Questions for the Record for
XAVIER BECERRA

Committee on Education and the Workforce
Full Committee Hearing:
"Examining the Policies and Priorities of the Department of Health and Human Services"
Tuesday, June 13, 2023
10:15 a.m.

Chairwoman Foxx (R-NC)

Question #1

1. The *Inflation Reduction Act* (IRA) included $33 billion to expand subsidies for Obamacare plans for an additional three years. The President's budget calls for a permanent expansion of enhanced subsidies, at a cost of $247.9 billion over the next decade. Wouldn't it be better to strengthen employer-sponsored insurance, which is consistently more affordable and of higher quality?

Question #2

2. Three out of four individuals in the *Affordable Care Act* (ACA) exchanges receive subsidies. Doesn't this demonstrate that these plans are unaffordable?

Question #3

3. Premiums on the ACA exchanges are skyrocketing. Recently, health plans in New York requested rate bumps of up to 40 percent. What is the administration's plan to lower the cost of ACA premiums, or is the plan simply to continue to pump money into the system with tax hikes?

Answer 1-3:

More than 16.3 million people selected an Affordable Care Act (ACA) Marketplace health plan nationwide during the 2023 Marketplace Open Enrollment Period (OEP) that ran from November 1, 2022-January 15, 2023 for most Marketplaces. More Americans signed up for high-quality, affordable health insurance during the 2023 Marketplace OEP than ever before, and millions of working families saved an average of $800 on their health insurance premiums last year due to the expanded premium tax credits extended in the Inflation Reduction Act. Total plan selections include 3.6 million people (22% of total) who are new to the Marketplaces for 2023, and 12.7 million people (78% of total) who had active 2022 coverage and made a plan selection for 2023 coverage or were automatically re-enrolled. Over 1.8 million more people have signed up for health insurance, or a 13% increase, from this time last year. The 3.6 million plan selections from

people who are new to the Marketplaces represent a 21% increase in new-to-Marketplace plan selections over last year.

This year, individuals benefited from a highly competitive Marketplace. Ninety-two percent of HealthCare.gov enrollees had access to options from three or more insurance companies when they shopped for plans. Also, new standardized plan options were available in 2023 through HealthCare.gov, which helped consumers compare and select plans.

To build on this success, the FY 2024 budget invests in making private insurance even more affordable. The FY 2024 budget permanently extends the enhanced premium tax credits that were extended through 2025 in the Inflation Reduction Act. The budget provides Medicaid-like coverage to low-income individuals living in states that have not expanded Medicaid under the Affordable Care Act, paired with financial incentives to ensure States maintain their existing expansions. The budget builds on the No Surprises Act to extend consumer surprise billing protections to ground ambulances. In addition, the budget extends the $35 cap per monthly insulin product, already in place for Medicare beneficiaries under the Inflation Reduction Act, to consumers with group and individual market coverage.

Question #4

4. Our debt is about to hit $32 trillion. You have long been a proponent of Medicare for All, which would cost $32 trillion over 10 years. Do you think it's a good idea to double our federal debt for Medicare for All?

Answer:
Medicare is a key pillar of our health care system and we are committed to strengthening the program both now and in the future. Thanks to our efforts, this year's Medicare Trustees Report estimated that the solvency of the Medicare Hospital Insurance (HI) Trust Fund has been extended by three years since last year's report. In addition, adoption of the proposals in the President's FY 2024 Budget would extend Medicare solvency by at least 25 years, without cutting benefits or raising costs for people with Medicare. The FY 2024 budget also includes a targeted package of Medicare proposals totaling $8 billion over 10 years that supports the Administration's priorities such as investing in mental health, strengthening nursing home oversight, and enhancing program benefits. We look forward to continuing to work with Congress to further strengthen this vital program that serves over 65 million Americans.[1]

Question #5

5. Telehealth, in many ways, was a silver lining of the COVID-19 pandemic. Many new patients gained access to these important services as the Department allowed employers to offer stand-alone telehealth coverage. However, telehealth excepted benefits will expire at the end of this plan year, as the declared Public Health Emergency came to an end on May 11. Do you believe this flexibility helped workers gain better access to care?

[1] FY 2024 HHS Budget in Brief

Answer:
In response to the COVID-19 public health emergency, which expired in May 2023, flexibilities for Medicare telehealth services were issued through legislative and regulatory authorities to increase access to care for patients and providers. The Consolidated Appropriations Act of 2023 recently extended many of these flexibilities through December 31, 2024. Extended telehealth flexibilities include waiving geographic and site of service originating site restrictions so that Medicare patients can continue to use telehealth services from their home and allowing audio-only telehealth services. Additionally, the expanded list of providers eligible to deliver telehealth services is also extended so Medicare beneficiaries can continue to receive telehealth services furnished by physical therapists, occupational therapists, speech language pathologists, and audiologists, as well as receive telehealth services from Rural Health Clinics and Federally Qualified Health Centers through December 31, 2024. If you are interested in drafting legislation to make these waivers permanent, CMS would be happy to provide technical assistance.

Additionally, recent legislative and regulatory changes made several telehealth flexibilities permanent. Federally Qualified Health Centers and Rural Health Clinics can furnish certain behavioral services via telecommunications technology. Medicare patients can continue to receive these telehealth services in their home as geographic restrictions on the originating site are eliminated for these telehealth services. Certain behavioral services can be delivered using audio-only communication platforms, and rural emergency hospitals can serve as an originating site for telehealth services.[2]

For Medicaid and CHIP, telehealth flexibilities are not tied to the end of the PHE and have been offered by many state Medicaid programs long before the pandemic. Medicaid and CHIP telehealth policies will ultimately vary by state. CMS encourages states to continue to cover Medicaid and CHIP services when they are delivered via telehealth.

Question #6

6. Medicare Part A is expected to go insolvent in 2031, and Medicare spending is expected to grow exponentially over the next few decades. The President's plan to address Medicare is simply to raise taxes and use accounting tricks to move money around. When will the President take the issue of health care costs seriously?

Answer:
Medicare is a key pillar of our health care system and we are committed to strengthening the program both now and in the future. Thanks to our efforts, this year's Medicare Trustees Report estimated that the solvency of the Medicare Hospital Insurance (HI) Trust Fund has been extended by three years since last year's report. In addition, adoption of the proposals in the President's FY 2024 Budget would extend Medicare solvency by at least 25 years, without cutting benefits or raising costs for people with Medicare. The FY 2024 budget also includes a targeted package of Medicare proposals totaling $8 billion over 10 years that supports the Administration's priorities such as investing in mental health and substance use disorder treatment, strengthening nursing home oversight, and enhancing program benefits. We look forward to continuing to work with Congress to further strengthen this vital program that serves over 65 million Americans.[3]

[2] FY 2024 HHS Budget in Brief (p. 69-70)
[3] FY 2024 HHS Budget in Brief

Question #7

7. According to Congressional Budget Office estimates, ACA plans per enrollee are three times more expensive for taxpayers than employer-sponsored insurance. Do you believe that shifting enrollment from ACA plans to the employer-sponsored market would be beneficial for the federal budget? If so, what steps will the Department of Health and Human Services (HHS) take to encourage migration?

Answer:

More than 16.3 million people have selected an ACA Marketplace health plan nationwide during the OEP that ran from November 1, 2022-January 15, 2023 for most Marketplaces. More Americans signed up for high-quality, affordable health insurance during the 2023 Marketplace OEP than ever before, and millions of working families saved an average of $800 on their health insurance premiums last year due to the expanded premium tax credits extended in the Inflation Reduction Act. Total plan selections include 3.6 million people (22% of total) who are new to the Marketplaces for 2023, and 12.7 million people (78% of total) who had active 2022 coverage and made a plan selection for 2023 coverage or were automatically re-enrolled. Over 1.8 million more people have signed up for health insurance, or a 13% increase, from this time last year. The 3.6 million plan selections from people who are new to the Marketplaces represent a 21% increase in new-to-Marketplace plan selections over last year.

This year, individuals benefited from a highly competitive Marketplace. Ninety-two percent of HealthCare.gov enrollees had access to options from three or more insurance companies when they shopped for plans. Also, new standardized plan options were available in 2023 through HealthCare.gov, which helped consumers compare and select plans. ACA plans are serving a demonstrated need for Americans who may not have the option to enroll in employer-sponsored coverage.

To build on this success, the FY 2024 budget invests in making private insurance even more affordable. The FY 2024 budget permanently extends the enhanced premium tax credits that were extended through 2025 in the Inflation Reduction Act. The budget provides Medicaid-like coverage to low-income individuals living in states that have not expanded Medicaid under the Affordable Care Act, paired with financial incentives to ensure States maintain their existing expansions. The budget builds on the No Surprises Act to extend consumer surprise billing protections to ground ambulances. In addition, the budget extends the $35 cap per monthly insulin product, already in place for Medicare beneficiaries under the Inflation Reduction Act, to consumers with group and individual market coverage.

Question #8

8. Association Health Plans (AHPs) are an effective way to expand health care coverage options to small businesses and lower premiums. Virginia recently passed a law to allow

realtors to join together to create AHPs. Unfortunately, HHS sent a notice to the state alleging it is violating coverage rules. Do you agree that Virginia's law would expand health coverage options and lower costs for realtors?

Answer:
On May 31, 2023, CMS issued a preliminary determination pursuant to 45 CFR 150.217 that the Commonwealth of Virginia failed to substantially enforce certain specified federal market reforms. CMS's preliminary determination is based on implementation and enforcement of a state law, § 38.2-3521.1G of the Code of Virginia, as enacted by HB 768/SB 335 (2022), which allows an association of real estate salespersons to purchase health insurance coverage in the large group market in Virginia. The state law conflicts with and in some cases prevents the application of the specified federal market reforms. CMS made this preliminary determination after consulting with the Office of the Governor of the Commonwealth of Virginia and the Virginia Bureau of Insurance on April 7, 2023, and after corresponding with the Commonwealth.

An association of real estate salespersons described in the state law cannot establish or maintain a group health plan as an "employer" under the Employee Retirement Income Security Act (ERISA) section 3(5) and Department of Labor regulations and guidance. Therefore, each association member must receive coverage that complies with the requirements arising out of the member's status as an individual, small employer, or large employer. By treating health insurance coverage sold to self-employed individuals and small employers through such an association as coverage offered in the large group market, the state law conflicts with and in some cases prevents the application of the specified federal market reforms that apply to coverage offered in the individual and small group markets.

Question #9

9. Small businesses rely on stop-loss insurance to provide affordable, higher quality health care coverage to their employees by self-insuring. Do you agree that stop-loss coverage is a necessary tool for many businesses to self-insure?

Question #10

10. Is a rule to amend regulations governing short-term, limited-duration insurance (STLDI) currently being reviewed by the White House?

Question #11

11. Does the Department expect to limit the duration of these plans to three months? How do you anticipate the changes to STLDI insurance will affect the rate of uninsured individuals?

Question #12

12. Do you agree that STLDI is a useful tool for individuals to use if their coverage is interrupted by Medicaid redeterminations?

Answer 9-12:
The Administration has announced, in the Unified Agenda for Regulatory and Deregulatory Actions, an intent to propose amendments to the current regulatory definition of short-term, limited-duration insurance (STLDI). The rule's proposals would be designed to ensure this type of coverage does not undermine the Affordable Care Act, including its protections for people with pre-existing conditions, the Health Insurance Exchanges, or the individual, small group, or large group markets for health insurance in the United States.

Patients and their families deserve the security of knowing that the insurance they buy will be there for them when they need it. STLDI is a type of health insurance that is designed to fill temporary gaps in coverage when an individual is transitioning from one source of coverage to another. STLDI is excluded from the definition of individual health insurance coverage under the Public Health Service Act and, therefore, is generally not subject to the applicable federal individual market consumer protections and requirements for comprehensive coverage under the ACA. For example, STLDI is not subject to the prohibition on discrimination based on health status, prohibition of preexisting condition exclusions, and the prohibition on lifetime and annual dollar limits on essential health benefits. Thus, individuals who enroll in STLDI are not guaranteed these key consumer protections under the ACA.

With respect to the use of stop-loss insurance by employers with self-insured group health plans, the Department of Labor is the agency primarily tasked with administration of requirements applicable to private employer sponsored self-insured group health plans under Title I of ERISA.

With respect to individuals no longer eligible for Medicaid after the redetermination process, CMS established a Marketplace Special Enrollment Period (SEP) for qualified individuals and their families who lose Medicaid or CHIP coverage due to the end of the continuous enrollment condition, also known as "unwinding." The Unwinding SEP allows individuals and families in Marketplaces served by HealthCare.gov to enroll in Marketplace health insurance coverage outside of the annual open enrollment period. Consumers will be required to attest to a loss of Medicaid or CHIP coverage as part of their application but will not be required to submit documentation of a qualifying life event to be eligible for the Unwinding SEP. In addition to important consumer protections, ACA Marketplace plans offer consumers standardized plan options and the same deductibles and cost-sharing for certain benefits. These plans have the same out-of-pocket limits as other standardized plans within the same health plan category, making it easier for consumers to compare and choose plans. Most of these standardized plan options offer many services pre-deductible, including primary care, generic drugs, preferred brand drugs, urgent care, specialist visits, mental health and substance use outpatient office visits, as well as speech, occupational, and physical therapies.

Question #13

13. In the recent ACA regulation, the Department significantly weakens program integrity tools by requiring exchanges to wait two consecutive tax years before determining whether an enrollee is eligible for the advanced premium tax credits. Do you agree that this policy change will increase tax liabilities owed and increase debt for individuals erroneously receiving tax credits?

