abortion. Simultaneously, it is within your authority to strengthen the workforce and increase training for providers. What is HHS's plan to increase the number of providers with the necessary skills to deliver appropriate care?

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

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

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

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

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

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

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

Response:

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

Senator Manchin

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

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

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

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

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

- The National Health Service Corps (NHSC) increases access to care in underserved areas by supporting qualified health care providers dedicated to working in underserved communities. The NHSC received supplemental funds through the American Rescue Plan Act to support the nation's COVID-19 response and to help address primary care provider need. In FY 2021, there were 242 NHSC clinicians serving in West

Virginia.[16][17]

- The Primary Care Training and Enhancement - Physician Assistant Rural Training (PCTE-PAR) Program develops and implements longitudinal clinical rotations in primary care in rural areas. The program also supports the training and development of preceptors in rural areas. In Fiscal Year (FY) 2022, West Virginia University and Marshall University were awarded PCTE-PAR Program grants.

- The Nurse Corps Program received supplemental funds through the American Rescue Plan Act to support our Nation's COVID-19 response and to help address nursing staffing. In FY 2021, Nurse Corps awarded three nursing scholarships in West Virginia and 14 Nurse Corps loan repayment awards.

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

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

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

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

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

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

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

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

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

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

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

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

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

Additionally, SAMHSA has state level programs that also include services for youth. SAMHSA's State Opioid Response (SOR) program provides resources to states and territories, to continue and enhance the development of comprehensive strategies focused upon preventing, intervening in, and promoting recovery from issues related to opioid use, and increasingly stimulant use. The Tribal

Opioid Response (TOR) program provides dedicated resources to perform these activities in Tribal communities. Both programs aim to address the overdose crisis by increasing access to the three FDA-approved medications for the treatment of OUD, reducing unmet treatment need, and reducing opioid-related overdose deaths through the provision of prevention, harm reduction, treatment, and recovery support for OUD (including prescription opioids, heroin and illicit fentanyl and fentanyl analogs) and stimulant use disorder as so elected by states.

A key component of SOR/TOR grantees' substance use prevention strategy is the implementation of Evidence Based Practices (EBPs). For prevention, EBPs are approaches and strategies shown to be effective in reducing the impact of social and population-based substance use concerns. Examples of EBPs that SOR grantees are implementing include Botvin Life Skills Training; Strengthening Families Program for Parents and Youth ages 10-14; Project Success; and Sources of Strength, Positive Action. All of these strategies focus on preventing the initiation of substance use for at-risk youth. SOR grantees also use funds to support interventions through Teen Courts, Recovery High Schools, Peer Mentor Programs, and Clubhouses. Between FY20 and FY21, approximately 7% of individuals receiving treatment and recovery support services with SOR funds were under the age of 24 at the time-of-service delivery.

The Substance Abuse Prevention and Treatment Block Grant (SABG) Program provides funds to all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, 6 Pacific jurisdictions, and 1 tribal entity to prevent SUD, provide treatment and promote recovery for those with SUD. Under the SABG program, grantees have the discretion to identify adolescents with SUDs and/or mental health disorders and children/youth at risk for behavioral health disorders as priority populations. Between FY2018- FY2021, the SABG program served 330,192 clients ages 17 and under and 729,024 clients ages 18-24.

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

The National Institute on Drug Abuse (NIDA), part of the NIH, supports research to understand and address substance use and its consequences across the lifespan, including among vulnerable children and adolescents. Research findings indicate that substance use and other drug-related harms are more likely to occur in the presence of specific risk factors, such as adverse social determinants of health, and less likely to occur among certain protective factors, like healthy family and peer relationships and financial stability. Prospective, longitudinal studies like the HEALthy

Brain and Child Development (HBCD)[18] and the Adolescent Brain Cognitive Development® (ABCD)[19] studies will help us better understand the specific brain, cognitive, social, and emotional factors that underlie healthy and unhealthy development from the prenatal period through young adulthood. These studies will contribute immeasurably to future substance use prevention strategies.

Because most opioid and other substance misuse begins during adolescence and young adulthood, this is a critical period for prevention. Older adolescents and young adults are at the highest risk for initiation of opioid use, opioid misuse, opioid use disorder (OUD), and death from overdose, and there is a need for evidence-based interventions to prevent OUD. With funding from the Helping to End Addiction Long-term® Initiative (NIH HEAL Initiative®), NIDA leads studies on effective strategies to identify and reach at-risk individuals in various settings, such as schools, health care, justice, and child welfare systems. For example, one study is testing a video game opioid use prevention intervention for older teens in school-based health centers (UH3DA050251-03)[20]. Another study utilizes a convenient smartphone application to engage high-risk youth in a mindfulness-based intervention to help them reduce or quit their substance use (UH3DA050189-03)[21]. Other NIDA-supported studies are aimed at improving the uptake and reach of existing evidence-based prevention interventions across settings, developing tailored approaches for diverse populations, and improving our understanding of the mechanisms of action for effective prevention approaches. NIDA also supports research to expand effective screening approaches for pregnant and postpartum women and school-age children in health care settings (NOT-OD-22-106[22] and NOT-OD-22-107[23]) and, through its NIDAMED initiative, translates research findings into evidence-based resources and tools for clinicians to screen for problematic substance use (Screening for Substance Use in the Pediatric/Adolescent Medicine Setting)[24].

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

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

[18] https://heal.nih.gov/research/infants-and-children/healthy-brain
[19] https://heal.nih.gov/research/infants-and-children/healthy-brain
[20] https://reporter.nih.gov/search/q7GOLosA3kSsoyk3nLnCtQ/project-details/10408897
[21] https://reporter.nih.gov/search/q16mokkSqkSYJFFKEUseMA/project-details/10441666
[22] https://grants.nih.gov/grants/guide/notice-files/NOT-OD-22-106.html
[23] https://grants.nih.gov/grants/guide/notice-files/NOT-OD-22-107.html
[24] https://nida.nih.gov/nidamed-medical-health-professionals/science-to-medicine/screening-substance-use/in-pediatric-adolescent-medicine-setting

forgo treatment all together, all so PBMs can receive rebates from the manufacturers.

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

b. **Are you monitoring this issue?**

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

Response to #3:
We are aware of the practices of pharmacy benefit managers under the 340B Drug Pricing Program (340B Program) that you reference. While there is no statutory provision in the 340B statute prohibiting the pharmacy benefit management programs from utilizing this approach, these practices are counter to the intent of the Program, which allows safety net providers to stretch scarce Federal resources and ensure that the safety net has access to discounted drugs for its patients. By pursuing this policy, pharmacy benefit management programs may make it cost prohibitive for certain covered entities to participate in the 340B Program and reduce services to their patients. We look forward to working with you on this issue and to continue to support the important work of the 340B program.

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

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

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

1. "Know Your Rights: Parity for Mental Health and Substance Use Disorder Benefits," an updated trifold pamphlet explaining mental health parity, detailing what it means to the

consumer, and listing the protections the parity law provides.

2. "Understanding Parity: A Guide to Resources for Families and Caregivers," which provides an overview of parity geared toward parents, family members or caregivers with information and tools to help them obtain behavioral health services for children or family members in their care.
3. "The Essential Aspects of Parity: A Training Tool for Policymakers," which provides state regulators and behavioral health staff an overview of mental health and substance use disorder parity and how to implement and comply with the federal parity law regarding employee-sponsored health plans and group and individual health insurance.

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

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

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

Senator Blunt

Title 42

1. Has the Department of Health and Human Services been asked to provide or provided any vaccines to the Department of Homeland Security for efforts to vaccinate illegal immigrants at the Southern border?
    i. **If yes, how many?**

Response:
No.

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

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

2. On March 30, 2022, DHS released a Fact Sheet entitled DHS Preparations for a Potential Increase in Migration. It states that "DHS has also been providing the COVID-19 vaccines to noncitizens in ICE custody since summer 2021." It goes on to state that "Beginning March 28, 2022, DHS expanded those efforts to cover migrants in CBP custody, so as to further safeguard public health and ensure the safety of border communities, the workforce, and migrants." What role is HHS playing in this decision?

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

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

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

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

    i. **What are the costs associated with their deployment?**

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

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

Response:

- USPHS deployed a flag officer, RADM Richard Childs, as the officer in charge of Operation Artemis, due to the significance of the operation and to ensure dedicated leadership personnel
- Officers provided administrative support, facility and engineering support, and clinical support on these deployments. Clinical support included: COVID-testing, nursing case management, COVID vaccination administration, general clinical evaluation and care, pharmacological management, infectious disease support, behavioral health management, and clinical coordination of services across multiple agencies for unaccompanied children and their families.
- Some of the roles in which officers were deployed to support these missions included: Incident Commander, Site Lead, Chief Medical Officer, Chief Nurse Officer, Safety Officer, Force Health Protection, Nurse/ Medical/ Quality Control/ Engineering/ Pharmacy/ Mental Health Officers to name the most common.

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

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

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

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

Aduhelm Decision

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

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

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

Response:
The agency is committed to using expedited programs to bring medicines to underserved populations with serious conditions and unmet medical need when the science supports the decision within the statutory authorities given to FDA by Congress. Our decision regarding Aduhelm exemplifies that commitment. It is important to distinguish between FDA's and CMS' role. The standard for Medicare coverage is not the same as the standards for FDA approval of a drug. Our role is to determine if drug is safe and effective. The agency cannot speak for CMS. We continue to see sponsors pursue accelerated approval.

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

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

The work of both agencies is critical to ensure that medical products are available to people across the

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

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

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

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

Supply Chain

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

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

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

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

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

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

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

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

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

COVID-19 Education Campaign

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

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

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

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

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

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

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

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

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

In addressing rural audiences, the campaign has focused on the more than 46 million Americans who live in "micropolitan" or "noncore" counties according to the National Center for Health Statistics 2013 Urban-Rural classification scheme. On a monthly basis, the campaign has identified heavy-up markets for additional local media purchases, and concentrations of population in the media market that reside in rural counties has been a factor when determining audiences.

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

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

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

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

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

Response:

FY20

Local Radio:	$ 8,512,770
FY20 Total:	$ 8,512,770

FY20 - Funding source

1) IAA with the CDC funded by CARES Act appropriation to CDC, [redacted]P.L. 116-136, 134 Stat. 281, 554-55.

FY21

Local Newspapers:	$ 11,136,940
Local Radio:	$ 14, 526,430
Local Television:	$ 4,428,756
FY21 Total:	**$ 30,092,126**

FY21 - Funding source

1) CARES Act appropriation to CDC, [redacted]P.L. 116-136, 134 Stat. 281, 554-55.
2) American Rescue Plan (ARP) P.L. 117-002

FY22

Local Newspapers:	$ 7,482,218
Local Radio:	$ 14,916,933
Local Television:	$ 11,082,786
FY22 Total:	**$ 33,481,938**

FY22 - Funding source

1) CARES Act appropriation to CDC, CARES Act, div. B, title VIII, P.L. 116-136, 134 Stat. 281, 554-55.
2) American Rescue Plan (ARP) P.L. 117-002

HRSA Poison Control

1. I remain concerned that the Department has failed to address the issue of misdirected calls to poison control centers, as required under the Poison Center Enhancement Act that passed in 2019 as part of the FY2020 appropriations bill. It is my understanding that poison centers in 12 states and the District of Columbia have more than ten percent of their calls misrouted to the wrong poison center. Critical medical treatment can be delayed when this occurs.

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

Response:

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

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

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

COVID-19 Commercialization

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

Response:

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

COVID-19 Tests

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

Response:

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

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

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

Response:

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

3. As of May 4, testing companies have not received additional volume commitments, but have been provided guidance from the Department to ramp up to maximum capacity. Will these

domestic manufacturers receive a concrete order from the Department?

Response:
As we have been saying for the past months, we need the additional requested funding to be able to provide ongoing support to domestic manufacturers in order to avoid production cuts and job layoffs. We have already heard from companies that they have reduced their production capacity by as much as 85% compared with maximum production capacity and laid off thousands of workers. We need the additional requested funding from Congress to avoid further reductions and ensure we have sufficient testing supply and capacity in the event of another surge.

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

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

988 and Behavioral Health Crisis Services

1. The Substance Abuse and Mental Health Services Administration (SAMHSA) submitted the "Report to Congress on 988 Resources" (Report to Congress), which was required by the National Suicide Hotline Designation Act of 2020, more than eight months after it was due. The new three-digit lifeline is set to launch in July this year, and the budget requests an increase of nearly $600 million for FY2023. SAMHSA has known about the July 2022 launch date for some time, yet SAMHSA's delay puts Congress in a difficult position to provide a fivefold increase or else appear to shortchange this critical effort. Further, the FY2023 funding will not be available for 988 for months after the launch, and that is a best case scenario.

   While the Report to Congress outlines projected annual resources to sustain 988, the FY2023 budget does not provide any detail as to how SAMHSA would allocate $696.9 million. While appreciated, the Report to Congress is not a budget document. Please provide a breakout of funding for the FY2023 request and a detailed description of each activity for the 988 and Behavioral Health Crisis Services, along with the allocation method for each activity.

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

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

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

Strengthening network operations ($117 million): As the network continues to scale, additional funding will be required for the Lifeline administrator and centralized network functions, including data and telephony infrastructure; standards, training, and quality improvement; evaluation and oversight. Funding will also be required to sustain and expand technology to promote access for marginalized populations. The FY 2023 investment further increases the capacity and performance of these key network infrastructure components and functions to the standard required for the projected contacts anticipated in FY 2023 and support collaborative efforts with partner organizations to improve local routing of contacts.

Sustaining the 988 & Behavioral Health Crisis Coordination Office ($10 million): The 988 transition will require continued extensive coordination at the federal, state, and local levels. Coordination activities led at a federal level include technical assistance to states, and crisis centers; strategic planning, performance management, evaluation, and oversight; and formal partnerships, convenings, and cross-entity coordination.

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

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

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

Organ Procurement and Transplantation Accountability

1. The HHS budget documents appear to be sending a mixed message with regard to the Administration's position on holding Organ Procurement Organizations (OPOs) accountable for poor performance. The FY2023 HHS Budget in Brief document includes a section called "Remove Restrictions on the Certification of New Entities as Organ Procurement Organizations and Increase Enforcement Flexibility," which proposes flexibility to recertify poor performing OPOs that lose certification because of failure to meet certain criteria. This narrative runs counter to the Final rule "Organ Procurement Organizations Conditions for Coverage: Revisions to the Outcome Measure Requirements for Organ Procurement Organizations" (42 CFR Part 486), which will bring much needed standardization to how OPOs measure performance and ensure all OPOs are performing at high quality standards. What is intended by this budget narrative and why is it proposed in light of the Final rule 42 CFR Part 486?

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

Response:
Organ procurement organizations (OPOs) are vital partners in the procurement, distribution, and

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

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

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

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

2. I was pleased to see HRSA released a Request for Information regarding the Organ Procurement and Transplantation Network (OPTN), seeking ways to improve and strengthen the OPTN ahead of the FY2023 Request for Proposal. Throughout the last four years, the OPTN contractor United Network for Organ Sharing (UNOS) has been exposed for its regional bias and inability to effectively improve the organ procurement and transplantation system. For example, records that UNOS fought vigorously to keep hidden from the public reveal UNOS colluded against certain regions of the country when it issued the liver allocation policy in December 2018. Further the National Academies of Science, Engineering, and Medicine (NASEM) revealed an astounding number of organs continue to unused, and NASEM made several recommendations related to the OPTN contract and HHS oversight to improve accountability, improve policymaking, and modernize the transplantation network. How is HHS planning to update the OPTN contract to hold the contractor accountable for system improvements?

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

Response:
HRSA recognizes that the Organ Procurement and Transplantation Network (OPTN) contract is critical

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

Provider Relief Fund (PRF)

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

Response:

As part of the Administration's ongoing commitment to equity, and to support providers with the most need, HHS included new elements in Phase 4 of the Provider Relief Fund (PRF). Rather than paying the same percentage of losses for all providers as in Phase 3, PRF Phase 4 reimburses smaller providers for their operating revenues net expenses at a higher rate compared to larger providers. That means, new providers who just opened their doors and have $10 million or less in annual patient care revenues in 2020 would receive 45% of their adjusted quarterly losses, compared to 25% or 10% for medium and large providers.

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

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

Response:

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

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

Attachment Q 48: How many hospitals and health care providers opened their doors in 2020, 2021, or 2022? Can HHS please provide a breakout by provider type, year, and an estimate of the emergency relief funding that these providers have requested and received from the PRF?

Table 1. Phase 3 Quarterly Losses[1] and Payments by Provider Type[2] for All Paid Providers and All Paid New Providers in 2020[3]

Applicant Type	Providers Paid			2020 New Providers Paid		
	Apps (#)	Total Adjusted[4] Quarterly Losses (QL)	Total Payments Issued[5]	Apps (#)	Total Adjusted QL[3]	Total Payments Issued
Ancillary Services - Chiropractors	1,289	$26,430,000	$26,210,000	53	$890,000	$670,000
Ancillary Services - Dental Service	24,215	$2,643,350,000	$1,760,760,000	1,157	$85,700,000	$63,270,000
Ancillary Services - Diagnostics	588	$323,790,000	$182,370,000	33	$6,700,000	$5,150,000
Ancillary Services - Eye and Vision Service Providers	2,441	$291,780,000	$171,680,000	86	$4,380,000	$3,500,000
Ancillary Services - Other Ancillary Service Providers	1,244	$251,630,000	$105,760,000	56	$990,000	$710,000
Ancillary Services - Respiratory, Developmental, Rehabilitative and Restorative Service Providers	459	$49,890,000	$34,360,000	24	$1,830,000	$1,130,000
DME / Suppliers	151	$4,370,000	$2,640,000	3	$0	$0
Emergency Medical Service Providers	472	$465,150,000	$188,290,000	23	$2,440,000	$1,430,000
Facilities - Acute Care Hospital	771	$23,375,320,000	$8,528,410,000	28	$96,700,000	$28,410,000
Facilities - Assisted Living Facilities	3,639	$590,860,000	$388,510,000	394	$15,310,000	$11,210,000
Facilities - Hospice Providers	49	$15,240,000	$4,430,000	11	$100,000	$50,000
Facilities - Inpatient Behavioral Health	359	$169,360,000	$125,030,000	33	$1,650,000	$1,130,000
Facilities - Nursing Homes	359	$299,400,000	$97,910,000	43	$2,350,000	$2,400,000
Facilities - Other Inpatient Facilities	294	$197,530,000	$80,170,000	18	$1,380,000	$840,000

[1] The application portal for Phase 3 did not collect providers' emergency funding requests. The data attached are Quarterly Losses, which are calculated based on changes in operating revenues and expenses pre- pandemic and COVID-19, as reported by applicants.
[2] The list of provider types changed slightly between Phase 3 and Phase 4/ARP Rural.
[3] These data reflect providers that were new in 2020 only. There are no PRF or ARP Rural payments associated with activities that occurred in 2021 or 2022, as a result no providers, including new providers, have received funds based on 2021 and 2022 revenues.

