helen Keller National Center's Deaf- Blind National Community of Practice (NCOP). With HKNC's leadership, a national network of local and state agencies will be able to initiate and expand existing services to the deaf-blind. Through this collaboration, these local and state agencies will maximize effectiveness and efficiency in

learning and research. The Center will continue to play the pivotal role disseminating resources among members of the NCOP and facilitate dialogue across professional disciplines. HKNC will require additional funding to expand field operations to implement this effort. The goal is to increase resources within the regions and leverage the national network by deploying twenty deaf-blind specialists throughout the regions to offer services, build collaborative teams working with consumers, their family members and service providers to successfully achieve vocational and independent living outcomes. HKNC and the national network will provide a wide array of services to America's deaf-blind citizens directly in their home communities, galvanize research efforts, increase sharing of expert knowledge and maximize resources. Greater federal investment will permit HKNC to partner with researchers, universities, private and state agencies, and consumer organizations to rebuild capacity and to reestablish needed services on a state and local basis throughout the nation.

In collaboration with state vocational rehabilitation programs and the Mississippi State University Research and Training Center on Blindness and Low Vision, HKNC has conducted five state wide needs assessments (Georgia, Arizona, Missouri, Oregon and New York) and a variety of national surveys to identify professional learning needs across the United States. In response, the Center has developed training modules for vocational rehabilitation counselors, mental health professionals, Support Service Providers (SSPs), Adaptive Technology Trainers, Orientation and Mobility Instructors among others. HKNC continues to address the expressed needs of deaf-blind individuals with course development in self advocacy and Haptics, an innovative touch signal system that can provide optimal environmental access to individuals who are deaf-blind. The recent FY 2016 increase of $1.2 million enabled HKNC to maintain staff experts to carry out these essential projects. With additional funding, distance learning professional training resources can become one of the driving forces for systematic change and capacity building across the country.

We can only continue this mission of building a national service delivery system that can touch the lives of deaf-blind individuals throughout the United States if given the resources commensurate with the scope and importance of the work to be done.

With a $4.7 million increase in funding we aim to:

(1) Maximize the effectiveness and outcomes of the Helen Keller National Center's Deaf-Blind National Community of Practice (NCOP) for service providers working with youth and adults who are deaf-blind.

(2) Replicate the HKNC Community Services Program, investing in four states to broaden and strengthen comprehensive and specialized service options by developing a core group of trained rehabilitation professionals in each. HKNC will strengthen its national collaborative approach to service delivery by expanding its workforce with two deaf-blind specialists in each region.

(3) Develop and offer an array of professional learning programs and products specifically designed to increase the number of trained professionals.

(4) Provide further research documenting needs, trends and best practices in the deaf-blind community.

(5) Maintain and enhance our capacity to offer comprehensive vocational rehabilitation services to a greater number of individuals on an annual basis.

Congressional leaders fifty years ago shared our commitment and vision for services to deaf-blind citizens. The Helen Keller National Center is at a critical moment in our history. The time has come for a national service delivery to be created so that all American citizens who are deaf-blind have an equal opportunity to live self-actualized lives as fully contributing and included members of their community.

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

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Your Name, Business Address, and Telephone Number:

Susan Ruzenski, 141 Middle Neck Rd. Sands Point, N.Y. 11050 , 516-944-8900 ext. 272

1. Are you appearing on behalf of yourself or a non-governmental organization? Please list organization(s) you are representing.

   Helen Keller National Center

2. Have you or any organization you are representing received any Federal grants or contracts (including any subgrants or subcontracts) since October 1, 2012 related to the agencies or programs funded by the Subcommittee?

   XYes No

3. Have you or any organization you are representing received any contracts or payments originating with a foreign government since October I, 2012 related to the agencies or programs funded by the Subcommittee?

   Yes NoX

4. If your response to question #2 and/or #3 is "Yes", please list the amount and source (by agency and program) of each Federal grant (or subgrant thereof) or contract (or subcontract thereof), and/or the amount and country of origin of any payment or contract originating with a foreign government. Please also indicate whether the recipient was you or the organization(s) you are representing.

H904A020001 ; $10,370,000.00 ; Helen Keller National Center for Deaf-Blind Youth and Adults; United States: Sub grant H326T130013-ISA via The Research Institute at Western Oregon University, $619,386

Signature: [redacted] Date: 3/6/2017

Mr. COLE. I thank the gentlelady her testimony and her appearance here today, our last witness. And let me just say in conclusion before I recognize my friend from Connecticut for whatever remarks she cares to make, we appreciate each and every one of you, the witnesses in particular, that traveled a long way and came here to offer your valuable testimony. We certainly will take them under advisement.

As my friend has pointed out, a lot of this depends on, frankly, what kind of allocation the subcommittee gets, and that has yet to be decided. We will not know that for several weeks yet. But anyway, this really does help us a great deal, and we would urge those of you that can to help us persuade our colleagues to get the 2017 bill done, and then obviously make sure that we have an adequate allocation to meet some of these really pressing national needs and priorities as we look forward to 2018.

I recognize my friend for one little comment she cares to make.

Ms. DELAURO. Thank you very much Mr. Chairman, and thank you for your commitment to, you know, making sure we get out the 2017 bill, and that we are ready to advocate for an increased allocation for 2018 because as you have remarked, the array of witnesses this morning demonstrate again, I think, for the two of us the expansive role that the Federal government has in these various areas that help to make a difference in people's lives. And they are all worthy causes.

And as an adjunct to that, to all of you who spend your lives and your professional careers to advocate on behalf of people who need the services that your organizations are providing to the young people who are making their way, but without the continued resources in some of these areas other youngsters will not be able to realize their own dreams and aspirations.

But that is why at the outset, I said this is a bill that affects every single aspect of a person's life. And after defense today, but in the subsequent days, to make sure that we have the resources in our allocation to be able to meet your needs. We cannot meet every need. The Federal government cannot do everything, but its role is to be an advocate, the same way that you are advocates for what you do.

Thank you for being with us today, and I know we will continue our contact over the next month. Many thanks. Thank you, Mr. Chairman.

Mr. COLE. I must say in closing, the dedication of our ranking member could not be more obvious. [Laughter.]

The fact that she was here the entire hearing when obviously this was not the easiest day for her to be here. And, you know, I just once again want to express my admiration and appreciation for my friend for her tireless advocacy. She never misses a chance to make a point, even when it is difficult for her to make that point as it was today, but always does it very well.

So, you know, I thank you all for attending. We are adjourned.

[Applause.]

[Statements submitted for the record follow:]