Answer:
In the 2024 Payment Notice, we finalized a proposal to amend the Failure to File and Reconcile (FTR) process

described so that an Exchange may only determine enrollees ineligible for advanced premium tax credit (APTC) after a taxpayer (or a taxpayer's spouse, if married) has failed to file a Federal income tax return and reconcile their past APTC for two consecutive years (specifically, years for which tax data will be utilized for verification of household income and family size). Under the previous policy, Exchanges determine an enrollee ineligible for APTC if the IRS, through data passed from the IRS to HHS, via the Federal Data Services Hub (the Hub), notifies an Exchange that the taxpayer did not comply with the requirement to file a Federal income tax return and reconcile APTC for one specific tax year. However, HHS has determined that the operational costs of the previous policy are significant and can be improved to provide a better consumer experience, while also preserving an Exchange's duty to protect program integrity. Exchanges have faced a longstanding operational challenge, specifically that Exchanges sometimes have to determine an enrollee ineligible for APTC without having up-to-date information on the tax filing status of households while Federal income tax returns are still being processed by the IRS.

Under this change, Marketplaces on the Federal platform will continue to send notices to consumers for any year in which they have failed to reconcile APTC as an initial warning to inform and educate consumers that they need to file and reconcile or risk being determined ineligible for APTC if they fail to file and reconcile for a second consecutive tax year and CMS recommends that SBMs take similar action. CMS is making this change as a result of analysis indicating that data lags in reporting from the IRS likely cause inappropriate coverage loss. CMS believes this change will help consumers avoid gaps in coverage by increasing retention in Marketplaces and will also help protect consumers from accruing large tax liabilities over multiple years. These changes will allow Marketplaces to maintain program integrity by denying APTC to consumers who have, over the course of two years, been given notification of their obligation to file and reconcile and failed to do so. This rule does not change the requirement for consumers receiving APTC to file taxes and reconcile their tax credits received.

Question #14

> 14.Your budget proposes to extend Medicare's $35 out-of-pocket cap for insulin to the commercial market, which will increase costs in the private sector by $2 billion a year. Will extending this cap to the commercial market raise premiums for individuals in small- and large-group plans?

Answer:
The Inflation Reduction Act limits Medicare beneficiary cost-sharing to $35 per covered insulin product for a month's supply. The President's FY 2024 Budget includes a proposal to extend the cap on patient cost-sharing to insulin products in commercial markets. This would allow more of the over 37 million Americans with diabetes to lock in this lower cost.

Question #15

> 15. The 340B program is intended to pass on savings and improve health outcomes for low- income patients. However, there are reports that hospitals and pharmacies are selling these drugs to commercially insured patients to help pad their bottom line, using employer-sponsored plans to subsidize the 340B program at the expense of workers' premiums. The President's budget includes funding for covered entities to report to the Health Resources and Services Administration on how the savings they achieve through

the 340B program are passed on to patients. Can you provide an update on these oversight efforts?

Answer:
HRSA places the highest priority on the integrity of the 340B Program and continually works to strengthen oversight of the Program within its current authority. Specifically, the FY 2024 President's Budget proposes to enhance program integrity by requiring covered entities to annually report to HRSA how savings achieved through the 340B Program benefits the communities they serve and provide HRSA with regulatory authority to implement this requirement. We look forward to working with Congress on these important issues, including opportunities to provide technical assistance on proposed statutory changes.

Question #16

16. According to a study from the University of Chicago, government price controls in the *Inflation Reduction Act* will result in 342 fewer cures reaching the market, which will take 330 million years off Americans' lives. What is the administration's plan to ensure that patients will not lose out on access to lifesaving cures and that America will continue to be the world leader in medical innovation?

Answer:
CMS supports continued drug innovation and believes it is vitally important that beneficiaries have access to innovative new therapies. The statute provides that drugs that have been approved by the FDA for at least seven years, or biologicals that have been licensed by the FDA for at least 11 years, are eligible for negotiation. Any drugs or biologicals selected for negotiation will have been on the market for quite some time.

The law requires CMS to exclude certain orphan drugs approved or licensed when identifying qualifying single source drugs, referred to as the orphan drug exclusion. To be considered for the orphan drug exclusion, the drug or biological product must (1) be designated as a drug for only one rare disease or condition by the FDA and (2) be approved by the FDA only for one or more indications within such designated rare disease or condition. As noted in the initial guidance, we are considering whether there are additional actions CMS can take in its implementation of the Negotiation Program to best support orphan drug development. The initial guidance can be accessed at: https://www.cms.gov/files/document/medicare-drug-price-negotiation-program-initial-guidance.pdf.

CMS has been regularly engaging with members of the public to get their feedback so that we are implementing the Negotiation Program in a thoughtful way that both improves drug affordability and accessibility for people with Medicare and supports innovation. CMS has made public comment letters available for download at https://www.cms.gov/inflation-reduction-act-and-medicare/medicare-drug-price-negotiation. We plan to get public input throughout the implementation of the Negotiation Program to make sure that we know what is occurring in the market.

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

- 2023 Draft Guidance for Industry*: Clinical Trial Considerations to Support Accelerated Approval of Oncology Therapeutics* [4]
- 2023 Draft Guidance for Industry: *Considerations for the Design and Conduct of Externally Controlled Trials for Drug and Biological Products*[5]
- 2022 Guidance for Industry: *Human Gene Therapy for Neurodegenerative Diseases*[6]
- 2022 Draft Guidance for Industry: *Tissue Agnostic Drug Development in Oncology*[7]

Question #17

17. The Centers for Medicare and Medicaid Services' (CMS) implementation of the *Inflation Reduction Act*'s drug-pricing provisions has lacked transparency and public engagement. One step would be to ensure that the text of the Negotiation Program Agreement is made available for public comment well in advance, at least 60 days, of the first selected drug publication date. Will CMS take this reasonable step while also continuing to find other ways to engage with stakeholders and be more transparent?

Answer:
The initial guidance details the requirements and parameters of the Medicare Drug Price Negotiation Program, including requests for public comment on key elements of the program, and announces the next steps for how the agency will implement the new program for 2026, which is the first year in which the first set of negotiated prices will apply. In the initial guidance, CMS decided on key topics to seek comment, including the terms and conditions contained in the manufacturer agreement, including the manufacturer's and CMS' responsibilities, and where CMS would like specific input from the public to operationalize the new program. Due to timing constraints and the statutory requirement to publish the selected drug list for initial price applicability year 2026 by September 1, 2023, CMS issued guidance on topics related to drug selection as final, without a comment solicitation.

As always, CMS broadly welcomes input from the public at all times. In the initial guidance for the Medicare Drug Price Negotiation Program, CMS voluntarily solicited comment on a number of key topics related to implementation of the new program, and CMS is using this feedback to inform revised guidance. In the revised guidance, CMS may clarify policies that were previously issued as final, as well as make changes to any policies, including policies on which CMS has not expressly solicited comment, based on the agency's further consideration of the relevant issues. CMS has made public comment letters available for download at https://www.cms.gov/inflation-reduction-act-and-medicare/medicare-drug-price-negotiation. CMS is striving for an effective negotiation process with participating manufacturers that lowers prescription drug prices and ensures people with Medicare have access to innovative therapies,

[4] https://www.fda.gov/regulatory-information/search-fda-guidance-documents/clinical-trial-considerations-support-accelerated-approval-oncology-therapeutics
[5] https://www.fda.gov/regulatory-information/search-fda-guidance-documents/considerations-design-and-conduct-externally-controlled-trials-drug-and-biological-products
[6] https://www.fda.gov/regulatory-information/search-fda-guidance-documents/human-gene-therapy-neurodegenerative-diseases
[7] https://www.fda.gov/regulatory-information/search-fda-guidance-documents/tissue-agnostic-drug-development-oncology

while meeting the ambitious timeframes specified under the law.

Question #18

18. Drug manufacturers are dealing with uncertainty as to whether their drugs will be selected for government negotiation. The negotiation process has the potential to upend each company's operations and research and development. It seems clear that CMS should have a pre-selection process where it notifies each manufacturer of each drug it intends to select for negotiation and solicits feedback from manufacturers. Will you commit to such a process?

Answer:
CMS is implementing the Medicare Drug Price Negotiation Program in accordance with the law, including provisions that set forth the drug selection process for this program.

Question #19

19. For the prescription-drug negotiation process, CMS has proposed a requirement that manufacturers destroy all records related to the process and that would prohibit disclosing or otherwise publicizing information in the initial offer or subsequent offers. This essentially allows CMS to operate in secret and with no accountability. What is the logic behind CMS having one-sided information control, and doesn't this show the so-called negotiation process is not a true negotiation?

Answer:
CMS intends to implement a confidentiality policy that is consistent with existing requirements for promoting an effective negotiation process, protecting proprietary information, and that strikes an appropriate balance between (1) protecting the highly sensitive information of manufacturers and ensuring that manufacturers submit the information CMS needs for the Negotiation Program, and (2) avoiding treating information that does not qualify for such protection as proprietary. In the initial guidance released for the Negotiation Program, CMS sought comment on the confidentiality policies and intends to explore approaches for the revised guidance.

Question #20

20. Do you think that patients should have the right to know how much a medical procedure is going to cost them before they obtain treatment?

Question #21

21. CMS has not been enforcing the hospital price transparency rule. What will you do to ensure there is greater compliance with this rule?

Question #22

22. Only four hospitals have been fined for violating the administration's hospital price transparency rule, while overall compliance is lacking. Why has the Department not done more to enforce the hospital price transparency rule?

Question #23

23. Do you think that the fact that patients essentially never know how much a treatment will cost, and that doctors and patients generally assume that someone else—either the insurance company or taxpayer through the government is going to pick up the bill—makes our health care system more expensive?

Answers to 20-23:
CMS's ongoing efforts to increase transparency across the health care system will help to incentivize competition, improve consumer experience, and realize additional savings across the health care system, including for patients. Lack of accessible information on prices makes it challenging for consumers to shop for services and limits competition. Over the past several years, CMS has implemented—and is continuing to implement—numerous complementary policies to promote transparency across the health care system.

In November 2019, CMS finalized the Hospital Price Transparency regulations[8] establishing requirements for hospitals operating in the U.S. to establish, update, and make public a list of their standard charges for the items and services they provide in addition to prices for 300 shoppable services, effective January 2021. In 2021, CMS undertook additional rulemaking[9] to increase the penalty for noncompliance with these requirements. As a result, the maximum potential penalty amount was increased beginning in 2022 to $10 per bed per day, for hospitals with a bed count over 30, up to a maximum daily civil monetary penalty amount of $5,500. Therefore, the annual potential penalty amount increased from just over $100,000 annually per hospital to over $2 million annually per hospital in 2022. A comparison of the results of a sequence of CMS compliance studies[10] shows progress in hospitals' implementation efforts since the Hospital Price Transparency regulation first went into effect, with 82 percent of hospitals in the sample meeting consumer-friendly display criteria by late CY 2022, up from 66 percent in early CY 2021; 82 percent posting a machine-readable file that met the website assessment criteria by late CY 2022, up from 30 percent in early CY 2021; and 70 percent doing both by late CY 2022, up from 27 percent in early CY 2021.

As of April 2023, CMS has issued over 730 warning notices and 269 requests for corrective action plans. CMS has issued civil monetary penalties to four hospitals for noncompliance (posted on the CMS website).[11] CMS helps hospitals come into compliance by conducting extensive technical assistance with hospitals throughout the compliance process. CMS continues to collaborate and work with hospitals and stakeholders to increase and improve compliance with the hospital price transparency requirements. In April 2023, CMS made compliance review and enforcement process updates to increase compliance with the hospital price transparency requirements. Moving forward, CMS plans to take additional aggressive steps to identify and prioritize action

[8] "Medicare and Medicaid Programs: CY 2020 Hospital Outpatient PPS Policy Changes and Payment Rates and Ambulatory Surgical Center Payment System Policy Changes and Payment Rates. Price Transparency Requirements for Hospitals To Make Standard Charges Public" https://www.govinfo.gov/content/pkg/FR-2019-11-27/pdf/2019-24931.pdf
[9] "Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Price Transparency of Hospital Standard Charges; Radiation Oncology Model" https://www.govinfo.gov/content/pkg/FR-2021-11-16/pdf/2021-24011.pdf
[10] HealthAffairs "Hospital Price Transparency: Progress And Commitment To Achieving Its Potential" https://www.healthaffairs.org/content/forefront/hospital-price-transparency-progress-and-commitment-achieving-its-potential
[11] https://www.cms.gov/hospital-price-transparency/enforcement-actions

against hospitals that have failed entirely to post files. By taking these additional steps, we believe that, together with stakeholders and members of the public, we can further unlock the potential of hospital price transparency and achieve greater competition in the health care system and lower costs for patients.

Question #24

24. Employers expect an increase in premiums of 5.4 percent this year. The RAND Corporation, the Congressional Budget Office, and other economists have identified provider consolidation as a main driver of health care cost increases. Perverse economic incentives have driven hospitals to acquire provider offices and then to bill incorrectly for services. Would you agree that this is a problem for employers and workers?

Answer:
Medicare payment methodologies are specified in statute by Congress and generally based on settings of care. The Medicare statute does not allow for adjustments to account for differences in facilities where care is received unless provided by statute.

Section 603 of the Bipartisan Budget Act of 2015 requires applicable items and services furnished by certain off-campus hospital outpatient departments on or after January 1, 2017 to be paid under an applicable payment system, which CMS determined is the Physician Fee Schedule, rather than the Hospital Outpatient Prospective Payment System (OPPS). Section 603 of the Bipartisan Budget Act of 2015 addresses some of the concerns related to shifts in settings of care and overutilization in the hospital outpatient setting, which often has higher payments than what would have been made if a similar service had been furnished in the physician office setting.

We understand this is an increasing concern, particularly as consolidation and closures continue to impact cost and access to care. CMS is happy to provide technical assistance on any legislation you have to modernize Medicare payment policies.

Question #25

25. Price transparency is vital for employers to help them make better decisions in choosing and administering employee health plans. HHS is indefinitely deferring enforcement of a rule requiring plans to make drug prices public and to submit them to HHS. Should Congress codify this rule to ensure proper implementation?