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

Applicant Type	Providers Paid			2020 New Providers Paid		
	Apps (#)	Total Adjusted[4] Quarterly Losses (QL)	Total Payments Issued [5]	Apps (#)	Total Adjusted QL[3]	Total Payments Issued
Facilities - Residential Treatment Facilities	202	$16,150,000	$38,060,000	10	$360,000	$260,000
Home and Community - Home and Community-based Support Providers	2,390	$265,970,000	$206,510,000	214	$3,060,000	$3,230,000
Home and Community - Home Health Agencies	2,243	$299,580,000	$190,100,000	209	$6,320,000	$5,010,000
Home and Community - Other Services	872	$65,420,000	$127,570,000	71	$1,080,000	$860,000
Other[6]	3,857	-	$877,340,000	254	$12,820,000	$10,270,000
Outpatient and Professional - Ambulatory Surgical Center	1,464	$893,120,000	$546,240,000	45	$14,830,000	$12,280,000
Outpatient and Professional - Behavioral Health Providers	6,730	$429,730,000	$393,050,000	715	$6,390,000	$5,210,000
Outpatient and Professional - Multi-specialty Practice	2,458	$3,987,020,000	$2,426,070,000	126	$23,890,000	$15,710,000
Outpatient and Professional - Other Outpatient Clinic	2,562	$746,340,000	$494,170,000	164	$19,740,000	$14,960,000
Outpatient and Professional - Other Single Specialty Practice	10,185	$1,934,550,000	$1,254,130,000	447	$37,830,000	$27,600,000
Outpatient and Professional - Pediatrics Practice	1,913	$335,790,000	$228,180,000	55	$1,490,000	$1,060,000
Outpatient and Professional - Podiatric Medicine and Surgery Practice	430	$29,320,000	$16,630,000	15	$430,000	$320,000
Outpatient and Professional - Primary Care Practice	4,781	$1,011,260,000	$664,760,000	262	$9,630,000	$7,540,000
TOTAL	**76,417**	**$38,718,340,000**	**$19,159,330,000**	**4,549**	**$358,270,000**	**$224,230,000**

Table 2. PRF Phase 4 and ARP Rural: Quarterly Losses[7] and Payments by Provider Type[8] for All Providers Paid and New Providers in 2020 Paid[9]

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

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

Losses, which are calculated based on changes in operating revenues and expenses pre-pandemic and COVID-19, as reported by applicants.
[8] This table does not include Phase 4 applicants who are pending adjudication or receiving no payment due to the deduction of remaining Phase 3 prior payments.
[9] These data reflect providers that were new in 2020 only. There are no PRF or ARP Rural payments associated with activities that occurred in 2021 or 2022, as a result no providers, including new providers, have received funds based on 2021 and 2022 revenues

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

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

Substance Use Harm Reduction

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

Response:

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

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

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

Response:

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

Unfortunately, traditional primary prevention programs are not always effective in preventing

substance misuse and/ or overdose deaths. CSAP programs that expand beyond primary prevention utilize data that targets trends and themes associated with overdose deaths and increased substance use. Including indicated and selective prevention activities such as psychosocial supports in CSAP programs is critical to connecting at risk individuals to support services and treatment services that are funded by CSAT. Funding multiple types of prevention programs that utilize evidence-based approaches saves lives.

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

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

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

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

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

    a. **What are the "appropriate guardrails" that are under discussion?**

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

Unaccompanied Children

1. In FY2021, the Department had the largest number of referrals of unaccompanied children ever. It spent almost $7 billion on the program, including almost $4 billion transferred from funding that was supposed to be spent on COVID-19 activities. FY2022 referrals to date are almost 40 percent higher than they were at this time in FY2021, and Congress has provided $8 billion to care for unaccompanied children this fiscal year. However, for FY2023, the Administration only requested $4.9 billion in discretionary funding for the program. Why do you think the Department will be able to cut $3.1 billion in costs when referrals of UACs and program costs have gone up the past two years?

Response:
The Administration requested a $4.9 billion discretionary appropriation for FY 2023 as well as two

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

2. As I mentioned in my opening statement, I'm concerned about the impact of the termination of the Title 42 Order. Even though unaccompanied children have been exempted from the order since January 2021, the Department of Homeland Security is projecting a large increase in illegal border crossings which will likely include unaccompanied children. What are your plans to handle a surge in UACs? Can the program support a surge at the level requested in the President's budget?

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

Response:

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

HHS's mission is to care for UC until they are safely released to a vetted sponsor or leave ORR custody following an immigration judge's order of removal, turn 18 years of age, or obtain legal immigration status in the United States. The number of children referred by DHS in ORR care can fluctuate, which is why ORR continuously reviews capacity needs throughout the year. These estimates are based on historic data and DHS predictions and consider several factors such as UC referral numbers, trends, projections, and COVID-19 infection rates and impact on staffing and bed availability. These estimates further inform program costs in real-time and impact budget numbers accordingly.

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

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

Members and staff apprised of changes in funding needs.

b. The budget proposes, again, a contingency fund for the UAC program. This has never been an effective way to manage the program, as witnessed in an FY2017 CR when the Democrats forced the inclusion of $200 million in funding for a contingency fund, its threshold trigger was set too high, and that funding was wasted. Knowing that, why would the Department propose a contingency fund again? It appears that it is simply a budget gimmick.

Response:

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

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

Senator Shelby

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

Response:

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

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

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

Senator Moran

1. Mr. Secretary, Congress has provided bipartisan support to help extend the reach of state and federal programs to serve more families and improve the overall quality of care. I was pleased to support significant funding increases for the Child Care Development Block Grant and Head Start in particular in the FY22 omnibus. I am also a cosponsor of the Child Care and Development Block Grant Reauthorization Act of 2022, which would build on the bipartisan Child Care and Development Block Grant program to provide greater support to working families to afford child care.

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

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

2. During the Senate Appropriations Subcommittee hearing on May 4th, you committed to fully stocking the biodefense and pandemic response supplies maintained by the Strategic National Stockpile. It is also imperative that the Stockpile is maintained with products manufactured in the U.S. and not depend on China as we did when COVID-19 first arose. I'm troubled to learn that HHS has cancelled 3 contracts to manufacture gowns for the Strategic National Stockpile in the past 6 months. We've also been told there are currently zero sterile surgical gowns in the Stockpile. However, your FY2023 budget does note that you have a target of 265M gowns and that procurements are in process.

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

Response:
The SNS currently holds approximately 60 million deployable isolation gowns.

While SNS has made progress in building its inventory of gowns, holding more than 12 times the amount held at the beginning of the COVID-19 response, the progress has been exclusively to the inventory of isolation gowns rather than surgical gowns. SNS currently

holds fewer than 1000 surgical gowns. SNS previously signaled its intention to procure domestically manufactured surgical gowns to help close the gap between current holdings and the COVID-19 target of 265 million gowns.

Senator John Kennedy

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

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

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

   a. **Mr. Secretary, first can you tell the Committee how many hospitals, as of today's hearing, have received warning letters and/or corrective action plans for non-compliance?**
   b. **Of the letters that went out to non-compliant hospitals, can you please tell me how many responded?**
   c. **Mr. Secretary, can you also tell me how many hospitals, who again have had over 15 months to comply, have been issued a civil monetary penalty?**
   d. **When do you expect to issue your first civil monetary penalty for non-compliance?**
   e. **Can you commit to this committee, Congress, and the American people that your Department will immediately post both compliant and non-compliant hospitals on your website and begin issuing fines to non-compliant hospitals?**

Response:

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

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

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

following order:

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

We expect hospitals to comply with these requirements and are enforcing these rules to make sure Americans have information regarding what the hospital will charge for their health care in advance. Prior to the effective date, CMS developed a dedicated hospital price transparency website found here: https://www.cms.gov/hospital-price-transparency. This website includes resources to help hospitals comply with the rule in addition to a method for consumers to contact CMS and submit specific complaints related to hospital noncompliance.

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

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

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

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

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

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

    a. **Will there be proper oversight to ensure these obstructive practices are not occurring, and that proper transparency, as required by law, is taking effect? What will the Administration to do prohibit these burdensome hurdles impacting Open Negotiations?**

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

We are committed to ensuring compliance with the requirements of the NSA and its implementing regulations. If you are hearing from providers or plans about issues regarding compliance with the requirements of the NSA, they should submit a complaint to the No Surprises Help Desk at

https://www.cms.gov/nosurprises/consumers/complaints-about-medical-billing or by calling 1-800-985-3059.

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

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

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

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

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

5. I understand that medical procedures account for 96% of all human exposure to man-made radiation. This can result in severe burns, cataracts, cognitive dysfunction, immunosuppression, and even cancer – in patients and clinicians. While the CDC embraces the guiding principle for radiation safety of "as low as reasonably achievable,"

or "ALARA", it is not aligned with current medical procedures; increased use of high-radiation procedures like fluoroscopy to place stents; extensive clinical data on the dangers of radiation exposure and need for utilizing better precautions; and the latest shielding technologies that can prevent this excessive, avoidable radiation exposure.

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

Response:

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

Senator Hyde-Smith

1. Local pharmacies and pharmacists have long been a trusted and vital part of our local health care community. 9 in 10 Americans live within 5 miles of a pharmacy, and many of those Americans have come to rely on their pharmacy during the pandemic to provide vital access to COVID-related services, including testing, vaccinations, and treatments. Pharmacists were central to combating COVID-19, providing more than 245 million vaccine doses and millions of tests across 20,000+ pharmacies nationwide. However, CMS treats pharmacists differently than other health care professionals when it comes to providing these services, and, ultimately, CMS does not have the necessary payment structure to appropriately reimburse pharmacists for these services.

    a. **Secretary Becerra, can you please elaborate on the efforts CMS has taken to expand pharmacist provider status/reimbursement during the COVID-19 PHE, and clarify which flexibilities granted to pharmacists can and will be extended beyond the PHE? Specifically, how will pharmacists receive reimbursement for COVID-19 tests and vaccine administration after the PHE?**

Response:
Pharmacists are essential parts of our health care system and are playing an important role in the response to the COVID-19 public health emergency. Pharmacists may perform certain tests if they are enrolled in Medicare as a laboratory, in accordance with a pharmacist's scope of practice and state law. In addition, pharmacists can enroll as mass immunizers and bill Medicare for administering Part B vaccines.

We have explicitly clarified that pharmacists fall within the regulatory definition of auxiliary personnel under our regulations. As such, pharmacists may provide services incident to the professional services and under the appropriate level of supervision of the billing physician or practitioner, if payment for the services is not made under the Medicare Part D benefit. This includes providing the services incident to the services of the billing physician or practitioner and in accordance with the pharmacist's state scope of practice and applicable state law.

2. Nearly 20 years ago, the CDC created the Chronic Kidney Disease Initiative to increase awareness of the disease and expand public health surveillance activities. Unfortunately, funding has been mostly stagnant throughout its history, and it currently receives only $3.5 million, despite the tremendous cost of CKD to society, Medicare, and Medicaid. We must increase awareness and early detection of kidney disease via a national kidney disease awareness public health initiative, which the CKD Initiative at CDC is poised to do with proper funding and community partnership.

    a. **Please comment on efforts to expand the Chronic Kidney Disease Initiative to meet this awareness and early detection need.**

Response:
The Chronic Kidney Disease (CKD) Initiative currently conducts several activities to promote

kidney health, including collaborating with partners to support and enhance the CKD Surveillance System. This system tracks kidney disease and its risk factors over time and monitors progress in prevention, detection, and management.

The CKD initiative works to:

- Increase public awareness of CKD, its risk factors, and complications through scientific publications, provider resources, featured articles, and other educational resources.
- Promote early diagnosis and treatment of CKD by
    - Encouraging providers to use the CKD e-phenotype to detect CKD in people early on, help manage CKD, and help reduce CKD-related complications such as heart disease and kidney failure.
    - Publishing on the state-level awareness of CKD in the U.S.
    - Sharing information for the public on prevention and risk management, and how to take care of your kidneys.
- Conduct surveillance, epidemiology, health outcomes, and economic studies in partnership with other offices at CDC, other government agencies, universities, and national organizations.

CDC is committed to the CKD Initiative, and its important work has been highlighted in HHS' Advancing American Kidney Health Initiative. In the FY 2022 Omnibus, the CKD Initiative received an increase of $1 million dollars from FY 2021 funding (total of $3.5 million). While continuing the current work of the CKD Initiative, CDC is using the funding increase to:

- Study the effects of youth-onset type 2 diabetes on kidney structure, function, and complications to identify novel and specific targets for CKD prevention and treatment.
- Update the CKD cost effectiveness studies to include new data, treatments, and numerous advances in our understanding of CKD and its causes, progression, and treatment.
- Expand the analytical capacity of the CKD Surveillance System, including analysis of large datasets and incorporating new indicators of the social determinants of health and CKD morbidity at the national, state, and county levels.
- Examine trends in incidence of end stage kidney disease, diabetes complications, and impact on high-risk populations.

3. There have been recent positive changes to clinical practice in the diagnosis of kidney disease, namely the adoption of new equations for estimating GFR that do not include race as a modifier.

    a. **What else is NIDDK doing to elevate kidney-specific research and interventions to eliminate racial and ethnic disparities in kidney care? Specifically, can you comment on investments in research initiatives that bridge existing deficits in CKD management and treatments to reduce incidence and progression, increase the number of CKD clinical trials related to kidney disease (including efforts to enhance participation of under-represented populations), identify strategies to improve the delivery of**

evidenced-base care in under-represented populations, and address issues related to kidney patients' quality of life?

Response:
Addressing disparities in kidney disease outcomes is a major research priority for the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK). Recognizing that new approaches are needed, the Institute held a workshop in February 2022 aimed at helping design interventions to address structural racism in kidney health disparities. An important outcome of this effort is a forthcoming initiative, recently approved by the NIDDK's Advisory Council, inviting clinical trials to develop and implement these and other interventions in hopes of providing new, evidence-based solutions to overcome disparities in chronic kidney disease and end stage renal disease (also known as ESRD or kidney failure) care and outcomes.
The NIDDK is also determined to improve care and reduce disparities in management of advanced kidney disease. For example, ESRD disproportionately affects African Americans and can severely affect quality of life, particularly for the roughly half of ESRD patients who experience severe pain. The Hemodialysis Pain Reduction Effort (HOPE) clinical trial is exploring non-opioid methods of pain management and improving quality of life, with a focus on heavily affected communities. The trial is engaging participants as partners in the research process and study management to strengthen the science—efforts that have also helped accelerate recruitment of new participants.

A variation in the *APOL1* gene that is more common in people of African descent than in other populations is one factor accounting for kidney disease disparities among African Americans. However, it is not yet well understood how *APOL1* variation might affect outcomes for kidney donors or recipients. The *APOL1* Long-term Kidney Transplantation Outcomes Consortium is currently addressing these vital questions, while employing a ground-breaking patient-engagement effort that served as a model for HOPE and other studies. Another factor that worsens disparities in outcomes for people with ESRD is the relative lack of access to transplanted kidneys for communities of color. The NIDDK and the Patient Centered Outcomes Research Institute are therefore working together to fund the System Interventions to Achieve Early and Equitable Transplants (STEPS) Study, an intervention designed to improve access to transplantation for African Americans through health care system change.

4. Studies indicate that we could have over one million people in kidney failure and need a transplant by 2030. Yet, each year, thousands of recovered kidneys go un-transplanted, while every day, 12 people die waiting for a kidney transplant. Recently there has been additional scrutiny into our organ procurement and transplantation system, yet no major policy proposals have been announced to improve this appalling failure of care. Organ Procurement Organizations are the sole stakeholders in the transplant ecosystem responsible for recovering and transporting deceased organs without legitimate oversight and accountability to ensure quality assurance and performance improvement. Transplant centers desperately need financial incentives to accept less than perfect kidneys and care for complex transplant patients. People of color and underserved communities face numerous hurdles in being referred for a transplant evaluation.

a. What is HHS planning to do to reduce organ discards, improve transplantation, and minimize racial and ethnic disparities in transplantation access?

Response:

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

In December 2020, CMS published "Medicare and Medicaid Programs; Organ Procurement Organizations Conditions for Coverage: Revisions to the Outcome Measure Requirements for Organ Procurement Organizations". This rule finalized new outcome measures OPOs are required to meet for re-certification and was published with the intention of increasing donation and organ transplantation rates by replacing the previous outcome measures with new transparent, reliable, and objective outcome measures that are used to make better certification decisions and incentivize better performance. The revised measure will encourage OPOs to pursue all potential donors, even those who are only able to donate one organ. CMS estimates that if every OPO were to meet or exceed this measure, we could have approximately 5,600 more organs per year to transplant.

HRSA is committed to an equitable and timely organ donation and transplant system. This spring, HRSA issued a Request for Information (RFI) to solicit feedback about opportunities to strengthen the Organ Procurement and Transplantation Network (OPTN). In particular, the RFI sought feedback on the ways to address many of the National Academies of Science, Engineering, and Medicine findings and recommendations in its report titled *Realizing the Promise of Equity in the Organ Transplantation System*. HRSA released the RFI to better support HRSA's efforts to increase accountability in OPTN operations, modernize performance of the OPTN IT system and related tools, and improve engagement with donors and patients. It specifically focuses on opportunities to strengthen equity, access, and transparency. HRSA is appreciative of the response to the RFI and is actively reviewing this important feedback to inform the development of the next contracting cycle. We look forward to continuing to engage with Congress as we develop the next contracting cycle and continue to identify strategies for modernization and accountability across the organ procurement and transplantation system. In addition, HRSA is collaboratively working with its CMS colleagues on an End Stage Renal Disease Treatment Learning Collaborative (ETCLC) project designed to capture and share best practices and processes to increase transplants and reduce discards. The ETCLC focuses on kidney transplants, which make up approximately 85% of the total waiting list. Improvements in this area will have a broad impact on the system. HRSA is committed to the critical work of continuously improving the organ donation and transplantation system, and looks forward to continuing to work with you on this issue.

From: (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=319BFFA9A39B432EB695810F0C3A7202-DORIS-PIERC <Molly.Doris-pierce@hhs.gov>

To: Rainer, Melanie Fontes (OS/IOS) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=9c7242f10a494d45bab72c452ecd9f80-Rainer, Mel <Melanie.Rainer@hhs.gov>

Subject: RE: Confirmed Travel: Manchester, NH and Rhode Island

Date: 2021/07/09 10:53:43

Priority: Normal

Type: Note

Thanks, Melanie! This is great. Feel free to connect me and feel free to call if you want to talk about it in more detail.

Molly Doris-Pierce, *she/her*
Special Assistant
Office of Intergovernmental and External Affairs, U.S. Dept. of Health and Human Services
Cell: 202(b)(6)

From: Rainer, Melanie Fontes (OS/IOS) <Melanie.Rainer@hhs.gov>
Sent: Friday, July 9, 2021 10:38 AM
To: Doris-Pierce, Molly (OS/IEA) <Molly.Doris-pierce@hhs.gov>
Subject: RE: Confirmed Travel: Manchester, NH and Rhode Island

Molly here is the info from CCIIO, me know if you want me to connect you with folks or talk more about this.

Melanie

Name: HealthSource RI
CEO: Lindsay Lang
- Adm offices located in East Providence. Also has a walk in center for consumers in East Providence.
- Has over 100 Navigators across state.
- 2 issuers
- Operating SEP through 8/15.
- Implemented ARPA through automatic redetermination of current consumers. Applied savings over 12 month period.

Melanie Fontes Rainer (she/her/ella)
Counselor to the Secretary
U.S. Department of Health and Human Services
Cell: (202) (b)(6)
Melanie.Rainer@hhs.gov

From: Doris-Pierce, Molly (OS/IEA) <Molly.Doris-pierce@hhs.gov>
Sent: Friday, July 9, 2021 10:22 AM
To: Palafox, Cynthia (HHS/IOS) <Cynthia.Palafox@hhs.gov>; Rainer, Melanie Fontes (OS/IOS) <Melanie.Rainer@hhs.gov>
Cc: Lovenheim, Sarah (HHS/ASPA) <Sarah.Lovenheim@hhs.gov>; Zelenko, Leslie (HHS/ASL) <Leslie.Zelenko@hhs.gov>; Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>; Pugh, Carrie (OS/IEA) <Carrie.Pugh@hhs.gov>; Wilson, Laurence (OS/IOS) <Laurence.Wilson@hhs.gov>; Hild, Jeff (HHS/ASL) <Jeff.Hild@hhs.gov>; Scott, Benjamin (OS/IOS) <Benjamin.Scott@hhs.gov>; Orozco, Esmeralda (HHS/IOS) <Esmeralda.Orozco@hhs.gov>; Lopez, Steven (HHS/OS/IOS) <Steven.Lopez@hhs.gov>; Jones, Kamara (HHS/ASPA) <Kamara.Jones@hhs.gov>; Despres, Sarah (HHS/IOS) <Sarah.Despres@hhs.gov>; Figueroa, Marvin (HHS/IEA) <Marvin.Figueroa@hhs.gov>; Espinosa, Kimberly (HHS/ASL) <Kimberly.Espinosa@hhs.gov>; Villanueva, Josie (OS/IOS) <Josie.Villanueva@hhs.gov>; Cha, Stephen (HHS/IOS) <Stephen.Cha@hhs.gov>; Arguello, Andres (OS/IOS) <Andres.Arguello@hhs.gov>; Schechter, Alia (OS/IOS) <Alia.Schechter@hhs.gov>; Seshasai, Karuna (HHS/IOS) <Karuna.Seshasai@hhs.gov>; Zardeneta, Lizeth (HHS/OS/IOS) <Lizeth.Zardeneta@hhs.gov>; Jee, Lauren (HHS/ASL) <Lauren.Jee@hhs.gov>; Friedman, Jennifer (OS/IOS) <Jennifer.Friedman@hhs.gov>; Reid, Anne (OS/IOS) <Anne.Reid@hhs.gov>; Higgins, Sean (HHS/ASPA) <Sean.Higgins@hhs.gov>
Subject: RE: Confirmed Travel: Manchester, NH and Rhode Island

Based on folks input this is what I'm tracking as a potential sketch:

New Hampshire
Site #1 – CTC Press Conference in the Park (@Palafox, Cynthia (HHS/IOS) does the WH have a preferred park or should we pick?)
Site #2 – Council for Thriving Children Roundtable on Early Childhood
Site #3 – SUD-related event

Rhode Island
Site #1 – Community Health Center and Navigator Roundtable
Note: This would be for the presser on SEP data and the ACA
Site #2 – Bradley Hospital Site Visit on child and adolescent BH
Site #3 – HCBS Roundtable in the 2nd CD

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From: Doris-Pierce, Molly (OS/IEA)
Sent: Thursday, July 8, 2021 9:17 PM
To: Rainer, Melanie Fontes (OS/IOS) <Melanie.Rainer@hhs.gov>
Cc: Lovenheim, Sarah (HHS/ASPA) <Sarah.Lovenheim@hhs.gov>; Palafox, Cynthia (HHS/IOS) <Cynthia.Palafox@hhs.gov>; Zelenko, Leslie (HHS/ASL) <Leslie.Zelenko@hhs.gov>; Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>; Pugh, Carrie (OS/IEA) <Carrie.Pugh@hhs.gov>; Wilson, Laurence (OS/IOS) <Laurence.Wilson@hhs.gov>; Hild, Jeff (HHS/ASL) <Jeff.Hild@hhs.gov>; Scott,

Benjamin (OS/IOS) <Benjamin.Scott@hhs.gov>; Orozco, Esmeralda (HHS/IOS) <Esmeralda.Orozco@hhs.gov>; Lopez, Steven (HHS/OS/IOS) <Steven.Lopez@hhs.gov>; Jones, Kamara (HHS/ASPA) <Kamara.Jones@hhs.gov>; Despres, Sarah (HHS/IOS) <Sarah.Despres@hhs.gov>; Figueroa, Marvin (HHS/IEA) <Marvin.Figueroa@hhs.gov>; Espinosa, Kimberly (HHS/ASL) <Kimberly.Espinosa@hhs.gov>; Villanueva, Josie (OS/IOS) <Josie.Villanueva@hhs.gov>; Cha, Stephen (HHS/IOS) <Stephen.Cha@hhs.gov>; Arguello, Andres (OS/IOS) <Andres.Arguello@hhs.gov>; Schechter, Alia (OS/IOS) <Alia.Schechter@hhs.gov>; Seshasai, Karuna (HHS/IOS) <Karuna.Seshasai@hhs.gov>; Zardeneta, Lizeth (HHS/OS/IOS) <Lizeth.Zardeneta@hhs.gov>; Jee, Lauren (HHS/ASL) <Lauren.Jee@hhs.gov>; Friedman, Jennifer (OS/IOS) <Jennifer.Friedman@hhs.gov>; Reid, Anne (OS/IOS) <Anne.Reid@hhs.gov>; Higgins, Sean (HHS/ASPA) <Sean.Higgins@hhs.gov>
Subject: Re: Confirmed Travel: Manchester, NH and Rhode Island

Hi all,

Apologies for the delay here. Below are the recommendations from the region. Note the overlap on the BH Hospital with Rachel's suggestion, so we feel confident about locking that in.

Additionally; we are planning on working with our ASL counterparts on swapping one event in RI to one about home and community based services based on the Members' recommendations. Appreciate your patience as we work that out!

Cynthia, if it makes sense for IEA to winnow down all the recs on this chain for the Secretary to review - let me know!

Thank you!

MDP

Suggestions for New Hampshire Events, Thursday 7/15/21

Press Conference TBD

Event 1: Roundtable meeting with Council for Thriving Children. This state early childhood council is managed cross-agency by the NH Department of Education and the Department of Health and Human Services in cross-sector partnership with the University of New Hampshire. Adopting a social determinants of health framework, the Council strives to meet the educational and health needs of children. With a two-generation lens, membership includesparent leaders, as well as state child care leaders, healthcare experts, businesses and legislators. Pulling a group together would not be difficult.

Event 2: New Hampshire Equity Group could lead a discussion on their Covid vaccine equity strategy with a roundtable of discussants/leaders from faith organizations, FQHCs, CBOs and philanthropies. The focus will be how the state is working to further improve vaccination coverage in BIPOC communities between now and September, as well as a broader discussion of (a) integration with flu vaccination, (b) Covid booster vaccination campaigns into the fall and winter, (c) the state's plan for addressing the EUA which will authorize vaccination of 5-12 year olds later this year and (d) the state's strategy for re-opening schools for the next academic year.

Suggestions for Rhode Island events, Friday 7/16/21

Press Conference TBD

Event 1: Roundtable on Pathways out of Poverty. Secretary Womazetta Jones and/or Dr. Nicole Alexander-Scott would lead a family poverty-reduction focused roundtable on pathways out of poverty. Topics to include a) how to keep the family in the center, b) child care access, c) equity and access of key services and opportunities d) social determinants of health as a primary way of practice e) the child care tax credit f) pilot Universal Basic Income (UBI) work in Providence and other cities. Participants could include community agencies, interfaith leaders, parents, state government. (*Located in Providence, in the 1st Congressional district.*)

Alternate suggestion for Event 1: Covid vaccine equity roundtable

Dr. Nicole Alexander-Scott, Rhode Island's public health commissioner, could lead a discussion on RI's Covid vaccine equity strategy with a roundtable of discussants/leaders from faith organizations, FQHCs, CBOs and philanthropies. The focus will be how the state is working to further improve vaccination coverage in BIPOC communities between now and September, as well as a broader discussion of (a) integration with flu vaccination, (b) Covid booster vaccination campaigns into the fall and winter, (c) the state's plan for addressing the EUA which will authorize vaccination of 5-12 year olds later this year and (d) the state's strategy for re-opening schools for the next academic year.

Event 2. A visit to Bradley Hospital, the nation's first psychiatric hospital devoted exclusively to children and adolescents; Bradley is a Lifespan partner and a teaching hospital for The Warren Alpert Medical School of Brown University. Bradley Hospital has established itself as the national center for training and research in child and adolescent psychiatry. The purpose of the visit would be to highlight and learn about how Rhode Island's Executive Office of Health and Human Services (EOHHS) has been leading a statewide strategic conversation to implement a comprehensive system of care for children's behavioral health. RI's current system is siloed, with responsibility for children fragmented across different state agencies. The goal is to make coordinated services more accessible for families, creating a single point of access that streamlines the process and removes barriers to obtaining timely, necessary services and supports children, youth and families. This will require patient-centered coordination and electronic referral management software to build a coordinated continuum of care network of health and social service providers in RI. The system will include care coordination, intensive home and community-based services, transition-age youth and young adult services, as well as prevention services. (*Located in Providence, in the 1st Congressional district.*)

Event 2. A health equity zone (HEZ) visit that would also include attention to Covid vaccine equity. Rhode Island's Health Equity Zones (HEZ), led by the RI Department of Health, use a social determinants of health framework to decrease family poverty across communities. These community collaborations braid federal/state funding, including Medicaid and public health dollars to link health, social services, families, education and neighborhoods. Through a collaborative, community-led process, each HEZ conducted a needs assessment and implemented a data-driven plan of action to address conditions that are preventing people from being as healthy as possible. As just one example of this initiative's success through improved community health outcomes, in the Pawtucket/Central Falls HEZ in 2019, the area saw a 63% decrease in elementary school absenteeism, a 44% drop in childhood lead poisoning, and a

24% decrease in teen pregnancy. When COVID-19 hit, the Tri-County HEZ leveraged community voice to build resilience and increase awareness and compliance with mitigation guidelines in the three communities served. (*Located in the 2nd Congressional district, and also proximate to the TF Green Airport, for departure.)*

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On Jul 8, 2021, at 7:34 PM, Rainer, Melanie Fontes (OS/IOS) <Melanie.Rainer@hhs.gov>wrote:

CCIIO can help connect but in RH they have a state-run exchange. And they do really good work, so would be good to do something with them and/or navigators/ community health center.

Sent from my iPhone

On Jul 8, 2021, at 7:23 PM, Lovenheim, Sarah (HHS/ASPA) <Sarah.Lovenheim@hhs.gov>wrote:

Desired press conference will focus on new special enrollment data coming so any location that could support that type of announcement would be great (a community health center or clinic, for example).

On Jul 8, 2021, at 6:59 PM, Palafox, Cynthia (HHS/IOS) <Cynthia.Palafox@hhs.gov>wrote:

Hi folks,

Checking-in on the draft sketches for the trips. Attached are the outlines that Ben &Laurence put together. Any updates on potential sites for each of the states?

Thanks,
Cynthia

From: Zelenko, Leslie (HHS/ASL) <Leslie.Zelenko@hhs.gov>
Sent: Thursday, July 8, 2021 3:22 PM
To: Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>; Pugh, Carrie (OS/IEA) <Carrie.Pugh@hhs.gov>; Doris-Pierce, Molly (OS/IEA) <Molly.Doris-pierce@hhs.gov>; Wilson, Laurence (OS/IOS) <Laurence.Wilson@hhs.gov>; Lovenheim, Sarah (HHS/ASPA) <Sarah.Lovenheim@hhs.gov>
Cc: Hild, Jeff (HHS/ASL) <Jeff.Hild@hhs.gov>; Scott, Benjamin (OS/IOS) <Benjamin.Scott@hhs.gov>; Palafox, Cynthia (HHS/IOS) <Cynthia.Palafox@hhs.gov>; Orozco, Esmeralda (HHS/IOS) <Esmeralda.Orozco@hhs.gov>; Lopez, Steven (HHS/OS/IOS) <Steven.Lopez@hhs.gov>; Jones, Kamara (HHS/ASPA) <Kamara.Jones@hhs.gov>; Despres, Sarah (HHS/IOS) <Sarah.Despres@hhs.gov>; Figueroa, Marvin (HHS/IEA) <Marvin.Figueroa@hhs.gov>; Espinosa, Kimberly (HHS/ASL) <Kimberly.Espinosa@hhs.gov>; Villanueva, Josie (OS/IOS) <Josie.Villanueva@hhs.gov>; Rainer, Melanie Fontes (OS/IOS) <Melanie.Rainer@hhs.gov>; Cha, Stephen (HHS/IOS) <Stephen.Cha@hhs.gov>; Arguello, Andres (OS/IOS) <Andres.Arguello@hhs.gov>; Schechter, Alia (OS/IOS)

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Subject: RE: Confirmed Travel: Manchester, NH and Rhode Island

Another quick update from ASL:

New Hampshire: Senator Hassan's office said that depending on when the last votes in the Senate end on Thursday, she may be able to make it back for an event in the afternoon.

Rhode Island: Both Members (Rep. Cicilline &Rep. Langevin) will be in the State and look forward to joining the Secretary for his trip. We discussed possible events focused on AFP's HCBS and child care investments. Said I would loop back with more details when I had it from our end.

Thanks!

From: Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>
Sent: Thursday, July 8, 2021 1:55 PM
To: Pugh, Carrie (OS/IEA) <Carrie.Pugh@hhs.gov>; Doris-Pierce, Molly (OS/IEA) <Molly.Doris-pierce@hhs.gov>; Wilson, Laurence (OS/IOS) <Laurence.Wilson@hhs.gov>; Lovenheim, Sarah (HHS/ASPA) <Sarah.Lovenheim@hhs.gov>
Cc: Zelenko, Leslie (HHS/ASL) <Leslie.Zelenko@hhs.gov>; Hild, Jeff (HHS/ASL) <Jeff.Hild@hhs.gov>; Scott, Benjamin (OS/IOS) <Benjamin.Scott@hhs.gov>; Palafox, Cynthia (HHS/IOS) <Cynthia.Palafox@hhs.gov>; Orozco, Esmeralda (HHS/IOS) <Esmeralda.Orozco@hhs.gov>; Lopez, Steven (HHS/OS/IOS) <Steven.Lopez@hhs.gov>; Jones, Kamara (HHS/ASPA) <Kamara.Jones@hhs.gov>; Despres, Sarah (HHS/IOS) <Sarah.Despres@hhs.gov>; Figueroa, Marvin (HHS/IEA) <Marvin.Figueroa@hhs.gov>; Espinosa, Kimberly (HHS/ASL) <Kimberly.Espinosa@hhs.gov>; Villanueva, Josie (OS/IOS) <Josie.Villanueva@hhs.gov>; Rainer, Melanie Fontes (OS/IOS) <Melanie.Rainer@hhs.gov>; Cha, Stephen (HHS/IOS) <Stephen.Cha@hhs.gov>; Arguello, Andres (OS/IOS) <Andres.Arguello@hhs.gov>; Schechter, Alia (OS/IOS) <Alia.Schechter@hhs.gov>; Seshasai, Karuna (HHS/IOS) <Karuna.Seshasai@hhs.gov>; Zardeneta, Lizeth (HHS/OS/IOS) <Lizeth.Zardeneta@hhs.gov>; Jee, Lauren (HHS/ASL) <Lauren.Jee@hhs.gov>; Friedman, Jennifer (OS/IOS) <Jennifer.Friedman@hhs.gov>; Reid, Anne (OS/IOS) <Anne.Reid@hhs.gov>; Higgins, Sean (HHS/ASPA) <Sean.Higgins@hhs.gov>
Subject: RE: Confirmed Travel: Manchester, NH and Rhode Island

Hello all,

A couple thoughts on events. If we are interested, Tom Coderre, Principle Deputy Assistant Secretary at SAMHSA, can facilitate any/all.

Thanks,
Rachel

In both states

Secretary Becerra could visit/do an event at a Certified Community Behavioral Health Clinic (CCBHC's). This is a huge program for many members on the Hill. NH and RI both have grantees and over $1 billion dollars have been invested in this program in the last year, $420 million from the American Rescue Plan. If this direction is of interest, we can track down the best site.

New Hampshire:

If you want to get Hassan's attention in NH, perhaps we should set up some visits to see how the state is spending their SOR grant money. We would have to navigate the state politics on this carefully as Sen. Hassan and Governor Sununu could be opponents next year (https://www.vnews.com/Many-factors-could-influence-a-Sununu-Senate-run-40918649). The state has used a majority of the money to stand up a Sununu priority for addiction treatment called The Doorway, a hub and spoke model. There are nine Doorway locations, providing single points of entry for people seeking help for substance use, whether they need treatment, support, or resources for prevention and awareness. The regional Doorways ensure that help is always less than an hour away. In addition, 24/7 access to services is also available by dialing 211. https://www.thedoorway.nh.gov/home

In addition to treatment, NH has great prevention and recovery programs as well. Safe Stations was started in Manchester (https://www.manchesternh.gov/Departments/Fire/Safe-Station). Governor Sununu started the first and most robust statewide Recovery Friendly Workplace program, visits to model employers is a possibility (https://www.recoveryfriendlyworkplace.com/). NH has a Recovery HUB with lots of recovery community centers and other programs which make for excellent visits (https://www.dhhs.nh.gov/dcbcs/bdas/recovery.htm).