Answer:

Stakeholders have expressed concern about potentially duplicative and overlapping reporting requirements for prescription drugs. For example, under the Transparency in Coverage Final Rule, plans and issuers must publicly post pricing information for all covered prescription drugs by January 1, 2022. Under the No Surprises Act, however, plans and issuers must also report some of the same prescription drug pricing information to the Departments. In response to this statutory enactment and stakeholder concerns, as an exercise of enforcement discretion, the Tri-Departments announced in August 2021, that they would defer enforcement of the requirement in the Final Rules that plans and issuers must publish machine-readable file related to prescription drugs while it considers, through notice-and-comment

rulemaking, whether the prescription drug machine-readable file requirement remains appropriate.

Question #26

26. Prescription drug middlemen like pharmacy benefit managers (PBMs) are raking in profits while evading congressional scrutiny. An executive for one of the big three PBMs recently told investors to "not worry about Congress" and that it "would find ways to maintain its level of profit if those reforms to things like drug rebates went into effect." What actions can Congress take to increase oversight and accountability on PBMs?

Answer:
HHS will be releasing a report which will include information on the impact of prescription drug rebates, fees, and other remuneration on premiums and out-of-pocket costs. The department looks forward to continuing to work with you on reforms to ensure that there are no unnecessary costs in our health care system.

In April 2022 CMS finalized a policy that requires Part D plans to apply all price concessions they receive from network pharmacies to the negotiated price at the point of sale, so that the beneficiary can also share in the savings. Specifically, CMS is redefining the negotiated price as the baseline, or lowest possible, payment to a pharmacy, effective January 1, 2024. CMS is applying the finalized policy across all phases of the Part D benefit. This policy reduces beneficiary out-of-pocket costs and improves price transparency and market competition in the Part D program.

Question #27

27. CMS' Framework for Health Equity declares, "Each person CMS serves should receive … care that is responsive to their … cultural health beliefs and practice, traditions, and other communication needs."
    a. In light of that statement, why did CMS reject an appeal from St. Francis Hospital in Oklahoma, which was threatened with termination from Medicare for having a lit candle behind two layers of glass in a hospital chapel?
    b. How did this threat ensure Medicare beneficiaries are receiving care that is responsive to them?
    c. Why did CMS finally agree to a compromise, which incidentally coincided with the story hitting the media?

Answer:
CMS was made aware of a safety finding involving a fire risk, made by an independent accrediting organization, the Joint Commission, issued to St. Francis Hospital in Oklahoma. Patient safety is CMS's paramount concern. CMS adopts fire safety standards from the National Fire Protection Association – and lighted candles in proximity to patients with oxygen is a safety issue. CMS did not reject a formal appeal from St. Francis Hospital, because there never was an appeal. On May 4, 2023, CMS hosted a meeting with the hospital and the Joint Commission and granted a waiver allowing the hospital to mitigate the potential fire risk and correct the safety finding. The parties agreed on mitigation steps so the hospital can maintain the sanctuary candle, and the hospital did not lose its Medicare certification. We

were happy that we could work with the hospital to find a reasonable solution.

Question #28

28 . You were quoted as saying "Abortion is health care" when announcing a new rule to mandate coverage of contraceptive services at Planned Parenthood.
   a. What does this rule have to do with abortion?
   b. Do you plan on expanding the individual contraceptive arrangement to abortion services?

Answer:
In January 2023, the U.S. Department of Health & Human Services (HHS) and the Departments of Labor and the Treasury (Departments) proposed a rule to strengthen access to birth control coverage under the Affordable Care Act (ACA). Under the ACA, most plans are required to offer coverage of birth control with no out-of-pocket cost. To date, millions of women have benefited from this coverage. The proposed rule would expand and strengthen access to this coverage so that all women who need or want birth control are able to obtain it. This rule is limited to contraception access and does not address abortion care.

HHS will continue to protect the religious, civil, and constitutional rights of all Americans. This means that we will continue to enforce conscience and religious freedom protections, including receiving complaints, investigating cases, and making findings consistent with the law.

Question #29

29. As I said in my opening statement, "The only health care experience you had before assuming office was litigating an appellate court case in which you attempted to strong-arm Catholic nuns into paying for others' contraceptives." Is the individual contraceptive arrangement a new way to circumvent the Little Sisters of the Poor's decision not to pay for abortifacients?

Answer:
In January 2023, the U.S. Department of Health & Human Services (HHS) and the Departments of Labor and the Treasury (Departments) proposed a rule to strengthen access to birth control coverage under the Affordable Care Act (ACA). Under the ACA, most plans are required to offer coverage of birth control with no out-of-pocket cost. To date, millions of women have benefited from this coverage. The proposed rule would expand and strengthen access to this coverage so that all women who need or want birth control are able to obtain it.

HHS will continue to protect the religious, civil, and constitutional rights of all Americans. This means that we will continue to enforce conscience and religious freedom protections, including receiving complaints, investigating cases, and making findings consistent with the law.

Question #30

30. On March 2, 2022, in a statement released in response to concerns regarding gender reassignment surgery and child welfare investigations, you encouraged those who are being targeted by child welfare investigations to contact the HHS Office for Civil Rights to report their experience. Will you ensure that any parent who is investigated by Child Protective Services and who asserts a parental right to protect his or her child against sex change operations will receive support from the Office for Civil Rights?

Answer:
HHS will continue to protect the religious, civil, and constitutional rights of all Americans. This means that we will continue to enforce conscience and religious freedom protections, including receiving complaints, investigating cases, and making findings consistent with the law.

Question #31

31. In a memo released by your Department on March 2, 2022, the memo stated, "The Department of Health and Human Services and all leading national medical and pediatric associations confirm that providing gender-affirming medical care is in the best interest of children and youth who need it."[1] The memo goes on to suggest that child welfare

services' funds under title IV-B of the *Social Security Act* should be used by states to "assist…in accessing gender-affirming health care." That is not an appropriate use of taxpayer dollars.

a. Does Title IV-B mention "gender-affirming" health care?
b. What are puberty blockers?
c. What effects do puberty blockers have on the brain development of children?
d. What about the effects of puberty blockers on fertility?
e. Are puberty blockers reversible?
f. Isn't it true that puberty blockers can cause permanent sterility in a healthy girl or boy?
g. Would providing puberty blockers be considered medical malpractice?

Answer:
Health care is between a patient and their health care provider. Research demonstrates that gender-affirming care can improve mental health, reduce the rate of substance use disorder, and promote the overall well-being of gender-diverse youth when medically necessary.

[1] HHS Administration on Children, Youth and Families, Log No: ACYF-CB-IM-22-01. https://www.acf.hhs.gov/sites/default/files/documents/cb/im2201.pdf.

Question #32

32. We know that the Centers for Disease Control and Prevention (CDC) closely consulted with teachers' unions such as the American Federation of Teachers (AFT) on school reopening guidance. The New York Post on April 25 of this year reported: "AFT and its fellow union, the National Education Association, also asked the White House and CDC for help shaping its press strategy to show the rank-and-file they and the Biden administration were on the same page."[2] Please tell us what communications advice the CDC gave to teachers' unions.

Answer:

Throughout the COVID-19 pandemic, CDC received numerous requests from school officials (including school superintendents and school district representatives, principals, school boards, and others) as well as employers to help understand how they could ensure safe work environments for their employees.

CDC conducted extensive partner engagements to disseminate its COVID-19 school guidance and share additional tools and resources to support schools in providing safe, in-person instruction. CDC used existing partner engagements and long-standing relationships to compile a list of impacted groups relevant to school guidance. The Division of Adolescent and School Health in CDC's National Center for HIV, Viral Hepatitis, STD, and TB Prevention and the Division of Population Health/School Health Branch in the National Center on Birth Defects and Developmental Disabilities Home were particularly engaged in identifying stakeholders. Additionally, CDC supported schools and school districts with direct technical assistance, through numerous calls and virtual engagements, including listening sessions and "virtual school walk-throughs" to provide recommendations and feedback. These collaborations and engagements were essential in shaping CDC's understanding of challenges for schools and informing CDC's guidance to ensure it is feasible and meets the needs of educators and families.

Beginning in late January of 2021, CDC partnered with the Department of Education to coordinate the National Safe School Reopening Summit. The purpose of this event was to facilitate discussion about the importance of schools reopening across the United States. This event was also focused on dissemination of best practices in schools that had safely reopened across the United States and sharing the key recommendations from CDC's K-12 Operational Strategy. Held in March 2021, the event reached hundreds of participants and highlighted rural, urban, and suburban school districts and schools that had safely reopened using CDC-recommended strategies.

Question #33

33. In February 2021, the CDC was planning to release new school reopening guidance. The guidelines would have advised schools that they could reopen regardless of community spread of COVID-19. But then the guidance changed. After consulting with the AFT, the CDC revised the guidance such that, according to CNN's Jake Tapper at the time, schools serving 99 percent of students could potentially close. We knew by then that COVID posed a low risk to school children. We also know that remote learning was a devastating experience for many children. Was it a mistake for the CDC to accept the AFT's edits to its reopening guidance?

Answer:
Evidence emerged from early data on COVID-19 that persons with certain medical conditions were more likely to get sick and at an increased risk for hospitalization, intensive care use, and death from COVID-19. A person's risk of severe illness from COVID-19 increases with the number of underlying medical conditions. In particular, people who are immunocompromised or have a weakened immune system because of a medical condition or a treatment for a condition are at a very high risk for severe illness and death from COVID-19. This includes people who have cancer and are on chemotherapy, or who have had a solid organ transplant and are taking medication to keep their transplant. CDC used information about the risks of exposure and illness from COVID-19 among immunocompromised and other high-risk persons to consider ways to ensure guidance for schools and other settings addressed the needs of varied populations. Throughout the COVID-19 pandemic, CDC received numerous requests from school officials (including school superintendents and school district representatives, principals, school boards, and others) as well as employers to help understand how they could ensure safe work environments for their employees.

As communities planned safe delivery of in-person instruction in K-12 schools, it was essential for schools to decide when and under what conditions to help protect students, teachers, and staff and slow the spread of SARS-CoV-2 virus. CDC's school guidance emphasized that staff and students at increased risk of severe illness or death if infected with SARS-CoV-2 should continue to have options for online or virtual education and employment. This approach, when implemented at times when vaccination was not available or not yet widely available, would allow school officials to adjust their strategies based on the unique needs of the population of students and staff served by their schools. In this way, the information in CDC's guidance noted what steps schools could take to address the needs of immunocompromised teachers, helping school officials to develop a COVID-19 prevention strategy that best met the profile and needs of their school community.

Question #34

34. On November 30, 2021, HHS issued an interim final rule for COVID-19 mitigation as a new provision to the Head Start Program Performance Standards. The rule required universal masking for all individuals two years of age and older, with immediate compliance, and vaccination for COVID-19 by January 31, 2022, for all Head Start staff, contractors providing services to children, and volunteers working with children. Although the CDC recommended in August 2022 universal masking only if there is a high community transmission rate, Head Start guidelines remained unchanged. Eventually, HHS, in a final rule, removed the universal masking requirement on January 6, 2023.[3] The vaccine mandate was struck down by a federal court on March 31 of this year on the grounds the mandate was arbitrary and capricious.[4] Why did HHS reverse course on universal masking so long after the CDC recommended otherwise, and why did it require a federal district court injunction to vacate the vaccine regulation on the

[2] https://nypost.com/2023/04/25/teacher-unions-had-bigger-hand-in-cdc-school-reopening-plan/.
[3] https://www.federalregister.gov/documents/2023/01/06/2022-28451/mitigating-the-spread-of-covid-19-in-head-start-programs
[4] *Texas v. Becerra*, No. 5:21-CV-300-H, 2023 BL 110050, 2023 US Dist. Lexis 56119 (N.D. Tex. Mar. 31, 2023) (nationwide injunction).

grounds it was arbitrary and capricious?

Answer:
HHS has consistently taken an evidence-based approach to protecting the health and safety of adults and children in the Head Start program. When the CDC updated its guidance on mask use in January 2022, HHS notified Head Start grant recipients that they would not be monitored for compliance with mask requirements. HHS decided to remove the vaccine and testing requirements when the public health emergency declaration ended on May 11, 2023. As COVID-19 remains an ongoing public health concern, Head Start programs must have an evidence-based COVID-19 mitigation strategy in place to protect individuals in the program that relies on the latest science.

Question #35

35. It is disheartening to read widespread reports of unaccompanied children who enter through our borders and end up lost in the hands of human traffickers or become subject to dangerous and unlawful child labor.[5] According to the U.S. Customs and Border Protection, roughly 340,000 unaccompanied children have shown up at the United States border since 2021.[6] Data obtained by the New York Times, however, suggest that during the two years from 2021 through the present, the Department has lost contact with 85,000 unaccompanied children.[7] I am concerned about allegations that the Department may have lost track of some unaccompanied children.
    a. What specific means does the Department use to reach out to these children?
    b. What specific steps has the Department taken to remedy your inability to keep track of unaccompanied children?
    c. Are you using person-to-person contact to reach unaccompanied children?
    d. What other means do you use to reach unaccompanied children?

Answer: The 85,000 number cited by the New York Times is a misrepresentation of the Department of Health and Human Services' (HHS) Office of Refugee Resettlement's (ORR) work serving unaccompanied children. It represents a misunderstanding of Safety and Well-being calls and the role that they play in ORR's overall communication with and service provision to unaccompanied children, including Post Release Services, legal representation, and the ORR National Call Center (ORRNCC), which provides children discharged from ORR care 24/7 help line access.