Looks like Hassan is working with neighbor Collins on workforce issues: https://www.seacoastonline.com/story/opinion/columns/guest/2021/03/18/collins-and-hassan-crisis-within-crisis/4715260001/. We could arrange something around this if you think the Secretary would find it interesting.

Rhode Island:

If you want to focus on **youth BH**, then Bradley Hospital is probably the best option. It's the nation's first psychiatric hospital devoted exclusively to children and adolescents. It's a Lifespan partner and a teaching hospital for The Warren Alpert Medical School of Brown University. Bradley Hospital has established itself as the national center for training and research in child and adolescent psychiatry. Bradley Hospital is a private, not-for-profit hospital. https://www.lifespan.org/locations/bradley-hospital/about-bradley-hospital

There is also BH Link. BH Link's mission is to ensure all Rhode Islanders 18+ experiencing mental health and substance use crises receive the appropriate services they need as quickly as possible in an environment that supports their recovery. https://www.bhlink.org/ This could be a good place to talk about crisis grant announcement and the building of crisis services in anticipation of 988. There is also a Kids Link, that I think Bradley manages.

There are a lot of options for recovery support and overdose related work – 5-6 recovery centers throughout the state (https://bhddh.ri.gov/substance-useaddiction/recovery-services), recovery coaches in ED's, Providence Safe (Fire) Stations (https://pvdsafestations.com/), and a recovery friendly workplace program (https://recoveryfriendlyri.com/). Rhode Island also has a renowned MAT behind the walls program, the only statewide program in the nation to offer all three FDA approved medications for OUD (https://www.statnews.com/2018/02/14/medication-assisted-treatment-

inmates/). Dr. Nicole Alexander Scott is the Director of the Department of Health and co-chairs the Governor's Overdose Prevention Task Force, I would suggest including her in some way.

The legislative session just concluded and it was a good one for drug policy. Caution though, the state passed and today the Governor signed a bill legalizing the first Safe Injection Facility. The state also reclassified drug crimes as misdemeanors and decriminalized possession of buprenorphine. This article references Secretary Becerra's support for SIF's when he was AG in CA: https://www.providencejournal.com/story/news/courts/2021/07/03/ri-could-first-state-in-nation-to-legalize-safe-injection-sites-for-opioid-addicts/7840401002/

From: Pugh, Carrie (OS/IEA) <Carrie.Pugh@hhs.gov>
Sent: Thursday, July 8, 2021 11:46 AM
To: Doris-Pierce, Molly (OS/IEA) <Molly.Doris-pierce@hhs.gov>; Wilson, Laurence (OS/IOS) <Laurence.Wilson@hhs.gov>; Lovenheim, Sarah (HHS/ASPA) <Sarah.Lovenheim@hhs.gov>
Cc: Zelenko, Leslie (HHS/ASL) <Leslie.Zelenko@hhs.gov>; Hild, Jeff (HHS/ASL) <Jeff.Hild@hhs.gov>; Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>; Scott, Benjamin (OS/IOS) <Benjamin.Scott@hhs.gov>; Palafox, Cynthia (HHS/IOS) <Cynthia.Palafox@hhs.gov>; Orozco, Esmeralda (HHS/IOS) <Esmeralda.Orozco@hhs.gov>; Lopez, Steven (HHS/OS/IOS) <Steven.Lopez@hhs.gov>; Jones, Kamara (HHS/ASPA) <Kamara.Jones@hhs.gov>; Despres, Sarah (HHS/IOS) <Sarah.Despres@hhs.gov>; Figueroa, Marvin (HHS/IEA) <Marvin.Figueroa@hhs.gov>; Espinosa, Kimberly (HHS/ASL) <Kimberly.Espinosa@hhs.gov>; Villanueva, Josie (OS/IOS) <Josie.Villanueva@hhs.gov>; Rainer, Melanie Fontes (OS/IOS) <Melanie.Rainer@hhs.gov>; Cha, Stephen (HHS/IOS) <Stephen.Cha@hhs.gov>; Arguello, Andres (OS/IOS) <Andres.Arguello@hhs.gov>; Schechter, Alia (OS/IOS) <Alia.Schechter@hhs.gov>; Seshasai, Karuna (HHS/IOS) <Karuna.Seshasai@hhs.gov>; Zardeneta, Lizeth (HHS/OS/IOS) <Lizeth.Zardeneta@hhs.gov>; Jee, Lauren (HHS/ASL) <Lauren.Jee@hhs.gov>; Friedman, Jennifer (OS/IOS) <Jennifer.Friedman@hhs.gov>; Reid, Anne (OS/IOS) <Anne.Reid@hhs.gov>; Higgins, Sean (HHS/ASPA) <Sean.Higgins@hhs.gov>
Subject: RE: Confirmed Travel: Manchester, NH and Rhode Island

Good flag – thanks.

From: Doris-Pierce, Molly (OS/IEA) <Molly.Doris-pierce@hhs.gov>
Sent: Thursday, July 8, 2021 11:12 AM
To: Wilson, Laurence (OS/IOS) <Laurence.Wilson@hhs.gov>; Lovenheim, Sarah (HHS/ASPA) <Sarah.Lovenheim@hhs.gov>
Cc: Zelenko, Leslie (HHS/ASL) <Leslie.Zelenko@hhs.gov>; Hild, Jeff (HHS/ASL) <Jeff.Hild@hhs.gov>; Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>; Scott, Benjamin (OS/IOS) <Benjamin.Scott@hhs.gov>; Palafox, Cynthia (HHS/IOS) <Cynthia.Palafox@hhs.gov>; Orozco, Esmeralda (HHS/IOS) <Esmeralda.Orozco@hhs.gov>; Lopez, Steven (HHS/OS/IOS) <Steven.Lopez@hhs.gov>; Jones, Kamara (HHS/ASPA) <Kamara.Jones@hhs.gov>; Despres, Sarah (HHS/IOS) <Sarah.Despres@hhs.gov>; Figueroa, Marvin (HHS/IEA) <Marvin.Figueroa@hhs.gov>; Espinosa, Kimberly (HHS/ASL) <Kimberly.Espinosa@hhs.gov>; Villanueva, Josie (OS/IOS) <Josie.Villanueva@hhs.gov>; Rainer, Melanie Fontes (OS/IOS) <Melanie.Rainer@hhs.gov>; Cha, Stephen (HHS/IOS) <Stephen.Cha@hhs.gov>; Pugh, Carrie (OS/IEA) <Carrie.Pugh@hhs.gov>; Arguello, Andres (OS/IOS) <Andres.Arguello@hhs.gov>; Schechter, Alia (OS/IOS) <Alia.Schechter@hhs.gov>; Seshasai, Karuna (HHS/IOS) <Karuna.Seshasai@hhs.gov>; Zardeneta, Lizeth (HHS/OS/IOS) <Lizeth.Zardeneta@hhs.gov>; Jee, Lauren (HHS/ASL) <Lauren.Jee@hhs.gov>; Friedman, Jennifer (OS/IOS) <Jennifer.Friedman@hhs.gov>; Reid,

Anne (OS/IOS) <Anne.Reid@hhs.gov>; Higgins, Sean (HHS/ASPA) <Sean.Higgins@hhs.gov>
Subject: RE: Confirmed Travel: Manchester, NH and Rhode Island

Wanted to flag for this group that he will be in NH, but we declined the ME opioid summit in person request and pre-recorded. I don't think it's an issue, but did want to flag the date overlap.

Molly Doris-Pierce, *she/her*
Special Assistant
Office of Intergovernmental and External Affairs, U.S. Dept. of Health and Human Services
Cell: 202-(b)(6)

From: Wilson, Laurence (OS/IOS) <Laurence.Wilson@hhs.gov>
Sent: Wednesday, July 7, 2021 9:45 PM
To: Lovenheim, Sarah (HHS/ASPA) <Sarah.Lovenheim@hhs.gov>
Cc: Zelenko, Leslie (HHS/ASL) <Leslie.Zelenko@hhs.gov>; Hild, Jeff (HHS/ASL) <Jeff.Hild@hhs.gov>; Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>; Scott, Benjamin (OS/IOS) <Benjamin.Scott@hhs.gov>; Palafox, Cynthia (HHS/IOS) <Cynthia.Palafox@hhs.gov>; Orozco, Esmeralda (HHS/IOS) <Esmeralda.Orozco@hhs.gov>; Lopez, Steven (HHS/OS/IOS) <Steven.Lopez@hhs.gov>; Jones, Kamara (HHS/ASPA) <Kamara.Jones@hhs.gov>; Despres, Sarah (HHS/IOS) <Sarah.Despres@hhs.gov>; Figueroa, Marvin (HHS/IEA) <Marvin.Figueroa@hhs.gov>; Espinosa, Kimberly (HHS/ASL) <Kimberly.Espinosa@hhs.gov>; Villanueva, Josie (OS/IOS) <Josie.Villanueva@hhs.gov>; Rainer, Melanie Fontes (OS/IOS) <Melanie.Rainer@hhs.gov>; Cha, Stephen (HHS/IOS) <Stephen.Cha@hhs.gov>; Pugh, Carrie (OS/IEA) <Carrie.Pugh@hhs.gov>; Arguello, Andres (OS/IOS) <Andres.Arguello@hhs.gov>; Schechter, Alia (OS/IOS) <Alia.Schechter@hhs.gov>; Seshasai, Karuna (HHS/IOS) <Karuna.Seshasai@hhs.gov>; Zardeneta, Lizeth (HHS/OS/IOS) <Lizeth.Zardeneta@hhs.gov>; Doris-Pierce, Molly (OS/IEA) <Molly.Doris-pierce@hhs.gov>; Jee, Lauren (HHS/ASL) <Lauren.Jee@hhs.gov>; Friedman, Jennifer (OS/IOS) <Jennifer.Friedman@hhs.gov>; Reid, Anne (OS/IOS) <Anne.Reid@hhs.gov>; Higgins, Sean (HHS/ASPA) <Sean.Higgins@hhs.gov>
Subject: Re: Confirmed Travel: Manchester, NH and Rhode Island

Resending New Hampshire sketch as additional folks have been added.

Best,

Laurence J. Wilson
Advance Representative
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On Jul 7, 2021, at 7:49 PM, Lovenheim, Sarah (HHS/ASPA) <Sarah.Lovenheim@hhs.gov>wrote:

+ Sean H, who will be our ASPA POC.

On Jul 7, 2021, at 5:18 PM, Zelenko, Leslie (HHS/ASL) <Leslie.Zelenko@hhs.gov>wrote:

Hi folks,

Quick update for New Hampshire:

Congressman Chris Pappas will not be in town on the 15th, his office asked if there was any flexibility on the date, I'm guessing there's not but just wanted to see.

Senator Shaheen was hoping to get more details on the events of the day, I said I would share when I have them. Her Chief flagged that the Senate is in session next week, which may make it difficult.

Thanks!
Leslie

From: Hild, Jeff (HHS/ASL) <Jeff.Hild@hhs.gov>
Sent: Wednesday, July 7, 2021 2:15 PM
To: Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>; Scott, Benjamin (OS/IOS) <Benjamin.Scott@hhs.gov>; Wilson, Laurence (OS/IOS) <Laurence.Wilson@hhs.gov>; Palafox, Cynthia (HHS/IOS) <Cynthia.Palafox@hhs.gov>; Zelenko, Leslie (HHS/ASL) <Leslie.Zelenko@hhs.gov>
Cc: Orozco, Esmeralda (HHS/IOS) <Esmeralda.Orozco@hhs.gov>; Lopez, Steven (HHS/OS/IOS) <Steven.Lopez@hhs.gov>; Jones, Kamara (HHS/ASPA) <Kamara.Jones@hhs.gov>; Despres, Sarah (HHS/IOS) <Sarah.Despres@hhs.gov>; Lovenheim, Sarah (HHS/ASPA) <Sarah.Lovenheim@hhs.gov>; Figueroa, Marvin (HHS/IEA) <Marvin.Figueroa@hhs.gov>; Espinosa, Kimberly (HHS/ASL) <Kimberly.Espinosa@hhs.gov>; Villanueva, Josie (OS/IOS) <Josie.Villanueva@hhs.gov>; Rainer, Melanie Fontes (OS/IOS) <Melanie.Rainer@hhs.gov>; Cha, Stephen (HHS/IOS) <Stephen.Cha@hhs.gov>; Pugh, Carrie (OS/IEA) <Carrie.Pugh@hhs.gov>; Arguello, Andres (OS/IOS) <Andres.Arguello@hhs.gov>; Schechter, Alia (OS/IOS) <Alia.Schechter@hhs.gov>; Seshasai, Karuna (HHS/IOS) <Karuna.Seshasai@hhs.gov>; Zardeneta, Lizeth (HHS/OS/IOS) <Lizeth.Zardeneta@hhs.gov>; Doris-Pierce, Molly (OS/IEA) <Molly.Doris-pierce@hhs.gov>; Jee, Lauren (HHS/ASL) <Lauren.Jee@hhs.gov>; Friedman, Jennifer (OS/IOS) <Jennifer.Friedman@hhs.gov>; Reid, Anne (OS/IOS) <Anne.Reid@hhs.gov>
Subject: RE: Confirmed Travel: Manchester, NH and Rhode Island

+ Leslie who is helping to coordinate with the Congressional offices.

From: Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>
Sent: Wednesday, July 7, 2021 1:22 PM
To: Scott, Benjamin (OS/IOS) <Benjamin.Scott@hhs.gov>; Wilson, Laurence (OS/IOS) <Laurence.Wilson@hhs.gov>; Palafox, Cynthia (HHS/IOS) <Cynthia.Palafox@hhs.gov>
Cc: Orozco, Esmeralda (HHS/IOS) <Esmeralda.Orozco@hhs.gov>; Lopez, Steven (HHS/OS/IOS) <Steven.Lopez@hhs.gov>; Jones, Kamara (HHS/ASPA) <Kamara.Jones@hhs.gov>; Despres, Sarah (HHS/IOS) <Sarah.Despres@hhs.gov>; Lovenheim, Sarah (HHS/ASPA) <Sarah.Lovenheim@hhs.gov>; Figueroa, Marvin (HHS/IEA) <Marvin.Figueroa@hhs.gov>; Espinosa, Kimberly (HHS/ASL) <Kimberly.Espinosa@hhs.gov>; Hild, Jeff (HHS/ASL) <Jeff.Hild@hhs.gov>; Villanueva, Josie (OS/IOS) <Josie.Villanueva@hhs.gov>; Rainer, Melanie Fontes (OS/IOS) <Melanie.Rainer@hhs.gov>; Cha, Stephen

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Subject: RE: Confirmed Travel: Manchester, NH and Rhode Island

We have a lot of HCBS and SUD opportunity in both NH and RI- pulling some good programs now- thanks, Rachel

---

From: Scott, Benjamin (OS/IOS) <Benjamin.Scott@hhs.gov>
Sent: Wednesday, July 7, 2021 1:03 PM
To: Wilson, Laurence (OS/IOS) <Laurence.Wilson@hhs.gov>; Palafox, Cynthia (HHS/IOS) <Cynthia.Palafox@hhs.gov>
Cc: Orozco, Esmeralda (HHS/IOS) <Esmeralda.Orozco@hhs.gov>; Lopez, Steven (HHS/OS/IOS) <Steven.Lopez@hhs.gov>; Jones, Kamara (HHS/ASPA) <Kamara.Jones@hhs.gov>; Despres, Sarah (HHS/IOS) <Sarah.Despres@hhs.gov>; Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>; Lovenheim, Sarah (HHS/ASPA) <Sarah.Lovenheim@hhs.gov>; Figueroa, Marvin (HHS/IEA) <Marvin.Figueroa@hhs.gov>; Espinosa, Kimberly (HHS/ASL) <Kimberly.Espinosa@hhs.gov>; Hild, Jeff (HHS/ASL) <Jeff.Hild@hhs.gov>; Villanueva, Josie (OS/IOS) <Josie.Villanueva@hhs.gov>; Rainer, Melanie Fontes (OS/IOS) <Melanie.Rainer@hhs.gov>; Cha, Stephen (HHS/IOS) <Stephen.Cha@hhs.gov>; Pugh, Carrie (OS/IEA) <Carrie.Pugh@hhs.gov>; Arguello, Andres (OS/IOS) <Andres.Arguello@hhs.gov>; Schechter, Alia (OS/IOS) <Alia.Schechter@hhs.gov>; Seshasai, Karuna (HHS/IOS) <Karuna.Seshasai@hhs.gov>; Zardeneta, Lizeth (HHS/OS/IOS) <Lizeth.Zardeneta@hhs.gov>; Doris-Pierce, Molly (OS/IEA) <Molly.Doris-pierce@hhs.gov>; Jee, Lauren (HHS/ASL) <Lauren.Jee@hhs.gov>; Friedman, Jennifer (OS/IOS) <Jennifer.Friedman@hhs.gov>; Reid, Anne (OS/IOS) <Anne.Reid@hhs.gov>
Subject: RE: Confirmed Travel: Manchester, NH and Rhode Island

Folks – find incredibly draft version of sketch for Rhode Island attached. Will start a new Rhode Island only thread once we identify staff. Thanks!!

Ben

Benjamin Scott
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From: Wilson, Laurence (OS/IOS) <Laurence.Wilson@hhs.gov>
Sent: Wednesday, July 7, 2021 11:50 AM
To: Palafox, Cynthia (HHS/IOS) <Cynthia.Palafox@hhs.gov>
Cc: Orozco, Esmeralda (HHS/IOS) <Esmeralda.Orozco@hhs.gov>; Lopez, Steven (HHS/OS/IOS) <Steven.Lopez@hhs.gov>; Jones, Kamara (HHS/ASPA) <Kamara.Jones@hhs.gov>; Despres, Sarah (HHS/IOS) <Sarah.Despres@hhs.gov>; Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>; Lovenheim,

Sarah (HHS/ASPA) <Sarah.Lovenheim@hhs.gov>; Figueroa, Marvin (HHS/IEA) <Marvin.Figueroa@hhs.gov>; Espinosa, Kimberly (HHS/ASL) <Kimberly.Espinosa@hhs.gov>; Hild, Jeff (HHS/ASL) <Jeff.Hild@hhs.gov>; Villanueva, Josie (OS/IOS) <Josie.Villanueva@hhs.gov>; Rainer, Melanie Fontes (OS/IOS) <Melanie.Rainer@hhs.gov>; Cha, Stephen (HHS/IOS) <Stephen.Cha@hhs.gov>; Pugh, Carrie (OS/IEA) <Carrie.Pugh@hhs.gov>; Scott, Benjamin (OS/IOS) <Benjamin.Scott@hhs.gov>; Arguello, Andres (OS/IOS) <Andres.Arguello@hhs.gov>; Schechter, Alia (OS/IOS) <Alia.Schechter@hhs.gov>; Seshasai, Karuna (HHS/IOS) <Karuna.Seshasai@hhs.gov>; Zardeneta, Lizeth (HHS/OS/IOS) <Lizeth.Zardeneta@hhs.gov>; Doris-Pierce, Molly (OS/IEA) <Molly.Doris-pierce@hhs.gov>; Jee, Lauren (HHS/ASL) <Lauren.Jee@hhs.gov>; Friedman, Jennifer (OS/IOS) <Jennifer.Friedman@hhs.gov>; Reid, Anne (OS/IOS) <Anne.Reid@hhs.gov>
Subject: Re: Confirmed Travel: Manchester, NH and Rhode Island

Thanks, Cynthia! Will do.

Best,

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On Jul 7, 2021, at 10:22 AM, Palafox, Cynthia (HHS/IOS) <Cynthia.Palafox@hhs.gov>wrote:

Hi team,

The Secretary approved the travel to Manchester, NH on Thursday, July 15 and to Rhode Island on Friday, July 16. We also received confirmation from ASL on RI availability, so we fully locked-in for that trip. And although we are still working on clarifying a few pieces with ethics, I would like to see a **draft sketch of both trips by COB tomorrow**. And as we have before, it would great to continue to highlight the AFP and vaccine confidence (if appropriate) as well as care economy in RI.

Below is the tentative schedule I created for both days based on potential arrival and departure times. Although we don't yet know where the Secretary will be needed first in RI, I am having him travel to Providence from Manchester, NH, but that can be changed.

Thursday, July 15, 2021
10:00am ET Wheels Down Manchester, NH
10:30am ET (30 min) HOLD for potential press
11:00am ET (60 min) CTC Press Conference (location: at a park – exact location TBD)
12:00pm ET Travel to lunch
12:15pm ET (60 min) Lunch
1:15pm ET Travel to site #2
1:30pm ET (90 min) Site #2

3:00pm ET Travel to site #3
3:15pm ET (90 min) Site #3
4:45pm ET Depart Manchester, NH and **drive** to Providence, RI
7:00pm ET Arrive at Providence RI
RON: Hotel in Providence, RI (location TBD)

Friday, July 16, 2021
9:00am ET Hold for press
9:30am ET Travel to site #1
10:00am ET (60 min) Site #1
11:00am ET Travel to site #2
11:30pm ET (60 min) Site #2
12:30pm ET (30 min) Lunch
1:00pm ET Depart for site #3
1:30pm ET (60 min) Site #3
2:30pm ET Depart for airport
4:00pm ET Arrive at airport
4:45pm ET Wheels-up Providence, RI

ASPA team – Sarah requested that we try and proactively hold time for press during each trip. Please let me know what time would work best. I'm currently holding time first thing in the morning but let me know if that doesn't work on your end.

ASL team – please confirm the Secretary's participation and let us know what they have in mind, especially for RI

IEA team – please confirm the Secretary's travel with regional office and keep us all posted on potential sites. Also, let me know if the time I've allocated is not enough – we could try to play round with timing based on the locations.

Counselors – please let us know if there's any specific policy and/or topics that the team should be aware of when building out the trip.

Ben – I know you are in Charlotte at the moment, but when you're free, can you please start creating the full sketch for RI?

Laurence – can you please start creating the sketch for Manchester, NH?

Thank you all!

Cynthia

Cynthia Palafox
Director of Scheduling &Advance
U.S. Department of Health and Human Services
202-(b)(6) (cell)

cynthia.palafox@hhs.gov

<7.15.21 Manchester, New Hampshire Trip Sketch v1.docx>
<Rhode Island - Sketch - v1.docx>

Sender:	Doris-Pierce, Molly (OS/IEA) /O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=319BFFA9A39B432EB695810F0C3A7202-DORIS-PIERC <Molly.Doris-pierce@hhs.gov>
Recipient:	Rainer, Melanie Fontes (OS/IOS) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=9c7242f10a494d45bab72c452ecd9f80-Rainer, Mel <Melanie.Rainer@hhs.gov>
Sent Date:	2021/07/09 10:53:42
Delivered Date:	2021/07/09 10:53:43

From: (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=319BFFA9A39B432EB695810F0C3A7202-DORIS-PIERC <Molly.Doris-pierce@hhs.gov>

To:
Palafox, Cynthia (HHS/IOS) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=fc909aa52772499d9b0aa2d3b88ea6eb-Palafox, Cy <Cynthia.Palafox@hhs.gov>;
Zelenko, Leslie (HHS/ASL) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=b14d75b301ff4872beb48588e0ad4c8e-Zelenko, Le <Leslie.Zelenko@hhs.gov>;
Wilson, Laurence (OS/IOS) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=161e6a3e157b42fb9f2c27260d697a79-Wilson, Lau <Laurence.Wilson@hhs.gov>;
Scott, Benjamin (OS/IOS) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=78e801f602f54f21a59156d5b1cd26cc-Scott, Benj <Benjamin.Scott@hhs.gov>;
Rainer, Melanie Fontes (OS/IOS) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=9c7242f10a494d45bab72c452ecd9f80-Rainer, Mel <Melanie.Rainer@hhs.gov>;
Jee, Lauren (HHS/ASL) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=a7771eca5c9448a8bb1f8860affd22c0-Jee, Lauren <Lauren.Jee@hhs.gov>

CC:
Lovenheim, Sarah (HHS/ASPA) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=47f3afc033df47b1aaa46c8e43961db5-Goldfarb, S <Sarah.Lovenheim@hhs.gov>;
Pryor, Rachel (HHS/OS/IOS) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=1e87a6df2de041fcb673dd5e40029b87-Pryor, Rach <Rachel.Pryor@hhs.gov>;
Pugh, Carrie (OS/IEA) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=600602937a904b288a2b2c0d1d75fc6a-Pugh, Carri <Carrie.Pugh@hhs.gov>;
Hild, Jeff (HHS/ASL) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=fece8d2d4b8f414ebd2bf636eac3ce50-Hild, Jeff <Jeff.Hild@hhs.gov>;
Orozco, Esmeralda (HHS/IOS) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=1b0828fef0414c538c6def9f15bbb6c1-Orozco, Esm <Esmeralda.Orozco@hhs.gov>;
Lopez, Steven (HHS/OS/IOS) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=fb54685278d24cae97d8548aa6232f53-Lopez, Stev <Steven.Lopez@hhs.gov>;
Jones, Kamara (HHS/ASPA) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=05cef78e341b467099676c353121c1ed-Jones, Kama <Kamara.Jones@hhs.gov>;
Despres, Sarah (HHS/IOS) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=15d1d64eacdf46b8a378310ae7caf6bd-Despres, Sa <Sarah.Despres@hhs.gov>;
Figueroa, Marvin (HHS/IEA) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=4a287d28c5d248d2a21ad454649a7f7e-Figueroa, M <Marvin.Figueroa@hhs.gov>;
Espinosa, Kimberly (HHS/ASL) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=3ea068cdda2a4a10a83d1050f1f874af-Espinosa, K <Kimberly.Espinosa@hhs.gov>;
Villanueva, Josie (OS/IOS) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=5f96c04c92d34952a184fecc1f9eb0cb-Villanueva, <Josie.Villanueva@hhs.gov>;
Cha, Stephen (HHS/IOS) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=23e67977d77947d69baf2ace846821a8-Cha, Stephe <Stephen.Cha@hhs.gov>;
Arguello, Andres (OS/IOS) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=a329ef44da0542b0b71f9c5c12b4ec91-Arguello, A <Andres.Arguello@hhs.gov>;
Schechter, Alia (OS/IOS) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=5fabc7f0f3614cbdb7c64f9fb62743cc-Schechter, <Alia.Schechter@hhs.gov>;
Seshasai, Karuna (HHS/IOS) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=f18c182cd9f74851af73f94ba2dffd06-Seshasai, K

<Karuna.Seshasai@hhs.gov>;
Zardeneta, Lizeth (HHS/OS/IOS) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=11beff59ebbd47cdb99e6b1d0d0f7c7d-Zardeneta, <Lizeth.Zardeneta@hhs.gov>;
Friedman, Jennifer (OS/IOS) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=f8a66be214774b15a58e5aa9b867e51c-Friedman, J <Jennifer.Friedman@hhs.gov>;
Reid, Anne (OS/IOS) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=2d168184a76848ad8576ae7c8fad8c62-Reid, Anne <Anne.Reid@hhs.gov>;
Higgins, Sean (HHS/ASPA) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=12cc04e1cb0147408f56f9efac699715-Higgins, Se <Sean.Higgins@hhs.gov>

Subject: RE: Confirmed Travel: Manchester, NH and Rhode Island
Date: 2021/07/12 14:44:47
Priority: Normal
Type: Note

Updated locations below:

New Hampshire
Site #1 – CTC Press Conference in Derryfield Park

Site #2 – Early Childhood Roundtable at Southern New Hampshire Services 40 Pine Street Manchester, NH 03103

Site #3 – SUD-related event Nashua NH pending final location

Rhode Island
Site #1: Disability/HCBS focused event in CD 2 with Rep. Langevin &Governor on investments from AJP for HCBS.
1130 Ten Rod Road, Suite B101, North Kingstown, RI 02852

Site #2: Blackstone Community Health Center Tour, Roundtable/Press Conference 964 Broad Street Central Falls Rhode Island 02863

Site #3: Bradley Hospital Site Visit on Child and Adolescent Behavioral Health 1011 Veterans Memorial Pkwy, Riverside, RI 02915

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From: Palafox, Cynthia (HHS/IOS) <Cynthia.Palafox@hhs.gov>
Sent: Monday, July 12, 2021 2:07 PM
To: Zelenko, Leslie (HHS/ASL) <Leslie.Zelenko@hhs.gov>; Doris-Pierce, Molly (OS/IEA) <Molly.Doris-

pierce@hhs.gov>; Wilson, Laurence (OS/IOS) <Laurence.Wilson@hhs.gov>; Scott, Benjamin (OS/IOS) <Benjamin.Scott@hhs.gov>; Rainer, Melanie Fontes (OS/IOS) <Melanie.Rainer@hhs.gov>; Jee, Lauren (HHS/ASL) <Lauren.Jee@hhs.gov>
Cc: Lovenheim, Sarah (HHS/ASPA) <Sarah.Lovenheim@hhs.gov>; Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>; Pugh, Carrie (OS/IEA) <Carrie.Pugh@hhs.gov>; Hild, Jeff (HHS/ASL) <Jeff.Hild@hhs.gov>; Orozco, Esmeralda (HHS/IOS) <Esmeralda.Orozco@hhs.gov>; Lopez, Steven (HHS/OS/IOS) <Steven.Lopez@hhs.gov>; Jones, Kamara (HHS/ASPA) <Kamara.Jones@hhs.gov>; Despres, Sarah (HHS/IOS) <Sarah.Despres@hhs.gov>; Figueroa, Marvin (HHS/IEA) <Marvin.Figueroa@hhs.gov>; Espinosa, Kimberly (HHS/ASL) <Kimberly.Espinosa@hhs.gov>; Villanueva, Josie (OS/IOS) <Josie.Villanueva@hhs.gov>; Cha, Stephen (HHS/IOS) <Stephen.Cha@hhs.gov>; Arguello, Andres (OS/IOS) <Andres.Arguello@hhs.gov>; Schechter, Alia (OS/IOS) <Alia.Schechter@hhs.gov>; Seshasai, Karuna (HHS/IOS) <Karuna.Seshasai@hhs.gov>; Zardeneta, Lizeth (HHS/OS/IOS) <Lizeth.Zardeneta@hhs.gov>; Friedman, Jennifer (OS/IOS) <Jennifer.Friedman@hhs.gov>; Reid, Anne (OS/IOS) <Anne.Reid@hhs.gov>; Higgins, Sean (HHS/ASPA) <Sean.Higgins@hhs.gov>
Subject: RE: Confirmed Travel: Manchester, NH and Rhode Island

Leslie – thank you for the update.

IEA &ASL – do we have confirmation on the site locations for each of the events? I can't really make a determination on whether we can push the start time on site #1 until we know what travel time will look like.

@Scott, Benjamin (OS/IOS)and @Wilson, Laurence (OS/IOS) – can you each pls send an updated sketch of each location based on the info that has been presented? Please also highlight what information is still outstanding.

Also Laurence – please make sure you update the NH sketch with the information we learned in today's call with the organizers of the 11am event.

Thanks,
Cynthia

From: Zelenko, Leslie (HHS/ASL) <Leslie.Zelenko@hhs.gov>
Sent: Friday, July 9, 2021 5:15 PM
To: Doris-Pierce, Molly (OS/IEA) <Molly.Doris-pierce@hhs.gov>; Wilson, Laurence (OS/IOS) <Laurence.Wilson@hhs.gov>; Scott, Benjamin (OS/IOS) <Benjamin.Scott@hhs.gov>; Palafox, Cynthia (HHS/IOS) <Cynthia.Palafox@hhs.gov>; Rainer, Melanie Fontes (OS/IOS) <Melanie.Rainer@hhs.gov>; Jee, Lauren (HHS/ASL) <Lauren.Jee@hhs.gov>
Cc: Lovenheim, Sarah (HHS/ASPA) <Sarah.Lovenheim@hhs.gov>; Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>; Pugh, Carrie (OS/IEA) <Carrie.Pugh@hhs.gov>; Hild, Jeff (HHS/ASL) <Jeff.Hild@hhs.gov>; Orozco, Esmeralda (HHS/IOS) <Esmeralda.Orozco@hhs.gov>; Lopez, Steven (HHS/OS/IOS) <Steven.Lopez@hhs.gov>; Jones, Kamara (HHS/ASPA) <Kamara.Jones@hhs.gov>; Despres, Sarah (HHS/IOS) <Sarah.Despres@hhs.gov>; Figueroa, Marvin (HHS/IEA) <Marvin.Figueroa@hhs.gov>; Espinosa, Kimberly (HHS/ASL) <Kimberly.Espinosa@hhs.gov>; Villanueva, Josie (OS/IOS) <Josie.Villanueva@hhs.gov>; Cha, Stephen (HHS/IOS) <Stephen.Cha@hhs.gov>; Arguello, Andres (OS/IOS) <Andres.Arguello@hhs.gov>; Schechter, Alia (OS/IOS) <Alia.Schechter@hhs.gov>; Seshasai, Karuna (HHS/IOS) <Karuna.Seshasai@hhs.gov>; Zardeneta, Lizeth (HHS/OS/IOS)

<Lizeth.Zardeneta@hhs.gov>; Friedman, Jennifer (OS/IOS) <Jennifer.Friedman@hhs.gov>; Reid, Anne (OS/IOS) <Anne.Reid@hhs.gov>; Higgins, Sean (HHS/ASPA) <Sean.Higgins@hhs.gov>
Subject: RE: Confirmed Travel: Manchester, NH and Rhode Island

Molly &I connected offline. No changes to NH sketch, just affirming we'll check with Sen. Hassan on any SUD event/location.

Updated the RI Sketch v3 (attached).

@Palafox, Cynthia (HHS/IOS) One thing Rep. Cicilline's office asked was whether the first event's start time in RI could be pushed to 10:30 (right now it is at 10 am). I believe this may allow the Congressman to join for the first event (which will now be the HCBS roundtable). I said I would check in on that.

Thanks all, have a great weekend!

Leslie

New Hampshire
Site #1 – CTC Press Conference in the Park (still waiting on WH's park recommendation)
Site #2 – Council for Thriving Children Roundtable on Early Childhood
Site #3 – SUD-related event ***note, we are still waiting to finalize the location and whatever we plug in here it is requested we run by Sen. Hassan's office.**

Rhode Island
Site #1: Disability/HCBS focused event in CD 2 with Rep. Langevin &Governor on investments from AFP for HCBS. Waiting on location from Rep. Langevin's office.
Site #2: Blackstone Community Health Center Tour, Roundtable/Press Conference (CD1)
- • This CHC is in Pawtucket and came from as a recommendation of Rep. Cicilline.

Site #3: Bradley Hospital Site Visit on Child and Adolescent Behavioral Health (CD1)

From: Doris-Pierce, Molly (OS/IEA) <Molly.Doris-pierce@hhs.gov>
Sent: Friday, July 9, 2021 12:13 PM
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Cc: Lovenheim, Sarah (HHS/ASPA) <Sarah.Lovenheim@hhs.gov>; Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>; Pugh, Carrie (OS/IEA) <Carrie.Pugh@hhs.gov>; Hild, Jeff (HHS/ASL) <Jeff.Hild@hhs.gov>; Orozco, Esmeralda (HHS/IOS) <Esmeralda.Orozco@hhs.gov>; Lopez, Steven (HHS/OS/IOS) <Steven.Lopez@hhs.gov>; Jones, Kamara (HHS/ASPA) <Kamara.Jones@hhs.gov>; Despres, Sarah (HHS/IOS) <Sarah.Despres@hhs.gov>; Figueroa, Marvin (HHS/IEA) <Marvin.Figueroa@hhs.gov>; Espinosa, Kimberly (HHS/ASL) <Kimberly.Espinosa@hhs.gov>; Villanueva, Josie (OS/IOS) <Josie.Villanueva@hhs.gov>; Cha, Stephen (HHS/IOS) <Stephen.Cha@hhs.gov>; Arguello, Andres (OS/IOS) <Andres.Arguello@hhs.gov>; Schechter, Alia (OS/IOS) <Alia.Schechter@hhs.gov>; Seshasai, Karuna (HHS/IOS) <Karuna.Seshasai@hhs.gov>; Zardeneta, Lizeth (HHS/OS/IOS)

<Lizeth.Zardeneta@hhs.gov>; Friedman, Jennifer (OS/IOS) <Jennifer.Friedman@hhs.gov>; Reid, Anne (OS/IOS) <Anne.Reid@hhs.gov>; Higgins, Sean (HHS/ASPA) <Sean.Higgins@hhs.gov>
Subject: RE: Confirmed Travel: Manchester, NH and Rhode Island

Leslie – for awareness, we're already working on locking in a different site for the ACA/SEP event – it would be first of the day, then Bradley, then HCBS. Would this work for the Reps?