ORR's custodial authority ends when a child is released from ORR care. However, ORR has policies in place to promote unaccompanied children's safety and well-being after they have been released from ORR care to the care of a sponsor who is typically a parent or other close family member. ORR has thorough sponsor screening and vetting processes in place for each category of sponsor and, pursuant to the Trafficking Victims Protection Reauthorization Act (TVPRA), ORR conducts a thorough assessment to determine if a sponsor is capable of providing for the child's physical and mental well-being. The TVPRA requires, among other things, that sponsor suitability assessments include verification of the sponsor's identity and relationship to the child and that the sponsor has not engaged in any activity that would indicate a potential risk to the child. All sponsors must complete a robust screening process that includes background checks, interviews, review of supporting documentation, and home visits as applicable. ORR takes its responsibility to care for and protect children in its custody seriously and works diligently to make sure every placement decision is made in the best interest of the

child. ORR's process for the safe and timely release of a child from federal custody includes several steps such as: separate interviews with the child and sponsor and speaking with the child's parents, if available; a sponsor application, address checks, and supporting documentation; background checks – which may include FBI fingerprint checks; and, home studies as applicable, including those required by the TVPRA, ORR policy, or at the discretion of ORR staff reviewing the facts of the case. Additional details on this process are available in ORR's Unaccompanied Children (UC) Program Policy Guide Section 2: Safe and Timely Release from ORR Case.

Per ORR policy, in ORR's network of funded grant or contract recipients, known as ORR care providers[12], are required to make at least three "Safety and Well-being" calls to speak with the child and sponsor individually to determine if the child is still residing with the sponsor, enrolled in and attending school, aware of any upcoming court dates, and otherwise safe, as well as to assess if either the child or the sponsor would benefit from additional support or services. Children and sponsors are not required to answer these calls. It is important to note that many sponsors and children may choose not to answer a call from an unknown phone number, may be fearful of government entities, or may simply miss the call. Despite the voluntary nature of the child's and the sponsor's participation in Safety and Well-being calls, in fiscal year (FY) 2022, ORR care providers made contact with either the child, the sponsor, or both in more than 81 percent of households. In addition, upon a child's release, ORR provides children with information on the ORRNCC, a 24-hour, seven days a week, resource not only for released children, but their family members, sponsors, legal service providers, Child Advocates, and other members of the community who can request assistance or report concerns to the ORRNCC on a child's behalf. The ORRNCC reports matters of safety concern to ORR and refers and reports to the appropriate law enforcement or other authority, such as child protective services.

In addition, ORR provides post-release services (PRS) to unaccompanied children who are required to receive follow-up services under the William Wilberforce Trafficking Victims Protection Reauthorization Act of 2008 (TVPRA) and to children who, in the determination of a care provider, would benefit from ongoing assistance, including all children who are victims of trafficking in any form. PRS includes timely referrals and connection to community resources as well as intensive case management services in cases where additional support is necessary to address a child's specific needs or challenges. These referral and case management services are offered by a network of ORR-funded grant recipients across the United States. PRS can include help with school enrollment, support in finding and accessing health care, including for mental health and substance use disorder, connections with local organizations, and other supports to ensure children's well-being.

Further, if ORR care provider staff, such as a case manager or clinician, identifies or suspects any safety concerns at any point during their interaction with an unaccompanied child either while a child is in ORR care or post-release through a Safety and Well-being call, they are required to issue a Notification of Concern to ORR and notify appropriate investigative agencies, including local law enforcement and child protective services. This includes any suspicion that the child has run away, is at risk of or posing a danger to themselves or others, or is at risk of human trafficking, exploitation, or other abuse. ORR then conducts further review and determines what actions should be taken, which may include additional reporting and engagement with local law enforcement, state child welfare authorities, and/or referral to PRS.

Question #36

[12] A care provider is any ORR funded program that is licensed, certified or accredited by an appropriate State agency to provide residential care for children, including shelter, group, foster care, staff-secure, secure, therapeutic or residential treatment care for children.

36. In a Department staff meeting last summer, you urged your staff to release minors into the United States at rapid-fire rates. You stated that the Department's efficiency in doing so was not meeting the standard of the assembly line that made Henry Ford rich and famous.[8]
    a. Do you disavow your "assembly line" comments?
    b. What is the administration doing to protect these children better and ensure that they do not become victims of trafficking or other crimes?

Answer: Providing care for unaccompanied children in ORR custody is the priority in all decisions made by ORR, HHS, and the Administration. Given ORR's child welfare mission, ORR knows that the best place for a child is with a family in a community, not in a congregate care setting. In the prior fiscal year, more than 85 percent of unaccompanied children released to vetted sponsors were placed with a parent, legal guardian, or other close family member.

HHS engages in constant efforts to improve care and information-sharing efforts for better human trafficking prevention. For example, in February 2023, ORR entered into a data sharing Memorandum of Agreement (MOA) with OTIP and the National Center for Missing and Exploited Children (NCMEC) to increase information sharing and visibility on unaccompanied children who are referred to NCMEC and who may be at risk of trafficking or exploitation.

ORR has thorough sponsor screening and vetting processes in place for each category of sponsor and, pursuant to 235(c)(3) of the TVPRA (8 U.S.C. 1232(c)(3)(B)). ORR determines if a sponsor is capable of providing for the child's physical and mental well-being. The TVPRA requires, among other things, that sponsor suitability assessments include verification of the sponsor's identity and relationship to the child and that the sponsor has not engaged in any activity that would indicate a potential risk to the child. All sponsors must complete a robust screening process that includes background checks, interviews, review of supporting documentation, and home visits as applicable. ORR takes its responsibility to care for and protect children in its custody seriously and works diligently to make sure every placement decision is made in the best interest of the child. ORR's process for the safe and timely release of a child from federal custody includes several steps such as: separate interviews with the child and sponsor; speaking with the child's parents, if available; a sponsor application; verification of address; review and verification of supporting documentation; background checks – which may include FBI fingerprint checks; and home studies when required by the TVPRA, ORR policy, or at the discretion of the case manager and ORR staff reviewing the facts of the case. Additional details on this process are available in ORR's Unaccompanied Children Program Policy Guide Section 2: Safe and Timely Release from ORR Case.

ORR has zero tolerance for abuse or mistreatment of children. If an ORR care provider identifies or suspects any safety concerns at any point during their interaction with an unaccompanied child formerly in ORR care, they are required to issue a Notification of Concern to ORR and notify appropriate investigative agencies, including local law enforcement and child protective services. This includes any suspicion that the child has run away, is at risk of or posing a danger to themselves or others, or is at risk of exploitation, human trafficking, or other abuse. ORR then conducts further review and determines what action should be taken, which may include additional reporting and engagement with local law enforcement, state child welfare authorities, and PRS.

Should an ORR care provider or case manager suspect that a child is a victim of trafficking or is at risk of trafficking at any point during this process, they must also make a referral to HHS' Administration for Children and Families' Office on Trafficking in Persons (OTIP) and to the Department of Homeland Security's (DHS) Homeland Security Investigations and the DHS Center for Countering Human Trafficking for further investigation.

Further, this Administration is committed to expanding PRS tailored to the unique needs of each child. In FY 2022, ORR more than doubled the rate of children offered PRS, providing access to more than 40 percent of children compared to just over 20 percent in FY 2021. With continued funding from Congress, we continue to advance toward our goal of providing all children access to PRS by the end of FY 2024.

Question #37

37. I am frankly shocked at the lack of coordination between the Department of Labor, HHS, and the Department of Homeland Security when it comes to protecting the health and safety of unaccompanied migrant children after they have entered the United States. It is the responsibility of HHS to ensure that these children are placed with responsible caregivers after they leave HHS. Yet, it appears as though many of these children were placed with human traffickers and were forced to work in jobs that are illegal for minors to hold. This was so prevalent that HHS stopped placing children with sponsors in certain zip codes.
    a. Did the Department of Labor warn HHS that these children were at risk for human labor trafficking at any point in 2021, 2022, or 2023?
    b. Do you believe that HHS properly vetted the sponsors of unaccompanied children who were found to be exploited by human labor traffickers?
    c. Did HHS follow all protocols when vetting sponsors for unaccompanied children?
    d. Did the Department's failure to vet sponsors contribute to the increase in child labor trafficking?
    e. If a child who was under the care of HHS' Unaccompanied Children Program is found to be a victim of human labor trafficking, is the sponsorship immediately terminated, and does the federal government reclaim custody of the child?
    f. Are there circumstances under which the child will be returned to the original sponsor?
    g. Are there circumstances under which the child will be returned to an immediate relative of the original sponsor? And, if so, what is the vetting process for these individuals?

Answer:

HHS does not tolerate abuse or mistreatment of children and recognizes that unaccompanied children may be particularly vulnerable. Thus, consistent with its statutory authorities, HHS is working closely in partnership with the Department of Labor (DOL) in federal efforts to protect children against labor exploitation. HHS and DOL's joint efforts to conduct due diligence to prevent and respond to child labor issues have been ongoing and, as of March 23, 2023, have also been formalized in an MOA between DOL's Wage and Hour Division and the Department's ACF, which oversees ORR. The MOA expands collaborative work to help identify communities and employers where children may be at risk of child labor exploitation; aid investigations with information that could help identify circumstances where

children are unlawfully employed; and further facilitate coordination to ensure that child labor trafficking victims or potential victims have access to critical services.

[5] See Tara Rodas, Opening Statement, Health and Human Services Whistleblower, Federal Inspector General Employee, https://judiciary.house.gov/sites/evo-subsites/republicans-judiciary.house.gov/files/evo-media-document/rodas-testimony.pdf.

[6] https://nypost.com/2023/04/28/republican-senators-want-feds-to-explain-losing-85000-migrant-kids/.

[7] https://www.nytimes.com/2023/02/25/us/unaccompanied-migrant-child-workers-exploitation.html.

[8] https://www.nytimes.com/2023/02/25/us/unaccompanied-migrant-child-workers-exploitation.html.

In April 2023, HHS and DOL developed and distributed new materials and trainings to provide information to children and sponsors about child labor laws in the United States so that children and vetted sponsors understand the laws on labor rights and restrictions to working in the United States. The cross-training efforts of DOL and HHS staff have been successful and robustly attended, with approximately 800 HHS staff trained by DOL and 250 DOL managers trained by HHS.

Additionally, HHS launched an audit of individuals who have sponsored multiple unrelated unaccompanied children, to ensure all necessary safeguards were followed. On June 2, 2023, HHS released the results of its audit, which found that ORR adhered to its program policies and procedures designed to meet or exceed statutory requirements in the placement of unaccompanied children with a vetted sponsor. The audit also identified areas for continued improvement. HHS announced additional efforts to protect the safety and well-being of unaccompanied children, including a new Program Accountability team in ORR that will be responsible for assessing and addressing potential exploitation risks faced by unaccompanied children. This new team will play a key role in working with an external entity to conduct an in-depth review of vetting and placement processes across all sponsor categories.

Further, HHS is committed to expanding PRS tailored to the unique needs of each child. In FY 2022, ORR more than doubled the rate of children offered PRS, providing access to more than 40 percent of children compared to just over 20 percent in FY 2021. With continued funding from Congress, HHS continues to advance toward its goal of providing all children access to PRS by the end of FY 2024.

When a child is released to a vetted sponsor, ORR's custodial authority ends. However, ORR takes reports of all forms of human trafficking, including labor trafficking, seriously and has put strong systems in place to support children who have been, or are at risk of, being trafficked. When ORR receives a report of suspected labor exploitation or trafficking, it takes a range of actions, which can include:

- Immediately halting discharges to specific neighborhoods (utilizing street information) as appropriate, or to individual sponsors until additional safety measures are put in place;
- Mandating home studies and/or supervisory reviews prior to case approval;
- Conducting welfare phone calls and/or in-person visits, and
- Flagging for the state's child welfare agency, local law enforcement, OTIP, and other relevant entities for certain locations and a geographically appropriate radius around those locations.

In addition, ORR requires care providers to create a Significant Incident Report for all suspected trafficking or exploitation concerns to notify ORR, OTIP, and investigative agencies within 24 hours. Further, the ORRNCC notifies local law enforcement and child welfare agencies, as the entities with the authority to determine whether to remove the child from their current home for their safety. ORR also recently engaged OTIP and NCMEC to enter into a Memorandum of Agreement where all parties share information on a weekly basis. The MOA also enables data-sharing between HHS and NCMEC to increase visibility on unaccompanied children who are referred to NCMEC and who may be at risk of trafficking or exploitation.

ORR identifies potential sponsors for unaccompanied children in different categories of cases: parents or legal guardians as Category 1; brothers, sisters, grandparents, or other immediate relatives as Category 2; distant relatives or unrelated individuals as Category 3; and unaccompanied children with a vetted sponsor yet to be identified as Category 4. ORR's

sponsor suitability assessment process includes verifying the sponsor's relationship to the child; speaking with the child's parents when possible; conducting separate interviews with the child and sponsor; collecting supporting documentation to verify the sponsors' information; and administering background and address verification checks—which include public records and sex offender registry checks, as well as FBI fingerprint checks in certain cases. Prior to placement, ORR also carries out home studies in certain circumstances, as required by the TVPRA and ORR policy. Home studies are in-depth investigations of a potential sponsor's ability to ensure the child's safety and well-being, which include background checks, not only of the sponsor, but also of adult household members, home visits, face-to-face sponsor interviews, and, if necessary, interviews with other household members. The conditions for which ORR will deny release to a potential sponsor are delineated in ORR policy, Unaccompanied Children (UC) Program Policy Guide Section 2.7.2.

In the event the sponsor is unable to provide care and custody for the child, and if they are not the child's parent or legal guardian, HHS provides instructions to contact the ORRNCC for support. The ORRNCC is a valuable resource where both sponsors and children can request assistance, report concerns, and be referred to essential community services to promote success and community permanence. The ORRNCC also reports to local law enforcement and the child welfare agencies in each state as appropriate.

Question #38

38. Is it accurate to say that some human traffickers promise young children that they can go to school or work in the United States to lure them into being trafficked?