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To: Wilson, Laurence (OS/IOS) <Laurence.Wilson@hhs.gov>; Scott, Benjamin (OS/IOS) <Benjamin.Scott@hhs.gov>; Palafox, Cynthia (HHS/IOS) <Cynthia.Palafox@hhs.gov>; Doris-Pierce, Molly (OS/IEA) <Molly.Doris-pierce@hhs.gov>; Rainer, Melanie Fontes (OS/IOS) <Melanie.Rainer@hhs.gov>; Jee, Lauren (HHS/ASL) <Lauren.Jee@hhs.gov>
Cc: Lovenheim, Sarah (HHS/ASPA) <Sarah.Lovenheim@hhs.gov>; Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>; Pugh, Carrie (OS/IEA) <Carrie.Pugh@hhs.gov>; Hild, Jeff (HHS/ASL) <Jeff.Hild@hhs.gov>; Orozco, Esmeralda (HHS/IOS) <Esmeralda.Orozco@hhs.gov>; Lopez, Steven (HHS/OS/IOS) <Steven.Lopez@hhs.gov>; Jones, Kamara (HHS/ASPA) <Kamara.Jones@hhs.gov>; Despres, Sarah (HHS/IOS) <Sarah.Despres@hhs.gov>; Figueroa, Marvin (HHS/IEA) <Marvin.Figueroa@hhs.gov>; Espinosa, Kimberly (HHS/ASL) <Kimberly.Espinosa@hhs.gov>; Villanueva, Josie (OS/IOS) <Josie.Villanueva@hhs.gov>; Cha, Stephen (HHS/IOS) <Stephen.Cha@hhs.gov>; Arguello, Andres (OS/IOS) <Andres.Arguello@hhs.gov>; Schechter, Alia (OS/IOS) <Alia.Schechter@hhs.gov>; Seshasai, Karuna (HHS/IOS) <Karuna.Seshasai@hhs.gov>; Zardeneta, Lizeth (HHS/OS/IOS) <Lizeth.Zardeneta@hhs.gov>; Friedman, Jennifer (OS/IOS) <Jennifer.Friedman@hhs.gov>; Reid, Anne (OS/IOS) <Anne.Reid@hhs.gov>; Higgins, Sean (HHS/ASPA) <Sean.Higgins@hhs.gov>
Subject: RE: Confirmed Travel: Manchester, NH and Rhode Island

Thanks everyone. I shared the updated sketches and have some more feedback from the Rhode Island Member offices. Here is our updated sketch for RI below.

Site #1: Disability/HCBS focused event in CD 2 with Rep. Langevin &Governor on investments from AFP for HCBS.

- • They are working with Tina Spears of the Community Provider Network of RI is currently looking for possible sites.
- • Format: Tour &host a roundtable discussion with providers/patients.
- • Time: 60-75 minutes
- • NOTE: Cicilline has a conflict in the morning due to a previously scheduled event around Transportation with both Senators.

Site #2: Blackstone Community Health Center Tour, Roundtable/Press Conference in CD1

- • This CHC is in Pawtucket and came from a recommendation of Rep. Cicilline.
- • Attendees: Both RI Members of Congress (Senators will be invited too).
- • Format: Tour and press conference on the SEP data &ACA

- • Time: 90 minutes

Site #3: Bradley Hospital Site Visit on Child and Adolescent Behavioral Health (CD1)

- • Format: Tour &standing/seated discussion on MH investments.
- • Attendees: Both RI Members of Congress (Senators will be invited too).
- • Time: 60 minutes
- • Note: Rep. Langevin's team flagged a prior issue Bradley had with medical records, but I am getting clarification from them on what it is. They were fine with having an event there but wanted to flag in case press were invited and it came up. I did some searching and found this article on the possible issue: https://www.jdsupra.com/legalnews/lifespan-pays-1m-to-settle-hipaa-case-22313/.

From: Wilson, Laurence (OS/IOS) <Laurence.Wilson@hhs.gov>
Sent: Friday, July 9, 2021 11:19 AM
To: Scott, Benjamin (OS/IOS) <Benjamin.Scott@hhs.gov>; Palafox, Cynthia (HHS/IOS) <Cynthia.Palafox@hhs.gov>; Doris-Pierce, Molly (OS/IEA) <Molly.Doris-pierce@hhs.gov>; Rainer, Melanie Fontes (OS/IOS) <Melanie.Rainer@hhs.gov>; Jee, Lauren (HHS/ASL) <Lauren.Jee@hhs.gov>
Cc: Lovenheim, Sarah (HHS/ASPA) <Sarah.Lovenheim@hhs.gov>; Zelenko, Leslie (HHS/ASL) <Leslie.Zelenko@hhs.gov>; Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>; Pugh, Carrie (OS/IEA) <Carrie.Pugh@hhs.gov>; Hild, Jeff (HHS/ASL) <Jeff.Hild@hhs.gov>; Orozco, Esmeralda (HHS/IOS) <Esmeralda.Orozco@hhs.gov>; Lopez, Steven (HHS/OS/IOS) <Steven.Lopez@hhs.gov>; Jones, Kamara (HHS/ASPA) <Kamara.Jones@hhs.gov>; Despres, Sarah (HHS/IOS) <Sarah.Despres@hhs.gov>; Figueroa, Marvin (HHS/IEA) <Marvin.Figueroa@hhs.gov>; Espinosa, Kimberly (HHS/ASL) <Kimberly.Espinosa@hhs.gov>; Villanueva, Josie (OS/IOS) <Josie.Villanueva@hhs.gov>; Cha, Stephen (HHS/IOS) <Stephen.Cha@hhs.gov>; Arguello, Andres (OS/IOS) <Andres.Arguello@hhs.gov>; Schechter, Alia (OS/IOS) <Alia.Schechter@hhs.gov>; Seshasai, Karuna (HHS/IOS) <Karuna.Seshasai@hhs.gov>; Zardeneta, Lizeth (HHS/OS/IOS) <Lizeth.Zardeneta@hhs.gov>; Friedman, Jennifer (OS/IOS) <Jennifer.Friedman@hhs.gov>; Reid, Anne (OS/IOS) <Anne.Reid@hhs.gov>; Higgins, Sean (HHS/ASPA) <Sean.Higgins@hhs.gov>
Subject: RE: Confirmed Travel: Manchester, NH and Rhode Island

Good morning Everyone and Happy Friday! New Hampshire sketch v2 is attached.

From: Scott, Benjamin (OS/IOS) <Benjamin.Scott@hhs.gov>
Sent: Friday, July 9, 2021 9:50 AM
To: Palafox, Cynthia (HHS/IOS) <Cynthia.Palafox@hhs.gov>; Doris-Pierce, Molly (OS/IEA) <Molly.Doris-pierce@hhs.gov>; Rainer, Melanie Fontes (OS/IOS) <Melanie.Rainer@hhs.gov>; Wilson, Laurence (OS/IOS) <Laurence.Wilson@hhs.gov>; Jee, Lauren (HHS/ASL) <Lauren.Jee@hhs.gov>
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Subject: RE: Confirmed Travel: Manchester, NH and Rhode Island

Thanks, folks! See updated draft sketch attached. Latest version is v2.

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Sent: Friday, July 9, 2021 10:39 AM
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Subject: RE: Confirmed Travel: Manchester, NH and Rhode Island

Thanks, Molly! Let me check-in with the WH on the park and I'll get back to the group.

@Scott, Benjamin (OS/IOS)and @Wilson, Laurence (OS/IOS) – can you please add these sites to the sketch and send it back around?

From: Doris-Pierce, Molly (OS/IEA) <Molly.Doris-pierce@hhs.gov>
Sent: Friday, July 9, 2021 10:22 AM
To: Palafox, Cynthia (HHS/IOS) <Cynthia.Palafox@hhs.gov>; Rainer, Melanie Fontes (OS/IOS) <Melanie.Rainer@hhs.gov>

Cc: Lovenheim, Sarah (HHS/ASPA) <Sarah.Lovenheim@hhs.gov>; Zelenko, Leslie (HHS/ASL) <Leslie.Zelenko@hhs.gov>; Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>; Pugh, Carrie (OS/IEA) <Carrie.Pugh@hhs.gov>; Wilson, Laurence (OS/IOS) <Laurence.Wilson@hhs.gov>; Hild, Jeff (HHS/ASL) <Jeff.Hild@hhs.gov>; Scott, Benjamin (OS/IOS) <Benjamin.Scott@hhs.gov>; Orozco, Esmeralda (HHS/IOS) <Esmeralda.Orozco@hhs.gov>; Lopez, Steven (HHS/OS/IOS) <Steven.Lopez@hhs.gov>; Jones, Kamara (HHS/ASPA) <Kamara.Jones@hhs.gov>; Despres, Sarah (HHS/IOS) <Sarah.Despres@hhs.gov>; Figueroa, Marvin (HHS/IEA) <Marvin.Figueroa@hhs.gov>; Espinosa, Kimberly (HHS/ASL) <Kimberly.Espinosa@hhs.gov>; Villanueva, Josie (OS/IOS) <Josie.Villanueva@hhs.gov>; Cha, Stephen (HHS/IOS) <Stephen.Cha@hhs.gov>; Arguello, Andres (OS/IOS) <Andres.Arguello@hhs.gov>; Schechter, Alia (OS/IOS) <Alia.Schechter@hhs.gov>; Seshasai, Karuna (HHS/IOS) <Karuna.Seshasai@hhs.gov>; Zardeneta, Lizeth (HHS/OS/IOS) <Lizeth.Zardeneta@hhs.gov>; Jee, Lauren (HHS/ASL) <Lauren.Jee@hhs.gov>; Friedman, Jennifer (OS/IOS) <Jennifer.Friedman@hhs.gov>; Reid, Anne (OS/IOS) <Anne.Reid@hhs.gov>; Higgins, Sean (HHS/ASPA) <Sean.Higgins@hhs.gov>
Subject: RE: Confirmed Travel: Manchester, NH and Rhode Island

Based on folks input this is what I'm tracking as a potential sketch:

New Hampshire
Site #1 – CTC Press Conference in the Park (@Palafox, Cynthia (HHS/IOS) does the WH have a preferred park or should we pick?)
Site #2 – Council for Thriving Children Roundtable on Early Childhood
Site #3 – SUD-related event

Rhode Island
Site #1 – Community Health Center and Navigator Roundtable
Note: This would be for the presser on SEP data and the ACA
Site #2 – Bradley Hospital Site Visit on child and adolescent BH
Site #3 – HCBS Roundtable in the 2nd CD

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To: Rainer, Melanie Fontes (OS/IOS) <Melanie.Rainer@hhs.gov>
Cc: Lovenheim, Sarah (HHS/ASPA) <Sarah.Lovenheim@hhs.gov>; Palafox, Cynthia (HHS/IOS) <Cynthia.Palafox@hhs.gov>; Zelenko, Leslie (HHS/ASL) <Leslie.Zelenko@hhs.gov>; Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>; Pugh, Carrie (OS/IEA) <Carrie.Pugh@hhs.gov>; Wilson, Laurence (OS/IOS) <Laurence.Wilson@hhs.gov>; Hild, Jeff (HHS/ASL) <Jeff.Hild@hhs.gov>; Scott, Benjamin (OS/IOS) <Benjamin.Scott@hhs.gov>; Orozco, Esmeralda (HHS/IOS) <Esmeralda.Orozco@hhs.gov>; Lopez, Steven (HHS/OS/IOS) <Steven.Lopez@hhs.gov>; Jones, Kamara (HHS/ASPA) <Kamara.Jones@hhs.gov>; Despres, Sarah (HHS/IOS) <Sarah.Despres@hhs.gov>; Figueroa, Marvin (HHS/IEA) <Marvin.Figueroa@hhs.gov>; Espinosa, Kimberly (HHS/ASL) <Kimberly.Espinosa@hhs.gov>; Villanueva, Josie (OS/IOS) <Josie.Villanueva@hhs.gov>; Cha, Stephen

(HHS/IOS) <Stephen.Cha@hhs.gov>; Arguello, Andres (OS/IOS) <Andres.Arguello@hhs.gov>; Schechter, Alia (OS/IOS) <Alia.Schechter@hhs.gov>; Seshasai, Karuna (HHS/IOS) <Karuna.Seshasai@hhs.gov>; Zardeneta, Lizeth (HHS/OS/IOS) <Lizeth.Zardeneta@hhs.gov>; Jee, Lauren (HHS/ASL) <Lauren.Jee@hhs.gov>; Friedman, Jennifer (OS/IOS) <Jennifer.Friedman@hhs.gov>; Reid, Anne (OS/IOS) <Anne.Reid@hhs.gov>; Higgins, Sean (HHS/ASPA) <Sean.Higgins@hhs.gov>
Subject: Re: Confirmed Travel: Manchester, NH and Rhode Island

Hi all,

Apologies for the delay here. Below are the recommendations from the region. Note the overlap on the BH Hospital with Rachel's suggestion, so we feel confident about locking that in.

Additionally; we are planning on working with our ASL counterparts on swapping one event in RI to one about home and community based services based on the Members' recommendations. Appreciate your patience as we work that out!

Cynthia, if it makes sense for IEA to winnow down all the recs on this chain for the Secretary to review - let me know!

Thank you!

MDP

Suggestions for New Hampshire Events, Thursday 7/15/21

Press Conference TBD

Event 1: Roundtable meeting with Council for Thriving Children. This state early childhood council is managed cross-agency by the NH Department of Education and the Department of Health and Human Services in cross-sector partnership with the University of New Hampshire. Adopting a social determinants of health framework, the Council strives to meet the educational and health needs of children. With a two-generation lens, membership includesparent leaders, as well as state child care leaders, healthcare experts, businesses and legislators. Pulling a group together would not be difficult.

Event 2: New Hampshire Equity Group could lead a discussion on their Covid vaccine equity strategy with a roundtable of discussants/leaders from faith organizations, FQHCs, CBOs and philanthropies. The focus will be how the state is working to further improve vaccination coverage in BIPOC communities between now and September, as well as a broader discussion of (a) integration with flu vaccination, (b) Covid booster vaccination campaigns into the fall and winter, (c) the state's plan for addressing the EUA which will authorize vaccination of 5-12 year olds later this year and (d) the state's strategy for re-opening schools for the next academic year.

Suggestions for Rhode Island events, Friday 7/16/21

Press Conference TBD

Event 1: Roundtable on Pathways out of Poverty. Secretary Womazetta Jones and/or Dr. Nicole Alexander-Scott would lead a family poverty-reduction focused roundtable on pathways out of poverty. Topics to include a) how to keep the family in the center, b) child care access, c) equity and access of key services and opportunities d) social determinants of health as a primary way of practice e) the child care tax credit f) pilot Universal Basic Income (UBI) work in Providence and other cities. Participants could include community agencies, interfaith leaders, parents, state government. (*Located in Providence, in the 1st Congressional district.*)

Alternate suggestion for Event 1: Covid vaccine equity roundtable

Dr. Nicole Alexander-Scott, Rhode Island's public health commissioner, could lead a discussion on RI's Covid vaccine equity strategy with a roundtable of discussants/leaders from faith organizations, FQHCs, CBOs and philanthropies. The focus will be how the state is working to further improve vaccination coverage in BIPOC communities between now and September, as well as a broader discussion of (a) integration with flu vaccination, (b) Covid booster vaccination campaigns into the fall and winter, (c) the state's plan for addressing the EUA which will authorize vaccination of 5-12 year olds later this year and (d) the state's strategy for re-opening schools for the next academic year.

Event 2. A visit to Bradley Hospital, the nation's first psychiatric hospital devoted exclusively to children and adolescents; Bradley is a Lifespan partner and a teaching hospital for The Warren Alpert Medical School of Brown University. Bradley Hospital has established itself as the national center for training and research in child and adolescent psychiatry. The purpose of the visit would be to highlight and learn about how Rhode Island's Executive Office of Health and Human Services (EOHHS) has been leading a statewide strategic conversation to implement a comprehensive system of care for children's behavioral health. RI's current system is siloed, with responsibility for children fragmented across different state agencies. The goal is to make coordinated services more accessible for families, creating a single point of access that streamlines the process and removes barriers to obtaining timely, necessary services and supports children, youth and families. This will require patient-centered coordination and electronic referral management software to build a coordinated continuum of care network of health and social service providers in RI. The system will include care coordination, intensive home and community-based services, transition-age youth and young adult services, as well as prevention services. (*Located in Providence, in the 1st Congressional district.*)

Event 2. A health equity zone (HEZ) visit that would also include attention to Covid vaccine equity. Rhode Island's Health Equity Zones (HEZ), led by the RI Department of Health, use a social determinants of health framework to decrease family poverty across communities. These community collaborations braid federal/state funding, including Medicaid and public health dollars to link health, social services, families, education and neighborhoods. Through a collaborative, community-led process, each HEZ conducted a needs assessment and implemented a data-driven plan of action to address conditions that are preventing people from being as healthy as possible. As just one example of this initiative's success through improved community health outcomes, in the Pawtucket/Central Falls HEZ in 2019, the area saw a 63% decrease in elementary school absenteeism, a 44% drop in childhood lead poisoning, and a 24% decrease in teen pregnancy. When COVID-19 hit, the Tri-County HEZ leveraged community voice to build resilience and increase awareness and compliance with mitigation guidelines in the three communities served. (*Located in the 2nd Congressional district, and also proximate to the TF Green Airport, for departure.)*

Molly Doris-Pierce, she/her
Special Assistant
Office of Intergovernmental and External Affairs, U.S. Dept. of Health and Human Services
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On Jul 8, 2021, at 7:34 PM, Rainer, Melanie Fontes (OS/IOS) <Melanie.Rainer@hhs.gov>wrote:

CCIIO can help connect but in RH they have a state-run exchange. And they do really good work, so would be good to do something with them and/or navigators/ community health center.

Sent from my iPhone

On Jul 8, 2021, at 7:23 PM, Lovenheim, Sarah (HHS/ASPA) <Sarah.Lovenheim@hhs.gov>wrote:

Desired press conference will focus on new special enrollment data coming so any location that could support that type of announcement would be great (a community health center or clinic, for example).

On Jul 8, 2021, at 6:59 PM, Palafox, Cynthia (HHS/IOS) <Cynthia.Palafox@hhs.gov>wrote:

Hi folks,

Checking-in on the draft sketches for the trips. Attached are the outlines that Ben &Laurence put together. Any updates on potential sites for each of the states?

Thanks,
Cynthia

From: Zelenko, Leslie (HHS/ASL) <Leslie.Zelenko@hhs.gov>
Sent: Thursday, July 8, 2021 3:22 PM
To: Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>; Pugh, Carrie (OS/IEA) <Carrie.Pugh@hhs.gov>; Doris-Pierce, Molly (OS/IEA) <Molly.Doris-pierce@hhs.gov>; Wilson, Laurence (OS/IOS) <Laurence.Wilson@hhs.gov>; Lovenheim, Sarah (HHS/ASPA) <Sarah.Lovenheim@hhs.gov>
Cc: Hild, Jeff (HHS/ASL) <Jeff.Hild@hhs.gov>; Scott, Benjamin (OS/IOS) <Benjamin.Scott@hhs.gov>; Palafox, Cynthia (HHS/IOS) <Cynthia.Palafox@hhs.gov>; Orozco, Esmeralda (HHS/IOS) <Esmeralda.Orozco@hhs.gov>; Lopez, Steven (HHS/OS/IOS) <Steven.Lopez@hhs.gov>; Jones, Kamara (HHS/ASPA) <Kamara.Jones@hhs.gov>; Despres, Sarah (HHS/IOS) <Sarah.Despres@hhs.gov>; Figueroa, Marvin (HHS/IEA) <Marvin.Figueroa@hhs.gov>; Espinosa, Kimberly (HHS/ASL) <Kimberly.Espinosa@hhs.gov>; Villanueva, Josie (OS/IOS) <Josie.Villanueva@hhs.gov>; Rainer, Melanie Fontes (OS/IOS) <Melanie.Rainer@hhs.gov>; Cha, Stephen (HHS/IOS) <Stephen.Cha@hhs.gov>; Arguello, Andres (OS/IOS) <Andres.Arguello@hhs.gov>; Schechter, Alia (OS/IOS) <Alia.Schechter@hhs.gov>; Seshasai, Karuna (HHS/IOS) <Karuna.Seshasai@hhs.gov>; Zardeneta, Lizeth (HHS/OS/IOS) <Lizeth.Zardeneta@hhs.gov>; Jee, Lauren (HHS/ASL) <Lauren.Jee@hhs.gov>; Friedman, Jennifer (OS/IOS) <Jennifer.Friedman@hhs.gov>; Reid, Anne (OS/IOS) <Anne.Reid@hhs.gov>; Higgins, Sean (HHS/ASPA) <Sean.Higgins@hhs.gov>
Subject: RE: Confirmed Travel: Manchester, NH and Rhode Island

Another quick update from ASL:

New Hampshire: Senator Hassan's office said that depending on when the last votes in the Senate end on Thursday, she may be able to make it back for an event in the afternoon.

Rhode Island: Both Members (Rep. Cicilline &Rep. Langevin) will be in the State and look forward to joining the Secretary for his trip. We discussed possible events focused on AFP's HCBS and child care investments. Said I would loop back with more details when I had it from our end.

Thanks!

From: Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>
Sent: Thursday, July 8, 2021 1:55 PM
To: Pugh, Carrie (OS/IEA) <Carrie.Pugh@hhs.gov>; Doris-Pierce, Molly (OS/IEA) <Molly.Doris-pierce@hhs.gov>; Wilson, Laurence (OS/IOS) <Laurence.Wilson@hhs.gov>; Lovenheim, Sarah (HHS/ASPA) <Sarah.Lovenheim@hhs.gov>
Cc: Zelenko, Leslie (HHS/ASL) <Leslie.Zelenko@hhs.gov>; Hild, Jeff (HHS/ASL) <Jeff.Hild@hhs.gov>; Scott, Benjamin (OS/IOS) <Benjamin.Scott@hhs.gov>; Palafox, Cynthia (HHS/IOS) <Cynthia.Palafox@hhs.gov>; Orozco, Esmeralda (HHS/IOS) <Esmeralda.Orozco@hhs.gov>; Lopez, Steven (HHS/OS/IOS) <Steven.Lopez@hhs.gov>; Jones, Kamara (HHS/ASPA) <Kamara.Jones@hhs.gov>; Despres, Sarah (HHS/IOS) <Sarah.Despres@hhs.gov>; Figueroa, Marvin (HHS/IEA) <Marvin.Figueroa@hhs.gov>; Espinosa, Kimberly (HHS/ASL) <Kimberly.Espinosa@hhs.gov>; Villanueva, Josie (OS/IOS) <Josie.Villanueva@hhs.gov>; Rainer, Melanie Fontes (OS/IOS) <Melanie.Rainer@hhs.gov>; Cha, Stephen (HHS/IOS) <Stephen.Cha@hhs.gov>; Arguello, Andres (OS/IOS) <Andres.Arguello@hhs.gov>; Schechter, Alia (OS/IOS) <Alia.Schechter@hhs.gov>; Seshasai, Karuna (HHS/IOS) <Karuna.Seshasai@hhs.gov>; Zardeneta, Lizeth (HHS/OS/IOS) <Lizeth.Zardeneta@hhs.gov>; Jee, Lauren (HHS/ASL) <Lauren.Jee@hhs.gov>; Friedman, Jennifer (OS/IOS) <Jennifer.Friedman@hhs.gov>; Reid, Anne (OS/IOS) <Anne.Reid@hhs.gov>; Higgins, Sean (HHS/ASPA) <Sean.Higgins@hhs.gov>
Subject: RE: Confirmed Travel: Manchester, NH and Rhode Island

Hello all,

A couple thoughts on events. If we are interested, Tom Coderre, Principle Deputy Assistant Secretary at SAMHSA, can facilitate any/all.

Thanks,
Rachel

In both states

Secretary Becerra could visit/do an event at a Certified Community Behavioral Health Clinic (CCBHC's). This is a huge program for many members on the Hill. NH and RI both have grantees and over $1 billion dollars have been invested in this program in the last year, $420 million from the American Rescue Plan. If this direction is of interest, we can track down the best site.

New Hampshire:

If you want to get Hassan's attention in NH, perhaps we should set up some visits to see how the state is spending their SOR grant money. We would have to navigate the state politics on this carefully as Sen. Hassan and Governor Sununu could be opponents next year (https://www.vnews.com/Many-factors-could-Influence-a-Sununu-Senate-run-40918649). The state has used a majority of the money to stand up a Sununu priority for addiction treatment called The Doorway, a hub and spoke model. There are nine Doorway locations, providing single points of entry for people seeking help for substance use, whether they need treatment, support, or resources for prevention and awareness. The regional Doorways ensure that help is always less than an hour away. In addition, 24/7 access to services is also available by dialing 211. https://www.thedoorway.nh.gov/home

In addition to treatment, NH has great prevention and recovery programs as well. Safe Stations was started in Manchester (https://www.manchesternh.gov/Departments/Fire/Safe-Station). Governor Sununu started the first and most robust statewide Recovery Friendly Workplace program, visits to model employers is a possibility (https://www.recoveryfriendlyworkplace.com/). NH has a Recovery HUB with lots of recovery community centers and other programs which make for excellent visits (https://www.dhhs.nh.gov/dcbcs/bdas/recovery.htm).

Looks like Hassan is working with neighbor Collins on workforce issues: https://www.seacoastonline.com/story/opinion/columns/guest/2021/03/18/collins-and-hassan-crisis-within-crisis/4715260001/. We could arrange something around this if you think the Secretary would find it interesting.

Rhode Island:

If you want to focus on **youth BH**, then Bradley Hospital is probably the best option. It's the nation's first psychiatric hospital devoted exclusively to children and adolescents. It's a Lifespan partner and a teaching hospital for The Warren Alpert Medical School of Brown University. Bradley Hospital has established itself as the national center for training and research in child and adolescent psychiatry. Bradley Hospital is a private, not-for-profit hospital. https://www.lifespan.org/locations/bradley-hospital/about-bradley-hospital

There is also BH Link. BH Link's mission is to ensure all Rhode Islanders **18+** experiencing mental health and substance use crises receive the appropriate services they need as quickly as possible in an environment that supports their recovery. https://www.bhlink.org/ This could be a good place to talk about crisis grant announcement and the building of crisis services in anticipation of 988. There is also a Kids Link, that I think Bradley manages.

There are a lot of options for recovery support and overdose related work – 5-6 recovery centers throughout the state (https://bhddh.ri.gov/substance-useaddiction/recovery-services), recovery coaches in ED's, Providence Safe (Fire) Stations (https://pvdsafestations.com/), and a recovery friendly workplace program (https://recoveryfriendlyri.com/). Rhode Island also has a renowned MAT behind the walls program, the only statewide program in the nation to offer all three FDA approved medications for OUD (https://www.statnews.com/2018/02/14/medication-assisted-treatment-inmates/). Dr. Nicole Alexander Scott is the Director of the Department of Health and co-chairs the Governor's Overdose Prevention Task Force, I would suggest including her in some way.

The legislative session just concluded and it was a good one for drug policy. Caution though, the state passed and today the Governor signed a bill legalizing the first Safe Injection Facility. The state also reclassified drug crimes as misdemeanors and decriminalized possession of buprenorphine. This article

references Secretary Becerra's support for SIF's when he was AG in CA: https://www.providencejournal.com/story/news/courts/2021/07/03/ri-could-first-state-in-nation-to-legalize-safe-injection-sites-for-opioid-addicts/7840401002/

From: Pugh, Carrie (OS/IEA) <Carrie.Pugh@hhs.gov>
Sent: Thursday, July 8, 2021 11:46 AM
To: Doris-Pierce, Molly (OS/IEA) <Molly.Doris-pierce@hhs.gov>; Wilson, Laurence (OS/IOS) <Laurence.Wilson@hhs.gov>; Lovenheim, Sarah (HHS/ASPA) <Sarah.Lovenheim@hhs.gov>
Cc: Zelenko, Leslie (HHS/ASL) <Leslie.Zelenko@hhs.gov>; Hild, Jeff (HHS/ASL) <Jeff.Hild@hhs.gov>; Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>; Scott, Benjamin (OS/IOS) <Benjamin.Scott@hhs.gov>; Palafox, Cynthia (HHS/IOS) <Cynthia.Palafox@hhs.gov>; Orozco, Esmeralda (HHS/IOS) <Esmeralda.Orozco@hhs.gov>; Lopez, Steven (HHS/OS/IOS) <Steven.Lopez@hhs.gov>; Jones, Kamara (HHS/ASPA) <Kamara.Jones@hhs.gov>; Despres, Sarah (HHS/IOS) <Sarah.Despres@hhs.gov>; Figueroa, Marvin (HHS/IEA) <Marvin.Figueroa@hhs.gov>; Espinosa, Kimberly (HHS/ASL) <Kimberly.Espinosa@hhs.gov>; Villanueva, Josie (OS/IOS) <Josie.Villanueva@hhs.gov>; Rainer, Melanie Fontes (OS/IOS) <Melanie.Rainer@hhs.gov>; Cha, Stephen (HHS/IOS) <Stephen.Cha@hhs.gov>; Arguello, Andres (OS/IOS) <Andres.Arguello@hhs.gov>; Schechter, Alia (OS/IOS) <Alia.Schechter@hhs.gov>; Seshasai, Karuna (HHS/IOS) <Karuna.Seshasai@hhs.gov>; Zardeneta, Lizeth (HHS/OS/IOS) <Lizeth.Zardeneta@hhs.gov>; Jee, Lauren (HHS/ASL) <Lauren.Jee@hhs.gov>; Friedman, Jennifer (OS/IOS) <Jennifer.Friedman@hhs.gov>; Reid, Anne (OS/IOS) <Anne.Reid@hhs.gov>; Higgins, Sean (HHS/ASPA) <Sean.Higgins@hhs.gov>
Subject: RE: Confirmed Travel: Manchester, NH and Rhode Island

Good flag – thanks.

From: Doris-Pierce, Molly (OS/IEA) <Molly.Doris-pierce@hhs.gov>
Sent: Thursday, July 8, 2021 11:12 AM
To: Wilson, Laurence (OS/IOS) <Laurence.Wilson@hhs.gov>; Lovenheim, Sarah (HHS/ASPA) <Sarah.Lovenheim@hhs.gov>
Cc: Zelenko, Leslie (HHS/ASL) <Leslie.Zelenko@hhs.gov>; Hild, Jeff (HHS/ASL) <Jeff.Hild@hhs.gov>; Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>; Scott, Benjamin (OS/IOS) <Benjamin.Scott@hhs.gov>; Palafox, Cynthia (HHS/IOS) <Cynthia.Palafox@hhs.gov>; Orozco, Esmeralda (HHS/IOS) <Esmeralda.Orozco@hhs.gov>; Lopez, Steven (HHS/OS/IOS) <Steven.Lopez@hhs.gov>; Jones, Kamara (HHS/ASPA) <Kamara.Jones@hhs.gov>; Despres, Sarah (HHS/IOS) <Sarah.Despres@hhs.gov>; Figueroa, Marvin (HHS/IEA) <Marvin.Figueroa@hhs.gov>; Espinosa, Kimberly (HHS/ASL) <Kimberly.Espinosa@hhs.gov>; Villanueva, Josie (OS/IOS) <Josie.Villanueva@hhs.gov>; Rainer, Melanie Fontes (OS/IOS) <Melanie.Rainer@hhs.gov>; Cha, Stephen (HHS/IOS) <Stephen.Cha@hhs.gov>; Pugh, Carrie (OS/IEA) <Carrie.Pugh@hhs.gov>; Arguello, Andres (OS/IOS) <Andres.Arguello@hhs.gov>; Schechter, Alia (OS/IOS) <Alia.Schechter@hhs.gov>; Seshasai, Karuna (HHS/IOS) <Karuna.Seshasai@hhs.gov>; Zardeneta, Lizeth (HHS/OS/IOS) <Lizeth.Zardeneta@hhs.gov>; Jee, Lauren (HHS/ASL) <Lauren.Jee@hhs.gov>; Friedman, Jennifer (OS/IOS) <Jennifer.Friedman@hhs.gov>; Reid, Anne (OS/IOS) <Anne.Reid@hhs.gov>; Higgins, Sean (HHS/ASPA) <Sean.Higgins@hhs.gov>
Subject: RE: Confirmed Travel: Manchester, NH and Rhode Island

Wanted to flag for this group that he will be in NH, but we declined the ME opioid summit in person request and pre-recorded. I don't think it's an issue, but did want to flag the date overlap.

Molly Doris-Pierce, *she/her*
Special Assistant
Office of Intergovernmental and External Affairs, U.S. Dept. of Health and Human Services
Cell: 202-(b)(6)

From: Wilson, Laurence (OS/IOS) <Laurence.Wilson@hhs.gov>
Sent: Wednesday, July 7, 2021 9:45 PM
To: Lovenheim, Sarah (HHS/ASPA) <Sarah.Lovenheim@hhs.gov>
Cc: Zelenko, Leslie (HHS/ASL) <Leslie.Zelenko@hhs.gov>; Hild, Jeff (HHS/ASL) <Jeff.Hild@hhs.gov>; Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>; Scott, Benjamin (OS/IOS) <Benjamin.Scott@hhs.gov>; Palafox, Cynthia (HHS/IOS) <Cynthia.Palafox@hhs.gov>; Orozco, Esmeralda (HHS/IOS) <Esmeralda.Orozco@hhs.gov>; Lopez, Steven (HHS/OS/IOS) <Steven.Lopez@hhs.gov>; Jones, Kamara (HHS/ASPA) <Kamara.Jones@hhs.gov>; Despres, Sarah (HHS/IOS) <Sarah.Despres@hhs.gov>; Figueroa, Marvin (HHS/IEA) <Marvin.Figueroa@hhs.gov>; Espinosa, Kimberly (HHS/ASL) <Kimberly.Espinosa@hhs.gov>; Villanueva, Josie (OS/IOS) <Josie.Villanueva@hhs.gov>; Rainer, Melanie Fontes (OS/IOS) <Melanie.Rainer@hhs.gov>; Cha, Stephen (HHS/IOS) <Stephen.Cha@hhs.gov>; Pugh, Carrie (OS/IEA) <Carrie.Pugh@hhs.gov>; Arguello, Andres (OS/IOS) <Andres.Arguello@hhs.gov>; Schechter, Alia (OS/IOS) <Alia.Schechter@hhs.gov>; Seshasai, Karuna (HHS/IOS) <Karuna.Seshasai@hhs.gov>; Zardeneta, Lizeth (HHS/OS/IOS) <Lizeth.Zardeneta@hhs.gov>; Doris-Pierce, Molly (OS/IEA) <Molly.Doris-pierce@hhs.gov>; Jee, Lauren (HHS/ASL) <Lauren.Jee@hhs.gov>; Friedman, Jennifer (OS/IOS) <Jennifer.Friedman@hhs.gov>; Reid, Anne (OS/IOS) <Anne.Reid@hhs.gov>; Higgins, Sean (HHS/ASPA) <Sean.Higgins@hhs.gov>
Subject: Re: Confirmed Travel: Manchester, NH and Rhode Island

Resending New Hampshire sketch as additional folks have been added.

Best,

Laurence J. Wilson
Advance Representative
Office of the Secretary
U.S. Department of Health &Human Services
202-(b)(6)
laurence.wilson@hhs.gov

On Jul 7, 2021, at 7:49 PM, Lovenheim, Sarah (HHS/ASPA) <Sarah.Lovenheim@hhs.gov>wrote:

+ Sean H, who will be our ASPA POC.

On Jul 7, 2021, at 5:18 PM, Zelenko, Leslie (HHS/ASL) <Leslie.Zelenko@hhs.gov>wrote:

Hi folks,

Quick update for New Hampshire:

Congressman Chris Pappas will not be in town on the 15th, his office asked if there was any flexibility on the date, I'm guessing there's not but just wanted to see.

Senator Shaheen was hoping to get more details on the events of the day, I said I would share when I have them. Her Chief flagged that the Senate is in session next week, which may make it difficult.

Thanks!
Leslie

From: Hild, Jeff (HHS/ASL) <Jeff.Hild@hhs.gov>
Sent: Wednesday, July 7, 2021 2:15 PM
To: Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>; Scott, Benjamin (OS/IOS) <Benjamin.Scott@hhs.gov>; Wilson, Laurence (OS/IOS) <Laurence.Wilson@hhs.gov>; Palafox, Cynthia (HHS/IOS) <Cynthia.Palafox@hhs.gov>; Zelenko, Leslie (HHS/ASL) <Leslie.Zelenko@hhs.gov>
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Subject: RE: Confirmed Travel: Manchester, NH and Rhode Island

+ Leslie who is helping to coordinate with the Congressional offices.