Answer:
HHS's principal responsibility is to care for unaccompanied children while they are in HHS custody and to make sure the child is placed with a safe, vetted sponsor. Everyone at HHS takes reports of all forms of trafficking very seriously and have put strong systems in place to support children who have been or are at risk of being trafficked. ORR screens all unaccompanied children for indicators of abuse, including abuse on their journey to the United States, and for potential trafficking concerns during intake, assessments, sponsor assessments, and Significant Incident Reports. ORR refers potential concerns of human trafficking to OTIP within 24 hours in accordance with reporting requirements. OTIP reviews the concerns to assess whether the unaccompanied child is eligible for benefits and services. Concerns of human trafficking are also reported to OTIP by post-release service providers, the ORRNCC, legal service providers, law enforcement, child welfare entities, healthcare providers, other child-serving agencies, and child advocates. Children who have experienced abuse during their journey receive tailored services, and their cases are reported to the appropriate partners. ORR also provides PRS to unaccompanied children who are required to receive follow-up services under the TVPRA, and to children who, in the determination of a care provider, would benefit from ongoing assistance, including all children who are victims of trafficking in any form.

Question #39

39. This seems to be a very lucrative business practice of cartels. Is HHS placing children with members of gangs and cartels, including MS-13?

Answer:
ORR screens all unaccompanied children for potential trafficking concerns, including during intake, assessments, sponsor assessments, and Significant Incident Reports. Moreover, ORR takes its responsibility to care for and protect children in its custody seriously and works diligently to make sure every placement decision is made in the best interest of the child. ORR has thorough sponsor screening and vetting processes in place for each category of sponsor and, pursuant to 235(c)(3) of the TVPRA (8 U.S.C. 1232(c)(3)(B)). TVPRA, ORR conducts a thorough assessment to determine if a sponsor is capable of providing for the child's physical and mental well-being. The TVPRA requires, among other things, that sponsor suitability assessments include verification of the sponsor's identity and relationship to the child and that the sponsor has not engaged in any activity that would indicate a potential risk to the child. All sponsors must complete a robust screening process that includes background checks, interviews, review of supporting documentation, and home visits as applicable.

ORR's process for the safe and timely release of a child from federal custody includes several steps such as: separate interviews with the child and sponsor; speaking with the child's parents, if available; a sponsor application; address checks; review and verification of supporting documentation; background checks - which may include FBI fingerprint checks; and home studies when required by the TVPRA, ORR policy, or at the discretion of the case manager and ORR staff reviewing the facts of the case. Additional details on this process are available in ORR's Unaccompanied Children (UC) Program Policy Guide Section 2: Safe and Timely Release from ORR Case.

ORR's custodial authority ends when a child is released from ORR care, though ORR has policies in place to promote unaccompanied children's safety and well-being after they have been released from ORR care. Per ORR policy, ORR care providers are required to make at least three Safety and Well-being calls to speak with the child and sponsor individually to determine if the child is still residing with the sponsor, enrolled or attending school, aware of any upcoming court dates, and otherwise safe, as well as to assess if either the child or the sponsor would benefit from additional support or services. Children and sponsors are not required to answer these calls. It is important to note that many sponsors and children may choose not to answer a call from an unknown phone number or because they may be fearful of government entities, or they may simply miss the call. Despite the voluntary nature of the child's and the sponsor's participation in Safety and Well-being calls, in FY 2022, ORR care providers made contact with either the child, the sponsor, or both in more than 81 percent of households.

Question #40

40. Is it true that HHS would release multiple unaccompanied children to the same address or building?

Answer:
The safety and well-being of every child is at the forefront of every decision HHS makes. ORR's vetting policy and process is intensive, and there are multiple quality controls, including third-party review of cases and federal field specialists who sign off on each discharge. HHS has made numerous improvements to streamline the process without sacrificing child safety.

ORR policy (UC Program Policy Guide Section 2.4.2) requires a home study before releasing any child to a non-relative sponsor who is seeking to sponsor multiple children, or who has previously sponsored or sought to sponsor a child and is seeking to sponsor additional children.

Further, HHS launched an audit of individuals who have sponsored multiple unrelated unaccompanied children, to ensure all necessary safeguards were followed. On June 2, 2023, HHS released the results of its audit, which found that ORR adhered to its program policies and procedures designed to meet or exceed statutory requirements in the placement of unaccompanied children with a vetted sponsor. HHS also announced additional efforts to protect the safety and well-being of unaccompanied children, including a new Program Accountability team in ORR that will be responsible for assessing and addressing potential exploitation risks faced by unaccompanied children. This new team will play a key role in working with an external entity to conduct an in-depth review of vetting and placement processes across all sponsor categories. HHS's ORR continuously reviews intensive vetting policies and procedures through ongoing individual case reviews and data analyses.

Question #41

41. One whistleblower recently testified that she saw "20, 30, and 40 unaccompanied children released in the same apartment building." What action is HHS taking to ensure that individuals are not sponsoring multiple children, and that multiple children are not being released to the same address?

Answer:
Per Office of Refugee Resettlement (ORR) policy, a home study is required for children being released to a non-relative sponsor who is seeking to sponsor multiple children or who has previously sponsored or sought to sponsor a child and is seeking to sponsor additional children. A home study consists of interviews, a home visit, and a written report containing the home study case worker's findings. More information about ORR's home study requirements is available in Section 2.4.2 of the Unaccompanied Children (UC) Policy Guide Section.
In addition, in February 2023, ORR launched an audit as part of its iterative, continuous process to ensure that all necessary safeguards are in place without unnecessarily keeping children in government-funded congregate care settings. The audit focused on case reviews of children in 2021 and 2022 to non-relative sponsors who sponsored three or more unrelated children. ORR utilized these criteria because it determined that doing so would ensure the audit was focused on cases of highest potential concern. On June 2, 2023, HHS released the results of the audit and found that ORR adhered to its program policies and procedures designed to meet or exceed statutory requirements in the placement of unaccompanied children with a vetted sponsor. The report also announced HHS' additional efforts to protect the safety and well-being of unaccompanied children, including a new Program Accountability team in ORR that will be responsible for assessing and addressing potential child exploitation risks associated with the UC Program. The new team will play a key role in working with an outside entity to conduct an in-depth review of vetting and placement processes across all sponsor categories.

Question #42

1. In the HHS budget, you propose an outlandish 76 percent increase in the Title X Family

Planning program from $286 million to $512 million. Would you agree that the proposed increase would be better directed to help low-income women and their families with prenatal care and supportive family services instead of providing taxpayer funds for taking the life of an unborn child?

Answer:
For over 50 years, Title X family planning clinics have played a significant role in ensuring access to equitable, affordable, client-centered, and high-quality preventive healthcare services for millions of low-income or uninsured women. The Title X family planning program is a critical part of the public health safety net and has served as a point of entry into care for nearly 195 million people in its history. Consistent with longstanding federal law, Title X funds cannot be used to pay for the provision of abortion services.

Despite the need for additional funding to support service expansion and mitigate inflation, the Title X program has been level-funded for over eight years. The proposed increase in funding is critical to meeting current demand and expanding much-needed access to Title X services such as pregnancy testing and counseling, access to contraceptives, STI testing, basic infertility services, cervical cancer screenings, and preconception care. Given women of reproductive age often visit their family planning provider as their primary source of health care, these providers often serve as an important linkage to other health care services, including for pregnant clients in need of prenatal care. The need for additional funding is even greater than what was proposed in the HHS budget, and the proposed increase would directly support the health and well-being of low-income women and their families.

Question #43

2. Why is the FDA allowing the off-label use of cross-sex hormones to be used on children when there has been no long-term study on how this affects their physical and mental health?

Answer:
If your question refers to Gonadotropin-Releasing Hormone (GnRH) agonists, FDA has approved such drug products for multiple indications. FDA approves drug products based on data and information submitted by a sponsor that establish the safety and effectiveness of the drug product for its proposed indication(s). You may review the approved labeling for individual drug products available at the FDA.gov website.[13]

FDA has not approved GnRH agonists to treat adolescents with gender dysphoria. If a sponsor submitted an application for such use, FDA would evaluate it under our statutory safety and effectiveness standards for approval. That said, FDA's regulatory framework recognizes the role of medical professionals in making treatment decisions for their individual patients. From FDA's perspective, healthcare providers generally may choose to use an approved drug for an unapproved use to treat a disease or medical condition if they determine that such use is medically appropriate for an individual patient (sometimes referred to as "off-label use").

[13] https://www.accessdata.fda.gov/scripts/cder/daf/index.cfm

FDA monitors the safety of drugs once they are on the market, regardless of whether they were prescribed for an on-label use or off-label use. Important safety information is presented in the drug labeling for healthcare providers and their patients on, among other things, the drug's side effects. This information can help inform a prescriber's judgment as to whether the drug is appropriate treatment for a particular patient. After approval, FDA monitors the safety of drug products, including the frequency and severity of reported adverse drug experiences, through a variety of sources, including its MedWatch program. FDA regulations set forth requirements with respect to reporting, by manufacturers and certain other entities, of adverse drug experiences to FDA. In addition, MedWatch reports voluntarily submitted by healthcare providers and consumers can help FDA to detect problems with marketed drug products. Reports of adverse drug experiences in our FDA Adverse Event Reporting System (FAERS) database are continually monitored for emerging safety patterns. FDA may use this and other information to require updates to drug labeling if warranted.

Question #44

1. Are you concerned that the medical community is essentially experimenting on children and may be condemning gender-confused children to lasting physical harm, including lost fertility and sexual health?

Answer:
The CDC has found that 47% of teenagers who identify as LGBTQ+ seriously considered a suicide attempt, while one in four LGBTQ+ teenagers attempted suicide. Research demonstrates that gender-affirming care can improve the mental health and overall well-being of adolescents when medically necessary. Health care is between a patient and their health care provider. Parents also play an important role in these conversations.

Question #45

3. Do you think that parents today know the risks and lasting physical consequences of taking cross-sex hormones?

Answer:
Health care is between a patient and their health care provider. There are well-established guidelines to counsel families concerning the treatment of gender-diverse youth, in addition to the rules of medical ethics and legal requirements concerning informed consent.

Question #46

4. Do you have any comment about other nations, including the UK, Finland, Norway, France, and Sweden, recently limiting adolescent gender transition?

Question #47

47. Why is the U.S. an outlier on this issue?

Answer:
The CDC has found that 47% of teenagers who identify as LGBTQ+ seriously considered a suicide attempt, while one in four LGBTQ+ teenagers attempted suicide. Research demonstrates that gender-affirming care can improve the mental health and overall well-being of adolescents when medically necessary.

Question #48

48. In the U.S., many lives were lost to COVID. However, many lives were also negatively impacted, and even shortened, due to our pandemic response. Substance abuse, domestic abuse, and deaths of despair increased, and overall general health decreased, as people became more socially isolated and less active. What is the administration doing to measure the human and health costs of our COVID response?

Answer:
The toll of the COVID-19 pandemic was immense in terms of direct and indirect impacts. The April 2022 Memorandum on Addressing the Long-Term Effects of COVID-19 directed the Secretary of Health and Human Services to coordinate the Government-wide response to the long-term effects of COVID-19, including mental health and substance use challenges and bereavement. Since last April, HHS's Office of the Assistant Secretary for Health has led the efforts to address the longer-term impacts of the pandemic. Given the toll of Long COVID, these efforts have focused on the continuing health impacts that some face after initial SARS-CoV-2 infection. Actions are being taken across HHS and the federal government to study Long COVID with the ultimate goal of discovering the underlying causes that can lead to prevention, diagnosis and treatment. Various efforts are also underway to better understand the impacts of the pandemic itself, particularly on children and families, such as a recent report published by the National Academies of Medicine at the request of HHS's Administration for Children and Families on Addressing the Long-Term Impact of the COVID-19 Pandemic on Children and Families.

Question #49

49. Why did you enact the COVID-19 vaccine mandate for federally operated health care and clinical research facilities against employees, contractors, trainees, and volunteers?

Answer:
CMS implemented the staff vaccination requirements in the Omnibus COVID-19 Health Care Staff Vaccination interim final rule with comment period (IFC) to assure health and safety during the COVID-19 Public Health Emergency declaration. We know that the COVID-19 vaccine saves lives, and this Administration has made it a priority to continually work to protect our most vulnerable communities across the country. The health care staff vaccination requirement for covered Medicare- and Medicaid-certified providers and suppliers was enforced in all states beginning on February 20, 2022. Most providers and suppliers that were subject to the requirements surveyed by states were found to have been in substantial compliance with this requirement. However, on June 5, 2023, CMS issued regulations to withdraw the requirements in the IFC. CMS recognizes that the incidence of severe COVID-19 has declined significantly since the IFC was issued but continues to recognize that vaccines are important for preventing severe illnesses and promoting public health.

Question #50

50. Why did you mandate the COVID-19 vaccination without an option to test out of the mandate?

Question #51

51. Why did you require that 300,000 educators in the Head Start program be vaccinated when scientific evidence was emerging that most children were not at grave risk of receiving or transmitting COVID?

Answers to #51-#52:
At the time of the IFC's publication, November 30, 2021, the COVID–19 vaccine was the most effective risk reduction strategy available to avoid severe illness, hospitalization, and death, as well as the most important measure for reducing risk for SARS–CoV–2 transmission for the predominant variants of SARS–CoV–2. Vaccines remain an important component of a multi-layered strategy to reduce the risk of serious illness and death from COVID-19.

Question #52

52. Do you recognize the negative health or economic ramifications of this vaccine mandate on federal workers?

Question #53

53. Did you ever consider the constitutionality of vaccine mandates before imposing them upon swaths of the federal workforce as well as those under your purview?

Question #54

54. Did you express any concerns to President Biden and other agency heads regarding vaccine mandates?

Answers to #52-#54
Please refer to the OMB Executive Order on Moving Beyond COVID-19 Vaccination Requirements for Federal Workers[14].

[14] https://www.whitehouse.gov/briefing-room/presidential-actions/2023/05/09/executive-order-on-moving-beyond-covid-19-vaccination-requirements-for-federal-workers/#:~:text=Considering%20this%20progress%2C%20and%20based,safety%20protocols%20for%20Federal%20contractors.

Question #55

55. Private health insurance is associated with superior health access and outcomes compared to Medicaid. What is the administration doing to ensure that patients who are not eligible for Medicaid have access to affordable private health insurance?

Answer:

CMS aims to ensure that as many people as possible maintain a source of coverage as states unwind from the Families First Coronavirus Response Act Medicaid continuous enrollment condition. When an individual is found to be ineligible for Medicaid and CHIP at application, renewal, or following a change in circumstances, state Medicaid and CHIP agencies send account information to the Marketplace. Following receipt of information about an individual that has been determined ineligible for Medicaid or CHIP, Marketplaces on the Federal platform reach out to the individual and invite them to apply for coverage at the Marketplace. This account transfer process is particularly important during states' unwinding periods as it will serve to help make potentially eligible consumers aware that quality affordable coverage may be available to them through the Marketplace, and what steps they need to take.

We also have a robust plan in place to reach people with Medicaid coverage so that they are aware of the steps they need to take to maintain their Medicaid or CHIP coverage, or, if no longer eligible for Medicaid or CHIP, to smoothly transition to the other forms of coverage for which they might be eligible, such as Marketplace coverage. This plan includes new policy and operational flexibilities, such as a temporary Exceptional Circumstances Special Enrollment Period (SEP) available through HealthCare.gov for qualified individuals and their families who lose Medicaid or CHIP coverage following the end of the continuous enrollment condition; multi-pronged, large-scale national and local outreach and stakeholder engagement efforts; and investments and innovations in enrollment assistance.

More than 16.3 million people selected an ACA Marketplace health plan nationwide during the OEP that ran from November 1, 2022-January 15, 2023 for most Marketplaces. More Americans signed up for high-quality, affordable health insurance during the 2023 Marketplace OEP than ever before, and millions of working families saved an average of $800 on their health insurance premiums last year due to the expanded premium tax credits extended in the Inflation Reduction Act. Total plan selections include 3.6 million people (22% of total) who are new to the Marketplaces for 2023, and 12.7 million people (78% of total) who had active 2022 coverage and made a plan selection for 2023 coverage or were automatically re-enrolled. Over 1.8 million more people have signed up for health insurance, or a 13% increase, from this time last year. The 3.6 million plan selections from people who are new to the Marketplaces represent a 21% increase in new-to-Marketplace plan selections over last year.

This year, individuals benefited from a highly competitive Marketplace. Ninety-two percent of HealthCare.gov enrollees had access to options from three or more insurance companies when they shopped for plans. Also, new standardized plan options were available in 2023 through HealthCare.gov, which helped consumers compare and select plans.

To build on this success, the FY 2024 budget invests in making private insurance even more affordable. The FY 2024 budget permanently extends the enhanced premium tax credits that were extended through 2025 in the Inflation Reduction Act. The budget provides Medicaid-like coverage to low-income individuals living in states that have not expanded Medicaid under the ACA, paired with financial incentives to ensure States maintain their existing expansions. The budget builds on the No Surprises Act to extend consumer surprise billing protections to ground ambulances. In addition, the budget extends the $35 cap per monthly insulin product, already in place for Medicare beneficiaries under the Inflation Reduction Act, to consumers with group and individual market coverage.

Rep. Suzanne Bonamici (D-OR)

Question #56

56. The proliferation of fentanyl and other synthetic opioids among teenagers continues to have disastrous consequences around the nation. Two years ago, the Beaverton School District in NW Oregon developed "Fake and Fatal: One Pill Can Kill," an education and awareness campaign to teach students about the dangers of fentanyl. The school district also made Naloxone available in all secondary schools to reverse the effects of drug overdoses. Since the implementation of both policies, not one student in Beaverton schools has lost their life to a fentanyl overdose. This successful effort was made possible by coordination among the school district and local nonprofits, public health officials and organizations, and practitioners proficient in evidence-based solutions to the crisis of opioid abuse and misuse.
    a. How is HHS leveraging its resources through SAMHSA, CDC, and NIH to mitigate the effects of opioid abuse and misuse among youth, and how can Congress support the ability of HHS to forge stronger relationships with the Department of Education to make solving this urgent crisis a priority?

Answer:
Adolescents develop a stronger sense of self, have a greater need for independence, and form important relationships with peers and people other than their parents.[15] During this stage, adolescents increasingly engage in risk-taking behaviors, including substance use. Negative relationships with family and an unsafe home environment can increase risk-taking and
substance use in adolescents.[16] Given these unique factors, substance use prevention and treatment for teenagers is a crucial part of SAMHSA's mission.

SAMHSA's national youth substance use prevention campaign - "Talk. They Hear You." – helps parents and caregivers, educators, and community members get informed, be prepared, and take action to prevent underage substance use. The aims to reduce underage substance use among youths under the age of 21 by providing

[15] Silvers, J. A., Squeglia, L. M., Rømer Thomsen, K., Hudson, K. A., & Feldstein Ewing, S. W. (2019). Hunting for what works: Adolescents in addiction treatment. Alcoholism: Clinical and Experimental Research, 43(4), 578-592.
[16] Otten, R., Mun, C. J., Shaw, D. S., Wilson, M. N., & Dishion, T. J. (2019). A developmental cascade model for early adolescent-onset substance use: the role of early childhood stress. Addiction, 114(2), 326-334. https://doi.org/https://doi.org/10.1111/add.14452

parents and caregivers with information and resources they need to address these issues with their children early and often.

While Medications for Opioid Use Disorder (MOUD) have been shown to be a safe and effective treatment for youth, access to MOUD for adolescents and young adults remains low. To enhance access to MOUD for youth who need it, adolescent health care providers must have the ability to prescribe these medications and must also have access to the latest resources and training to be able to prescribe MOUD safely and effectively. SAMHSA's Preventing Youth Overdose: Treatment, Recovery, Education Awareness and Training (PYO-TREAT) was a new grant program in FY 2023 that aims to increase access MOUD for adolescents and young adults and to train healthcare providers on the safe prescribing of MOUD.

The program aims for healthcare providers and other entities to create SUD treatment and prevention programs that include the appropriate use of MOUD for adolescents and young adults. SAMHSA intends to advance the goal of increasing integrated behavioral health access to children, youth, and families by allocating funding for FY 2023 to support the Youth Prevention and Recovery Initiative for Adolescents and Young Adults Program. The PYO TREAT new awards will address the overdose crisis that continues to endanger adolescents and young adults and has led to numerous preventable deaths.

In September of 2023, the Centers for Disease Control and Prevention (CDC) announced the new iteration of the Overdose Data to Action (OD2A) award to states and localities to expand harm reduction strategies, link people to life-saving care, and make the latest data available so that we can get ahead of the constantly evolving drug overdose crisis. For the first time, in addition to funding state health departments to prevent drug overdose, CDC has provided funding to directly support city, county, and territorial health departments, to help with collecting and using data to inform action, engaging with people with lived experience, and addressing health disparities. Funded recipients will be able to respond quickly and more equitably to the needs of their community, using and translating data to drive action that reduces overdose deaths and related harms in communities as fast as possible.

OD2A recipients use data to identify trends, gaps, and high-priority populations to focus targeted prevention activities. In many jurisdictions this includes a focus on adolescents at risk for overdose. For example, the OD2A jurisdiction in Riverside, California implemented youth overdose prevention training that addresses stigma surrounding opioid, overdose, help-seeking/treatment, and naloxone. They also piloted a youth-based curriculum package for overdose prevention and developed messages for those who use illicit drugs about fentanyl in the drug supply and harm reduction strategies.

Additionally, the Drug Free Communities (DFC) program, administered by the White House Office of National Drug Control Policy (ONDCP), and managed through a partnership between ONDCP and CDC, provides grants to community coalitions to strengthen the infrastructure among local partners to create and sustain a reduction in local youth substance use. The DFC program is aimed at mobilizing community leaders to identify and respond to the drug problems unique to their community and change local community environmental conditions tied to substance use. Currently, 750 community coalitions across the country receive funding up to $125,000 per year to strengthen collaboration among local partners and create an infrastructure that reduces youth substance use.

In 2023 ONDCP, CDC and NIH participated in a Department of Education (National Center on Safe and Supportive Learning Environments) webinars for educators concerning fentanyl and use of overdose reversal medicines called "Knowing the Facts About Fentanyl". This type of activity was helpful to orient school

personnel to the problem of pressed pills and the need for naloxone. Because many schools -- either because of school policy or state law -- forbid students to have any form of medicine on their person while on campus, schools could use financial support to provide overdose reversal medications to designated school staff so youth may have access to it in the event of an overdose on campus.

Question #57

57. Many Head Start programs are facing staffing challenges because of low compensation and direct workforce competition from other early childhood programs and other industries. Directors are continuing to recruit and train staff but are also working to change the scope of their grants, which may include converting Head Start slots to Early Head Start or reducing the number of children served. Change-in-scope applications are time-consuming and can take months to be resolved with the Office of Head Start. With summer being an essential time for planning for the upcoming program year, Head Start directors are eager to know the composition of the programs they will be running in the fall.
    a. What steps is the Office of Head Start taking to quickly resolve the large number of change-of-scope applications that are currently awaiting resolution?

Answer:

The Office of Head Start (OHS) is committed to partnering with grant recipients to expedite the process for Change in Scope applications. On July 25, 2023, OHS hosted a webinar to discuss Change in Scope application considerations and what to expect during the process for grant recipients, designed to help recipients strengthen their applications with the goal of shortening the approval process timeline. OHS also discussed common challenges, tips, and resources to aid grant recipients in submitting more complete and effective applications.

Since the date of the hearing, OHS has significantly expanded its capacity for processing Change in Scope applications, and will continue to process requests as quickly as possible. There are 251 actively pending Change in Scope requests, down from 443 requests as of the date of the hearing, with 70% of active requests pending under 180 days.

Question #58

58. The Preschool Development Grants Birth through Five (PDG B-5) program – which your agency recently awarded to 42 states – allows states to create more effective, efficient programs by collaborating across multiple systems and agencies. The PDG B-5 grants encourage states to focus on five major activities, including aligning existing programs, maximizing parental choice, building on the success of existing programs, fostering partnerships among stakeholders, and leveraging data for continued improvement.
    a. What progress have we seen in states that participate in the Preschool Development Grant Birth through Five program?

Answer:
The 42 PDG B-5 grant recipients are advancing stronger state early childhood systems by improving partnerships, collaboration, and coordination among existing birth through age five (B-5) programs and services focusing on advancing priorities based on state needs. With strengthened early childhood systems, states can leverage private, local, state, and federal funding and other resources to increase the quality of, and access to, early care and education (ECE), maximize parental choice and meaningful family engagement, improve and sustain quality in early childhood programs, support the ECE workforce, and improve state infrastructure to sustain system improvements. Examples from prior PDG B-5 recipients' efforts include:

- To support program alignment and improve the efficiency and effectiveness of the ECE system at the state level, Missouri transitioned 20 state programs serving children and families or providing professional development to providers into the Office of Childhood. By developing a cross-sector collaborative Early Childhood Career and Professional Development Network, Arizona increased collaboration among the many training and technical assistance programs and agencies across the state and improved their overall professional development system. Louisiana used PDG B-5 to expand community-based Ready Start Networks, which measure quality and coordinate enrollment across early childhood programs.

- To maximize parental choice and family engagement, the Connecticut Office of Early Childhood created its first Parent Cabinet, a diverse, parent-led advisory group that works directly with the state agency to improve child care, home visiting, licensing, and early intervention programs. To support families and connect them to the resources they need, North Carolina incorporated its Family Engagement and Leadership Framework throughout state and local early childhood education agencies, governance, and advisory bodies.

- To build on success of existing programs and expand access to high-quality ECE, Wyoming awarded infant-toddler sub-grants to improve the state's supply and quality of infant and toddler care and education. Rhode Island supported Health Equity Zones (HEZs), integrating funding from up to 20 sources to offer a range of services and programs to children and families living in that zone. HEZs use PDG B-5 funds to offer family navigators who use their extensive knowledge to support families and connect them with programs and services that meet their unique needs.

- To foster partnerships among stakeholders, Illinois enhanced an aligned, cross-systems approach for the infant and early childhood mental health consultant workforce serving child care, early intervention, preschool, and home visiting programs. Through PDG B-5 efforts, New Mexico was able to build and strengthen relationships between Housing Authority leadership and staff, and early childhood home visitors, case managers, and families receiving services.

- To better leverage data for continued improvement, South Carolina is developing a longitudinal data system that connects early childhood and K–12 data. Through PDG B-5, Kansas analyzed six years of historical, integrated

data on early childhood services funded by the Children's Cabinet to determine whether those services prevented foster care placement during the same period.

Question #59

59. The Low-Income Heating and Energy Assistance Program (LIHEAP) provides federally funded assistance in managing costs associated with home energy bills, energy crises, weatherization, and energy-related minor home repairs. The President's proposed budget would allow LIHEAP grantees to use up to 2.7 percent of their FY 2024 LIHEAP funds to assist low-income households with their water and wastewater utility bills. In my home state, Oregon Housing and Community Services worked effectively with Community Action Teams to deliver resources to Oregonians who needed assistance with their water bill during the pandemic. Despite the effectiveness of this program, it will end – but many people are still struggling with their water bills, especially in the rural communities I represent.
    a. How has the Low-Income Household Water Assistance Program (LIHWAP) been successful, and why did the Department propose to continue allowing funding to support low-income people with their water and wastewater utility bills in their FY24 budget?

Answer:

Since 2021, LIHWAP has helped households with low income with their water and wastewater bills. LIHWAP ensures water access by restoring services for households that have been disconnected, preventing service disconnections, and reducing rates so that households can maintain the continuous service that is critical for health and safety.

As of June 30th, 2023, LIHWAP has served over 1 million households across the country. LIHWAP funding has been used to:

- Reconnect water and wastewater services 84,514 times.
- Pay 565,273 past due bills for families and individuals with low incomes, preventing water shutoff.
- Reduce 486,628 household water bills.

In FY21 and FY22, LIHWAP served households with an average benefit of $415, weighted by number of services provided by comparing service amounts to benefits spent. Additionally, LIHWAP grant recipients have formed over 14,000 partnerships with water utilities across the county. Some of those utility providers are working to establish on-going assistance programs with local or state funding.

Many grant recipients have expended all or nearly all of their entire LIHWAP award. This includes North Carolina who has expended 99% of their award and served over 94,000 households. Another example is in the state of Kentucky. Kentucky received over $18 million in LIHWAP funding and exhausted all funding within seven months. The program restored water for 2,121 households, prevented 23,365 disconnections and provided a rate reduction for 19,322 households. LIHWAP was authorized as a temporary emergency program during the public health emergency, but continuous access to water and wastewater services is not

a temporary need. Research estimates that over two million people in the U.S. live without access to running water and basic indoor plumbing. In 2016, 1 in 20 households were disconnected from water services because of nonpayment, and in some cities, as many as 1 in 5 were disconnected. We know there are many people across the country who need the vital support that LIHWAP offers. Based on a calculation from 2021 American Community Survey 1-year estimates, there are 2,276,694 individuals with income below 150% poverty level that would be eligible annually for LIHWAP. LIHWAP grant recipient annual reports for fiscal year 2022 showed benefits went to households that need them the most; 55% of households served had vulnerable population members, 53% of households had incomes at or below 75% of the Federal Poverty Level.

Research also indicates that the cost of water is continuing to rise. The average residential water bill has increased almost 50% since 2010, and water rates are increasing at a rate that outpaces other utilities, including electricity and gas.

The need for ongoing LIHWAP funding has also been echoed by our grant recipients who administer the program at the state, tribal, and territorial level.

Additional information regarding how funds have been utilized can be found on the LIHWAP data dashboard. The Department has also highlighted the success of the program through spotlight videos which can be viewed on the OCS LIHWAP webpage.

Question #60

60. According to the 2021 report, GAO-21-540, from the Government Accountability Office (GAO), "about 1 in 10 young adults and 1 in 30 minors under age 18 experience homelessness without a parent or caregiver over the course of a year." As a Co-Chair of the Congressional Caucus on Homelessness, I want to emphasize that this is unacceptable.
    a. What has the Department done to implement the GAO's recommendations, and what has the Department done specifically to provide communities with additional information on strategies and promising practices for coordinating their programs on Continuum of Care (CoC) and Runaway and Homeless Youth (RHY)?
    b. How would the proposed FY24 budget combat homelessness among our nation's young people?
    c. Additionally, how does HHS focus on the disproportionate rates of LGBTQI+ young people and BIPOC youth experiencing homelessness?

Answer:
The Administration for Children and Families' (ACF) Family and Youth Services Bureau (FYSB) has convened several interagency meetings including with the Department of Housing and Urban Development (HUD) to strengthen its understanding of ways that communities address and serve the needs of unaccompanied minors experiencing homelessness, including the role of the Continuum of Care (CoC) program and other entities such

as Runaway and Homeless Youth (RHY) providers and child welfare agencies. These meetings have focused on identifying platforms to gather information and best practices across communities.

FYSB and HUD are working to identify programs that receive funding from both RHY and HUD's Youth Homelessness Demonstration Project (YHDP) or CoC programs, including programs that provide shelter or longer-term housing resources to youth under 18 years of age. This information will be used to better understand ways that organizations are leveraging funding across HUD and RHY resources and ways these organizations are serving minors experiencing homelessness. Information will be used to identify promising practices and share information across FYSB and HUD networks. Additionally, FYSB and HUD plan to host a joint webinar focused on ways communities and programs have leveraged RHY and HUD YHDP funds to prevent and respond to youth experiencing homelessness or housing instability.

FYSB has also engaged training and technical assistance providers in conducting listening sessions focused on support for minors experiencing homelessness or housing instability; identifying best practices from FYSB's RHY providers and HUD's YHDP grantees; educating youth services providers through national conferences; and other training opportunities. FYSB will continue to engage youth with lived expertise to help enhance services and improve outcomes for youth.

In addition, ACF is reviewing its 2014 Information Memorandum titled, *"Serving Youth Who Run Away from Foster Care"*[1] for potential updates. To support this work, in fall of 2023, FYSB and the Children's Bureau plan to conduct joint site visits in communities to discuss the roles and responsibilities of child welfare and RHY programs when youth and young adults experience homelessness or housing instability.

Further, FYSB participates in the Federal Regional Interagency Council on Homelessness (FRICH). FRICH meetings are also attended by HUD and several other federal agencies. FYSB has presented during FRICH convenings on ways the U.S. Department of Health and Human Services (HHS), HUD, and other federal agencies can coordinate and leverage existing resources to best support youth at risk of or currently experiencing homelessness or housing instability.

b. How would the proposed FY24 budget combat homelessness among our nation's young people?

Answer:
The FY 2024 President's Budget[2] request for the RHY program is $136.8 million, an increase of $11.5 million from the FY 2023 enacted level. These funds are estimated to support 562 awards, with an average award of $209,261 and a range of $70,000 to $350,000.

This additional funding will support the Whole Family Community-Based Demonstration project aimed at preventing and reducing youth homelessness, while also working to increase outcomes for youth and young adults experiencing or at risk of homelessness or housing instability. This human centric project will fund up to 20 grants to support organizations working with minors experiencing homelessness or housing instability. It will implement a whole-family, community-based prevention approach with the goal of supporting youth under 18 years of age to maintain safe and stable housing when appropriate or to seek alternative stability options to include connections to kinship support, caring adults, or other safe and stable housing. Grants will allow communities to create partnerships with schools, child welfare, youth justice systems, behavior health systems, housing and other youth systems to prevent youth homelessness. ACF will use this demonstration opportunity to identify effective strategies in preventing and stabilizing minors experiencing housing instability.

The funding will also support training and technical assistance and an evaluation component to support knowledge sharing and bridge a critical gap in services to improve whole-family, community-based prevention services. The budget includes legislative proposals to reauthorize and revise the Runaway and Homeless Youth Act (RHY Act) through 2026. In particular, the budget proposes to amend definitions and authorities to reflect current terminology and support youth at risk or victims of commercial sexual exploitation and human trafficking.

c. Additionally, how does HHS focus on the disproportionate rates of LGBTQI+ young people and BIPOC youth experiencing homelessness?

Answer:
Through FYSB, HHS continues to seek ways incorporate the voices of homeless youth. This includes continued coordination with the Runaway and Homeless Youth Training Technical Assistance and Capacity Building Center (RHYTTAC) and the National Runaway Safeline youth advisory boards to seek input from LGBTQIA2S+ youth on how to improve service delivery to better meet the needs of youth. RHYTTAC has developed a tip sheet that provides tools and resources for programs to implement to ensure that services comply with nondiscrimination requirements, are informed by the specific challenges faced by youth experiencing homelessness who identify as LGBTQIA2S+, and affirm the strengths and address the needs of the youth they serve.

Existing federal law and regulation establish non-discrimination requirements that apply to all RHY grant recipients. RHY's Final Rule (RHY Rule) (45 CFR Part 1351) reflects existing statutory requirements in the RHY Act and changes made via the Reconnecting Homeless Youth Act of 2008. Specifically, the RHY Rule established (1) non-discrimination protections for youth and young adults seeking to access RHY services, (2) expectations that RHY grant recipients implement non-discrimination and culturally and linguistically sensitive services and training, (3) expectations that services have a positive youth development approach, and (4) a specific ban on the use of RHY funding to support "treatment or referral to treatment that aims to change someone's sexual orientation, gender identity or gender expression." In addition, the RHY Rule developed program performance standards for RHY grant recipients providing services to youth and their families to be used as measures for successful outcomes and that the "standards […] be responsive to the complex social identities,"[3] such as the gender identity/expression and sexual orientation, of RHY clients.

While RHY grant recipients have the flexibility to serve specific populations of youth based on identified need, they must also have a plan to provide clear support in linking youth who do not meet the organization's eligibility criteria to a service which can accept the youth. For example, some Maternity Group Home recipients design specialized programs for pregnant and parenting youth and/or young adult females. These organizations must have a plan to support not only young men who are parents and experiencing homelessness, but also youth and young adults who identify as LGBTQIA2S+ who are experiencing homelessness and parenting.

Further, FYSB is finalizing an Information Memorandum (IM) to be disseminated to FYSB RHY Program Grant Recipients. This IM will reiterate program policy and offer practical strategies for how to best meet the needs of youth and young adults experiencing homelessness who identify as LGBTQIA2+.

Question 61

61. I'm very concerned about the shortage of behavioral health workers and the barriers that exist in recruiting and retaining a diverse and qualified behavioral health workforce. I am encouraged that HHS operates several loan repayment programs (LRPs) through HRSA's National Health Service Corps (NHSC), including the Substance Use Disorder Workforce LRP, NHSC LRP, Rural Community LRP, and Substance Use Disorder Treatment and Recovery (STAR) LRP. Despite these programs, I continue to hear from practitioners and providers that high student debt burdens are a prohibitive factor for graduates seeking to enter behavioral health professions.
    a. What more is HHS doing to expand access to these loan repayment programs and create opportunities for diverse, underrepresented students to pursue careers in the behavioral health workforce?

Answer:
In FY 2022, the National Health Service Corps (NHSC) provided scholarships and loan repayment assistance to more than 9,600 participants providing direct behavioral health services in communities identified as Health Professional Shortage Areas (HPSA), and more than a third of these providers were providing services in rural communities. The NHSC is not only an important recruitment tool for rural and underserved communities, but also is instrumental to keeping these providers in communities. Approximately 87 percent of NHSC clinicians who completed their service obligation between FY 2012 and FY 2021 still work in a HPSA or within the same community they served.

The President's Budget requests $965.6 million to extend and increase mandatory funding for the NHSC through FY 2026, which would allow the program to sustain its historic FY 2022 field strength levels of more than 20,000 clinicians serving in the field, along with another 3,500 in school or residency training to serve areas of greatest need. The request includes a total increase of $50 million in discretionary funding for loan repayment for behavioral health providers, including peer support specialists in crisis centers and clinicians providing opioid and other substance use disorder treatment.

The Substance Use Disorder Treatment and Recovery (STAR) Loan Repayment Program provides loan repayment for individuals working in a full-time substance use disorder treatment job that involves direct patient care in a community where the mean overdose death rate exceeds the national average or a Mental Health HPSA. The demand for this program has been great. In FY 2022, HRSA was able to make only 208 awards from over 2,600 eligible applications with the funding available. The FY 2024 President's Budget request would sustain the increase in funding Congress realized in FY 2023 to support the program's potential as a tool to expand our response to the substance use disorder crisis. The President's Budget also proposes extending the tax-exempt status that is provided to NHSC Program recipients to similar workforce programs operated by HRSA, including the STAR Loan Repayment Program. The savings generated from this proposal would allow HRSA to make additional awards to grow and expand the behavioral health workforce.

Answer:
SAMHSA aims to increase the diversity in the behavioral health workforce through the Minority Fellowship Program, which provides stipends to increase the number of culturally competent behavioral health professionals who teach, administer, conduct services research, and provide direct mental illness or substance use disorder treatment services for minority populations that are underserved. Since its start in 1973, the program has helped to enhance services for racial and ethnic minority communities through specialized training of mental health professionals in psychiatry, nursing, social work, marriage and family therapy, mental health counseling, psychology; substance use/addiction counseling, marriage and family therapists and professional counselors. In

FY 2023, SAMHSA added addiction medicine as a component of the MFP. This program is jointly administered by SAMHSA's Center for Substance Use Services (CSUS), the Center for Substance Use Prevention (CSUP), and the Center for Mental Health Services (CMHS) at SAMHSA. Combined, this program will support fellowships for hundreds of students as well as support additional training through webinars on culturally appropriate services to thousands of students.

Question 62

62. No one should have to worry about whether they will receive needed elder care support and services because of their identity or who they love. In June of 2022, President Biden demonstrated his commitment to this principle by advancing an LGBTQ+ Long Term Care Bill of Rights to protect at-risk LGBTQ+ elders in long-term care settings by Executive Order.
    a. What's the status of the drafting process and when we should expect to see concrete next steps on the LGBTQ+ Long Term Care Bill of Rights?
    b. By what date will the protections be put into place so LGBTQ+ older people in long-term care settings will know that the federal government is committed to their health and well-being?

Answer:

The Biden-Harris Administration is committed to protecting and advancing the health and rights of LGBTQI+ people, including addressing discrimination, social isolation, and health disparities faced by LGBTQI+ older adults. You can find updated information about HHS's resources related to the health and wellbeing of LGBTQI+ individuals at https://www.hhs.gov/programs/topic-sites/lgbtqi/resources/index.html. This website includes information about HHS-funded programs through Services and Advocacy for GLBT Elders (SAGE).

The June 2022 Executive Order on Advancing Equality for Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex Individuals continues to expand the reach of this Administration's commitment to LGBTQI+ older adults and HHS is working diligently to finalize regulations cementing nondiscrimination on the basis of age. In a Notice of Proposed Rulemaking issued in August of 2022, both the Office for Civil Rights and the Centers for Medicare & Medicaid Services proposed strong regulations to protect LGBTQI+ older adults across federally funded health programs and activities, such as Programs of All-Inclusive Care for the Elderly. *See* 87 FR 47824, 47894 (August 4, 2022) (1557 NPRM). Such proposals will serve as the bedrock for continued development of guidance and resources.

Rep. Teresa Leger Fernandez (D-NM)

Question 63

63. As you may know, I attended Head Start as a child and, to this day, I'm a strong advocate of the program. With that in mind, I was thankful to see that President Biden included

$575 million for an increase in Head Start wages in his proposed budget for FY24. However, that only represents an increase of 4.8% which, if enacted, would still leave a significant difference between Head Start teacher wages and those earned by public school teachers. Question A

a) How does HHS/OHS plan to address that discrepancy?

Answer:
We are aware of the significant discrepancy between Head Start teacher wages and those earned by public school teachers. Supporting the Head Start workforce is one of OHS's top priorities . Since the 2007 reauthorization of the Head Start Act, the share of Head Start Preschool teachers with a bachelor's degree has steadily increased, but the inflation-adjusted salaries of those teachers *decreased* by 2 percent and the gap between Head Start teacher salaries and kindergarten teacher salaries is considerably wide ($35,000 and $65,000, respectively). Meanwhile, Head Start enrollment is at the lowest level in 30 years primarily due to empty classrooms that cannot open due to a lack of qualified staff. Additionally, the Head Start teacher turnover rate reached an all-time high of 22 percent in 2022, compared to 10 percent teacher turnover in public schools. For context, in 2022, 63 percent of Head Start education staff were people of color. These trends lay bare that the Head Start model has long relied on women—primarily women of color—being willing to accept very low wages because they believe in the Head Start mission. This too often comes at the expense of their own well-being; many staff in Head Start receive wages that leave their own families below the federal poverty threshold. In 2019, one in four Head Start teachers nationally worked in programs that paid an average teacher salary below the poverty threshold for a family of four. This is why OHS is committed to investing in our workforce. The FY 2024 President's Budget includes a request for $574.6 million to invest in Head Start staff compensation, as a down payment toward achieving pay parity between Head Start educators and elementary school teachers.

In the meantime, OHS has several ongoing initiatives and supports for grant recipients that address this priority. In November, HHS announced a new proposed rule to strengthen Head Start's ability to recruit and retain qualified staff, raise teacher wages, and provide consistent quality programming for the children and families they serve. The new proposed rule follows President Biden's April 2023 Executive Order, which directed HHS to develop strategies to encourage comparability of compensation and benefits between staff employed by Head Start grant recipients and elementary school teachers and make child care and Head Start more accessible for those families most in need. If finalized, the new proposed rule would raise Head Start teacher annual wages by more than $10,000 on average. And it will put Head Start teachers on a path to parity with public school teachers by ensuring that their salaries are at least equivalent to preschool teachers in public school settings without impacting children currently enrolled in Head Start.

Last year, OHS published two Information Memorandums (IM) calling for grant recipients to improve compensation in order to be competitive with elementary schools (Competitive Bonuses for the Head Start Workforce and Strategies to Stabilize the Head Start Workforce). This guidance encourages grant recipients to consider restructuring their programs as a sustainable mechanism for providing increased compensation and other necessary support to staff. This may include consolidating grants, restructuring management or organizations, or requesting a reduction in the overall number of funded slots while continuing to prioritize services to the children and families who are most in need. The guidance outlines several areas programs could reinvest freed up funds, including permanently increasing compensation, offering bonuses, and supporting career advancement opportunities.

In response, OHS has seen a significant increase in change in scope requests from programs that propose to reduce enrollment in order to increase staff compensation. Many of these programs are already under-enrolled, primarily due to the workforce shortage. These programs are restructuring to ensure they have a stable, high-quality workforce that is able to consistently meet the needs of the children and families in their communities.

Rep. Glenn "GT" Thompson (R-PA)

Question 64

64. In the 115th Congress, I was proud to champion the *Veterans E-Health and Telemedicine Support Act,* which allowed physicians at the Department of Veterans Affairs (VA) to treat veterans via telehealth across state lines. This simple fix greatly expanded access to care for our nation's veterans who could previously drive across state lines to see a VA physician but could not receive those services via telehealth. These services are particularly helpful in rural areas where the nearest in-person provider may be hours away. As you may know, there are certain specialties and practices in some states that allow providers to meet with patients via telehealth regardless of state boundaries.

Unfortunately, this patchwork of policies is not particularly effective, and it results in confusion and added layers of bureaucracy for patients and providers alike. How do you think we can build on the successful model at the VA to allow any physician to treat their patient via telehealth across state lines?

Answer:
In response to the COVID-19 public health emergency, which expired in May 2023, flexibilities for Medicare telehealth services were issued through legislative and regulatory authorities to increase access to care for patients and providers. The Consolidated Appropriations Act of 2023 recently extended many of these flexibilities through December 31, 2024. Extended telehealth flexibilities include waiving geographic and site of service originating site restrictions so that Medicare patients can continue to use telehealth services from their home and allowing audio-only telehealth services. Additionally, the expanded list of providers eligible to deliver telehealth services is also extended so Medicare beneficiaries can continue to receive telehealth services furnished by physical therapists, occupational therapists, speech language pathologists, and audiologists, as well as receive telehealth services from Rural Health Clinics and Federally Qualified Health Centers through December 31, 2024. If you are interested in drafting legislation to make these waivers permanent, CMS would be happy to provide technical assistance.

Additionally, recent legislative and regulatory changes made several telehealth flexibilities permanent. Federally Qualified Health Centers and Rural Health Clinics can furnish certain behavioral services via telecommunications technology. Medicare patients can continue to receive these telehealth services in their home as geographic restrictions on the originating site are eliminated for these telehealth services. Certain mental telehealth services can be delivered using audio-only communication platforms, and rural emergency hospitals can serve as an originating site for telehealth services.

With regard to furnishing services across state lines, CMS' longstanding policy for Medicare is to defer to state law with regard to licensure issues. This is a permanent policy that was not limited to the public health emergency for COVID-19. While CMS did issue a blanket waiver of requirements that out-of-state practitioners be licensed in the state where they are providing services when they are licensed in another state during the PHE when certain conditions were met, this was not specific to telehealth. This waiver also facilitated the ability of physicians and practitioners to travel to states to furnish in-person services in areas that were overwhelmed due to COVID-19.

The waiver of Medicare requirements that the practitioner be licensed in the state where services are furnished worked in tandem with state waivers of their licensure requirements to permit care to be furnished to Medicare patients across state lines, either in person or through telehealth. The waiver of Medicare requirements ended with the PHE, and Medicare regulations continue to defer to state law as to whether a practitioner is authorized to practice in a state.

Data about Medicare fee-for-service beneficiaries who used telehealth services between January 1, 2020 and September 30, 2022, and a Medicare telehealth trends report, are available at https://data.cms.gov/summary-statistics-on-use-and-payments/medicare-service-type-reports/medicare-telehealth-trends. The data will be updated quarterly.

For Medicaid and CHIP, telehealth flexibilities are not tied to the end of the PHE and have been offered by many state Medicaid programs long before the pandemic. Medicaid and CHIP telehealth policies will ultimately vary by state. CMS encourages states to continue to cover Medicaid and CHIP services when they are delivered via telehealth.

Rep. Gregorio Kilili Camacho Sablan (D-MP)

Question 65

65. As Medicaid unwinds due to the end of the COVID-19 public health emergency, most States have been able to mitigate the loss of coverage by directing people to the Exchange. However, my district and the other territories do not have access to the Exchange.
    a. What support can your Department offer in developing a strategy for the establishment of Exchanges in the U.S. territories?

Answer:
Section 1323 of the Affordable Care Act (ACA) provided the territories the option of establishing a Marketplace and allocated funding to each territory for premium and cost-sharing assistance. In March 2011, the Department of Health and Human Services (HHS) awarded federal grants, known as "Territory Establishment Grants," to each of the territories that elected to establish a Marketplace for a variety of Marketplace-related implementation activities, including background research (such as market analysis, development of projected enrollment figures, capacity-building for consumer assistance, etc.,) and initial consultation with interested parties. In July 2014, HHS issued letters to each of the territories to clarify the applicability of certain ACA provisions to health insurance issuers in the territories. Ultimately, none of the five U.S. territories found that the option to establish a Marketplace was feasible at the time and instead received the funding allocated under section 1323 of the ACA for premium and cost-sharing assistance in the form of federal Medicaid matching funds during the time period of 2014 to 2019. Specifically, American Samoa received a total of $16.5 million; Guam received a total of $24.4 million; the Commonwealth of the Northern Mariana Islands received a total of $9.1 million; Puerto Rico received a total of $925 million; and the U.S. Virgin Islands received a total of $24.9 million.

As HHS implements the changes enacted under the Consolidated Appropriations Act, 2023 (CAA, 2023), we are working to protect beneficiaries and ensure states and territories follow Medicaid eligibility redetermination

requirements as they return to normal enrollment and eligibility operations after the end of the Medicaid continuous enrollment condition under the Families First Coronavirus Response Act (FFCRA). HHS shares your commitment to preventing coverage losses for eligible individuals, and we are already working to ensure state compliance with these requirements.

To support implementation of the CAA, 2023's changes, CMS has worked expeditiously to provide guidance and ongoing technical assistance to states. As this dynamic work continues, CMS will continue to provide states with additional guidance and support in complying with unwinding-related requirements, including those enacted in the CAA, 2023.

Even before states started unwinding from the Medicaid continuous enrollment condition, CMS met one-on-one with every state and territorial Medicaid agency to complete an initial assessment of compliance with federal eligibility redetermination requirements. Where necessary, CMS supported the development and approval of states' mitigation plans to redress areas of noncompliance in a manner that mitigates adverse consequences for and protects beneficiaries. As part of these mitigation plans, CMS is directing some states to delay procedural terminations until the state is able to implement such mitigations. During each state's unwinding period, CMS is reviewing data, state activities, and other information to ensure that states are complying with federal eligibility renewal requirements, and stepping in where necessary. CMS is closely monitoring to ensure that states claiming the temporary FMAP increase comply with the applicable conditions under the FFCRA (as amended by the CAA, 2023).

In addition, CMS is using a multi-pronged outreach approach to reach as many individuals and families as possible during the Medicaid and CHIP renewal process, and to make sure they know where to turn if they or their children lose coverage. This includes national and local public engagement, paid advertising, media engagement, toolkits and materials, and direct-to-consumer communications. CMS has conducted targeted outreach on unwinding to populations of color and at regular meetings with American Indian/Alaska Native tribes and tribal organizations, as well as via targeted campaigns in Spanish and other languages. State renewal forms, notices, and the fair hearing materials must be provided in a format that is accessible to individuals who have limited English proficiency.

Regulations implementing Section 1557 of the Affordable Care Act, which prohibits discrimination on the grounds of race, color, national origin, sex, age or disability in certain health programs and activities, require health programs, including Medicaid and CHIP programs, that receive federal financial assistance to take reasonable steps to provide meaningful language access to individuals with limited English proficiency. Reasonable steps to provide meaningful language access may include translating documents written in English, such as notices pertaining to renewals and other eligibility actions during the unwinding period, by a qualified translator. Meaningful access may also require provision of oral language assistance from a qualified interpreter, either in-person or using remote communication technology (e.g., telephone, internet, or video).

States are responsible for ensuring that eligible individuals maintain their coverage, and that those who are found ineligible for Medicaid are transferred to other insurance affordability programs for which they may be eligible. HHS appreciates the significant effort many states have put into protecting coverage for eligible individuals and supporting transitions to other forms of health care coverage where necessary, and we continue to work with states as they evaluate and address challenges they face during their unwinding periods. At the same time, the enforcement authorities Congress added in the CAA, 2023 provide HHS with important tools to ensure that states comply with federal requirements during a period that generally aligns with states' unwinding periods, and we will not hesitate to use them.

Representative Susan Wild (D-PA)

Question 66

66. It was recently reported that call center workers at Maximus, one of the largest federal contractors for HHS, went on strike after the company announced surprise layoffs impacting over 700 workers. The workers impacted by the layoffs were customer service representatives who managed calls for millions of Americans reaching out with questions related to the Affordable Care Act and Medicare. The company attributed the layoffs to overstaffing; however, the company then recruited for many of these same positions at non-union organizing sites almost immediately after the layoffs were announced. In response to these surprise layoffs, the need for fairer wages, and the lack of career advancement opportunities, Maximus workers in four states went on their fourth strike.
    a. Secretary Becerra, does HHS intend to investigate Maximus' labor practices as it pertains to these seemingly unfair layoffs?
    b. If Maximus is found to have committed wrongdoing, how does HHS plan to remedy the harm done to laid-off workers and hold Maximus accountable?
    c. Will you call on Maximus to rehire laid-off workers?

Answer:
CMS values and respects the contribution of the call center representatives and strongly supports the right of workers to voice concerns about working conditions. Recently, CMS has worked with Maximus to improve the working conditions for their employees:

- Increased pay ahead of required Executive Orders and Department of Labor Wage Determinations. Pay was increased above $15 in September 2021 ahead of the Biden Executive Order that went into effect in January 2022. Increased wages again in January 2023, in accordance with new Department of Labor wage determinations.
- Improved the health insurance options available to employees. In February 2022, Maximus offered health plans with lower deductibles for both employee-only and family coverage plans, reducing the total out of pocket costs for employees.
- Increased the amount of sick leave as a result of the CARES ACT and then increased the amount of paid sick leave, in accordance with recent Executive Orders
- Found positions on other contracts to transition workers that were laid-off as a result of our annual ramp down after Open Enrollment.

The call center annually must staff up to support increased call volumes for Open Enrollment for both Medicare and the Marketplace. To have the appropriate staffing to handle lower call volumes for the non-open enrollment period, the call center had to ramp down approximately 700 representatives that support Marketplace and Medicare to ensure appropriate staffing for the remainder of the year, until it begins to ramp up again for the next annual enrollment periods. Due to the nature of this work and to ensure the most efficient usage of Government resources and funding, this is a common challenge that the contractor has to manage.

Because Maximus Federal has other contracts with both state and federal call centers, they were able to offer employment on other contracts to those staff. This is not a requirement of the contract, but a benefit of

contracting with a vendor who has other state and federal work. Eligible staff did receive severance as well as opportunities to transition to other programs where positions may be available, and will be considered when additional staff is required in the future to support the annual enrollment period.

CMS recognizes the invaluable contribution of the thousands of call center representatives who ensure that those with Medicare or Marketplace questions receive accurate, high-quality information. One of CMS's top priorities is providing excellent customer service to people with Medicare and to Marketplace consumers as they navigate these programs.