From: Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>
Sent: Wednesday, July 7, 2021 1:22 PM
To: Scott, Benjamin (OS/IOS) <Benjamin.Scott@hhs.gov>; Wilson, Laurence (OS/IOS) <Laurence.Wilson@hhs.gov>; Palafox, Cynthia (HHS/IOS) <Cynthia.Palafox@hhs.gov>
Cc: Orozco, Esmeralda (HHS/IOS) <Esmeralda.Orozco@hhs.gov>; Lopez, Steven (HHS/OS/IOS) <Steven.Lopez@hhs.gov>; Jones, Kamara (HHS/ASPA) <Kamara.Jones@hhs.gov>; Despres, Sarah (HHS/IOS) <Sarah.Despres@hhs.gov>; Lovenheim, Sarah (HHS/ASPA) <Sarah.Lovenheim@hhs.gov>; Figueroa, Marvin (HHS/IEA) <Marvin.Figueroa@hhs.gov>; Espinosa, Kimberly (HHS/ASL) <Kimberly.Espinosa@hhs.gov>; Hild, Jeff (HHS/ASL) <Jeff.Hild@hhs.gov>; Villanueva, Josie (OS/IOS) <Josie.Villanueva@hhs.gov>; Rainer, Melanie Fontes (OS/IOS) <Melanie.Rainer@hhs.gov>; Cha, Stephen (HHS/IOS) <Stephen.Cha@hhs.gov>; Pugh, Carrie (OS/IEA) <Carrie.Pugh@hhs.gov>; Arguello, Andres (OS/IOS) <Andres.Arguello@hhs.gov>; Schechter, Alia (OS/IOS) <Alia.Schechter@hhs.gov>; Seshasai, Karuna (HHS/IOS) <Karuna.Seshasai@hhs.gov>; Zardeneta, Lizeth (HHS/OS/IOS) <Lizeth.Zardeneta@hhs.gov>; Doris-Pierce, Molly (OS/IEA) <Molly.Doris-pierce@hhs.gov>; Jee, Lauren (HHS/ASL) <Lauren.Jee@hhs.gov>; Friedman, Jennifer (OS/IOS) <Jennifer.Friedman@hhs.gov>; Reid,

Anne (OS/IOS) <Anne.Reid@hhs.gov>
Subject: RE: Confirmed Travel: Manchester, NH and Rhode Island

We have a lot of HCBS and SUD opportunity in both NH and RI- pulling some good programs now- thanks, Rachel

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From: Scott, Benjamin (OS/IOS) <Benjamin.Scott@hhs.gov>
Sent: Wednesday, July 7, 2021 1:03 PM
To: Wilson, Laurence (OS/IOS) <Laurence.Wilson@hhs.gov>; Palafox, Cynthia (HHS/IOS) <Cynthia.Palafox@hhs.gov>
Cc: Orozco, Esmeralda (HHS/IOS) <Esmeralda.Orozco@hhs.gov>; Lopez, Steven (HHS/OS/IOS) <Steven.Lopez@hhs.gov>; Jones, Kamara (HHS/ASPA) <Kamara.Jones@hhs.gov>; Despres, Sarah (HHS/IOS) <Sarah.Despres@hhs.gov>; Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>; Lovenheim, Sarah (HHS/ASPA) <Sarah.Lovenheim@hhs.gov>; Figueroa, Marvin (HHS/IEA) <Marvin.Figueroa@hhs.gov>; Espinosa, Kimberly (HHS/ASL) <Kimberly.Espinosa@hhs.gov>; Hild, Jeff (HHS/ASL) <Jeff.Hild@hhs.gov>; Villanueva, Josie (OS/IOS) <Josie.Villanueva@hhs.gov>; Rainer, Melanie Fontes (OS/IOS) <Melanie.Rainer@hhs.gov>; Cha, Stephen (HHS/IOS) <Stephen.Cha@hhs.gov>; Pugh, Carrie (OS/IEA) <Carrie.Pugh@hhs.gov>; Arguello, Andres (OS/IOS) <Andres.Arguello@hhs.gov>; Schechter, Alia (OS/IOS) <Alia.Schechter@hhs.gov>; Seshasai, Karuna (HHS/IOS) <Karuna.Seshasai@hhs.gov>; Zardeneta, Lizeth (HHS/OS/IOS) <Lizeth.Zardeneta@hhs.gov>; Doris-Pierce, Molly (OS/IEA) <Molly.Doris-pierce@hhs.gov>; Jee, Lauren (HHS/ASL) <Lauren.Jee@hhs.gov>; Friedman, Jennifer (OS/IOS) <Jennifer.Friedman@hhs.gov>; Reid, Anne (OS/IOS) <Anne.Reid@hhs.gov>
Subject: RE: Confirmed Travel: Manchester, NH and Rhode Island

Folks – find incredibly draft version of sketch for Rhode Island attached. Will start a new Rhode Island only thread once we identify staff. Thanks!!

Ben

Benjamin Scott
Advance Representative | U.S. Department of Health &Human Services
benjamin.scott@hhs.gov
Domestic: +1 202 (b)(6)

From: Wilson, Laurence (OS/IOS) <Laurence.Wilson@hhs.gov>
Sent: Wednesday, July 7, 2021 11:50 AM
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Cc: Orozco, Esmeralda (HHS/IOS) <Esmeralda.Orozco@hhs.gov>; Lopez, Steven (HHS/OS/IOS) <Steven.Lopez@hhs.gov>; Jones, Kamara (HHS/ASPA) <Kamara.Jones@hhs.gov>; Despres, Sarah (HHS/IOS) <Sarah.Despres@hhs.gov>; Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>; Lovenheim, Sarah (HHS/ASPA) <Sarah.Lovenheim@hhs.gov>; Figueroa, Marvin (HHS/IEA) <Marvin.Figueroa@hhs.gov>; Espinosa, Kimberly (HHS/ASL) <Kimberly.Espinosa@hhs.gov>; Hild, Jeff (HHS/ASL) <Jeff.Hild@hhs.gov>; Villanueva, Josie (OS/IOS) <Josie.Villanueva@hhs.gov>; Rainer, Melanie Fontes (OS/IOS) <Melanie.Rainer@hhs.gov>; Cha, Stephen (HHS/IOS) <Stephen.Cha@hhs.gov>; Pugh, Carrie (OS/IEA) <Carrie.Pugh@hhs.gov>; Scott, Benjamin (OS/IOS) <Benjamin.Scott@hhs.gov>; Arguello,

Andres (OS/IOS) <Andres.Arguello@hhs.gov>; Schechter, Alia (OS/IOS) <Alia.Schechter@hhs.gov>; Seshasai, Karuna (HHS/IOS) <Karuna.Seshasai@hhs.gov>; Zardeneta, Lizeth (HHS/OS/IOS) <Lizeth.Zardeneta@hhs.gov>; Doris-Pierce, Molly (OS/IEA) <Molly.Doris-pierce@hhs.gov>; Jee, Lauren (HHS/ASL) <Lauren.Jee@hhs.gov>; Friedman, Jennifer (OS/IOS) <Jennifer.Friedman@hhs.gov>; Reid, Anne (OS/IOS) <Anne.Reid@hhs.gov>
Subject: Re: Confirmed Travel: Manchester, NH and Rhode Island

Thanks, Cynthia! Will do.

Best,

Laurence J. Wilson
Advance Representative
Office of the Secretary
U.S. Department of Health &Human Services
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On Jul 7, 2021, at 10:22 AM, Palafox, Cynthia (HHS/IOS) <Cynthia.Palafox@hhs.gov>wrote:

Hi team,

The Secretary approved the travel to Manchester, NH on Thursday, July 15 and to Rhode Island on Friday, July 16. We also received confirmation from ASL on RI availability, so we fully locked-in for that trip. And although we are still working on clarifying a few pieces with ethics, I would like to see a **draft sketch of both trips by COB tomorrow**. And as we have before, it would great to continue to highlight the AFP and vaccine confidence (if appropriate) as well as care economy in RI.

Below is the tentative schedule I created for both days based on potential arrival and departure times. Although we don't yet know where the Secretary will be needed first in RI, I am having him travel to Providence from Manchester, NH, but that can be changed.

Thursday, July 15, 2021
10:00am ET Wheels Down Manchester, NH
 HOLD for potential press
11:00am ET (60 min) CTC Press Conference (location: at a park – exact location TBD)
12:00pm ET Travel to lunch
12:15pm ET (60 min) Lunch
1:15pm ET Travel to site #2
1:30pm ET (90 min) Site #2
3:00pm ET Travel to site #3
3:15pm ET (90 min) Site #3
4:45pm ET Depart Manchester, NH and **drive** to Providence, RI
7:00pm ET Arrive at Providence RI

RON: Hotel in Providence, RI (location TBD)

Friday, July 16, 2021

9:00am ET Hold for press
9:30am ET Travel to site #1
10:00am ET (60 min) Site #1
11:00am ET Travel to site #2
11:30pm ET (60 min) Site #2
12:30pm ET (30 min) Lunch
1:00pm ET Depart for site #3
1:30pm ET (60 min) Site #3
2:30pm ET Depart for airport
4:00pm ET Arrive at airport
4:45pm ET Wheels-up Providence, RI

ASPA team – Sarah requested that we try and proactively hold time for press during each trip. Please let me know what time would work best. I'm currently holding time first thing in the morning but let me know if that doesn't work on your end.

ASL team – please confirm the Secretary's participation and let us know what they have in mind, especially for RI

IEA team – please confirm the Secretary's travel with regional office and keep us all posted on potential sites. Also, let me know if the time I've allocated is not enough – we could try to play round with timing based on the locations.

Counselors – please let us know if there's any specific policy and/or topics that the team should be aware of when building out the trip.

Ben – I know you are in Charlotte at the moment, but when you're free, can you please start creating the full sketch for RI?

Laurence – can you please start creating the sketch for Manchester, NH?

Thank you all!

Cynthia

Cynthia Palafox
Director of Scheduling &Advance
U.S. Department of Health and Human Services
202-[b)(6)] (cell)
cynthia.palafox@hhs.gov

<7.15.21 Manchester, New Hampshire Trip Sketch v1.docx>
<Rhode Island - Sketch - v1.docx>

Sender:	Doris-Pierce, Molly (OS/IEA) /O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=319BFFA9A39B432EB695810F0C3A7202-DORIS-PIERC <Molly.Doris-pierce@hhs.gov>
Recipient:	Palafox, Cynthia (HHS/IOS) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=fc909aa52772499d9b0aa2d3b88ea6eb-Palafox, Cy <Cynthia.Palafox@hhs.gov>; Zelenko, Leslie (HHS/ASL) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=b14d75b301ff4872beb48588e0ad4c8e-Zelenko, Le <Leslie.Zelenko@hhs.gov>; Wilson, Laurence (OS/IOS) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=161e6a3e157b42fb9f2c27260d697a79-Wilson, Lau <Laurence.Wilson@hhs.gov>; Scott, Benjamin (OS/IOS) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=78e801f602f54f21a59156d5b1cd26cc-Scott, Benj <Benjamin.Scott@hhs.gov>; Rainer, Melanie Fontes (OS/IOS) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=9c7242f10a494d45bab72c452ecd9f80-Rainer, Mel <Melanie.Rainer@hhs.gov>; Jee, Lauren (HHS/ASL) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=a7771eca5c9448a8bb1f8860affd22c0-Jee, Lauren <Lauren.Jee@hhs.gov>; Lovenheim, Sarah (HHS/ASPA) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=47f3afc033df47b1aaa46c8e43961db5-Goldfarb, S <Sarah.Lovenheim@hhs.gov>; Pryor, Rachel (HHS/OS/IOS) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=1e87a6df2de041fcb673dd5e40029b87-Pryor, Rach <Rachel.Pryor@hhs.gov>; Pugh, Carrie (OS/IEA) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=600602937a904b288a2b2c0d1d75fc6a-Pugh, Carri <Carrie.Pugh@hhs.gov>; Hild, Jeff (HHS/ASL) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=fece8d2d4b8f414ebd2bf636eac3ce50-Hild, Jeff <Jeff.Hild@hhs.gov>; Orozco, Esmeralda (HHS/IOS) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=1b0828fef0414c538c6def9f15bbb6c1-Orozco, Esm <Esmeralda.Orozco@hhs.gov>; Lopez, Steven (HHS/OS/IOS) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=fb54685278d24cae97d8548aa6232f53-Lopez, Stev <Steven.Lopez@hhs.gov>; Jones, Kamara (HHS/ASPA) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=05cef78e341b467099676c353121c1ed-Jones, Kama <Kamara.Jones@hhs.gov>; Despres, Sarah (HHS/IOS) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=15d1d64eacdf46b8a378310ae7caf6bd-Despres, Sa <Sarah.Despres@hhs.gov>; Figueroa, Marvin (HHS/IEA) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=4a287d28c5d248d2a21ad454649a7f7e-Figueroa, M <Marvin.Figueroa@hhs.gov>; Espinosa, Kimberly (HHS/ASL) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=3ea068cdda2a4a10a83d1050f1f874af-Espinosa, K <Kimberly.Espinosa@hhs.gov>; Villanueva, Josie (OS/IOS) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=5f96c04c92d34952a184fecc1f9eb0cb-Villanueva, <Josie.Villanueva@hhs.gov>; Cha, Stephen (HHS/IOS) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=23e67977d77947d69baf2ace846821a8-Cha, Stephe <Stephen.Cha@hhs.gov>; Arguello, Andres (OS/IOS) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=a329ef44da0542b0b71f9c5c12b4ec91-Arguello, A <Andres.Arguello@hhs.gov>; Schechter, Alia (OS/IOS) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=5fabc7f0f3614cbdb7c64f9fb62743cc-Schechter, <Alia.Schechter@hhs.gov>;

Seshasai, Karuna (HHS/IOS) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=f18c182cd9f74851af73f94ba2dffd06-Seshasai, K <Karuna.Seshasai@hhs.gov>;
Zardeneta, Lizeth (HHS/OS/IOS) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=11beff59ebbd47cdb99e6b1d0d0f7c7d-Zardeneta, <Lizeth.Zardeneta@hhs.gov>;
Friedman, Jennifer (OS/IOS) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=f8a66be214774b15a58e5aa9b867e51c-Friedman, J <Jennifer.Friedman@hhs.gov>;
Reid, Anne (OS/IOS) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=2d168184a76848ad8576ae7c8fad8c62-Reid, Anne <Anne.Reid@hhs.gov>;
Higgins, Sean (HHS/ASPA) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=12cc04e1cb0147408f56f9efac699715-Higgins, Se <Sean.Higgins@hhs.gov>

Sent Date: 2021/07/12 14:44:42

Delivered Date: 2021/07/12 14:44:47

From: (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=319BFFA9A39B432EB695810F0C3A7202-DORIS-PIERC <Molly.Doris-pierce@hhs.gov>

To: Rainer, Melanie Fontes (OS/IOS) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=9c7242f10a494d45bab72c452ecd9f80-Rainer, Mel <Melanie.Rainer@hhs.gov>

CC: Lovenheim, Sarah (HHS/ASPA) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=47f3afc033df47b1aaa46c8e43961db5-Goldfarb, S <Sarah.Lovenheim@hhs.gov>;
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Schechter, Alia (OS/IOS) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=5fabc7f0f3614cbdb7c64f9fb62743cc-Schechter, <Alia.Schechter@hhs.gov>;
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Subject: Re: Confirmed Travel: Manchester, NH and Rhode Island

Date: 2021/07/08 21:17:19

Priority: Normal

Type: Note

Hi all,

Apologies for the delay here. Below are the recommendations from the region. Note the overlap on the BH Hospital with Rachel's suggestion, so we feel confident about locking that in.

Additionally; we are planning on working with our ASL counterparts on swapping one event in RI to one about home and community based services based on the Members' recommendations. Appreciate your patience as we work that out!

Cynthia, if it makes sense for IEA to winnow down all the recs on this chain for the Secretary to review - let me know!

Thank you!

MDP

Suggestions for New Hampshire Events, Thursday 7/15/21

Press Conference TBD

Event 1: Roundtable meeting with Council for Thriving Children. This state early childhood council is managed cross-agency by the NH Department of Education and the Department of Health and Human Services in cross-sector partnership with the University of New Hampshire. Adopting a social determinants of health framework, the Council strives to meet the educational and health needs of children. With a two-generation lens, membership includesparent leaders, as well as state child care leaders, healthcare experts, businesses and legislators. Pulling a group together would not be difficult.

Event 2: New Hampshire Equity Group could lead a discussion on their Covid vaccine equity strategy with a roundtable of discussants/leaders from faith organizations, FQHCs, CBOs and philanthropies. The focus will be how the state is working to further improve vaccination coverage in BIPOC communities

between now and September, as well as a broader discussion of (a) integration with flu vaccination, (b) Covid booster vaccination campaigns into the fall and winter, (c) the state's plan for addressing the EUA which will authorize vaccination of 5-12 year olds later this year and (d) the state's strategy for re-opening schools for the next academic year.

Suggestions for Rhode Island events, Friday 7/16/21

Press Conference TBD

Event 1: Roundtable on Pathways out of Poverty. Secretary Womazetta Jones and/or Dr. Nicole Alexander-Scott would lead a family poverty-reduction focused roundtable on pathways out of poverty. Topics to include a) how to keep the family in the center, b) child care access, c) equity and access of key services and opportunities d) social determinants of health as a primary way of practice e) the child care tax credit f) pilot Universal Basic Income (UBI) work in Providence and other cities. Participants could include community agencies, interfaith leaders, parents, state government. (*Located in Providence, in the 1st Congressianol district.*)

Alternate suggestion for Event 1: Covid vaccine equity roundtable

Dr. Nicole Alexander-Scott, Rhode Island's public health commissioner, could lead a discussion on RI's Covid vaccine equity strategy with a roundtable of discussants/leaders from faith organizations, FQHCs, CBOs and philanthropies. The focus will be how the state is working to further improve vaccination coverage in BIPOC communities between now and September, as well as a broader discussion of (a) integration with flu vaccination, (b) Covid booster vaccination campaigns into the fall and winter, (c) the state's plan for addressing the EUA which will authorize vaccination of 5-12 year olds later this year and (d) the state's strategy for re-opening schools for the next academic year.

Event 2. A visit to Bradley Hospital, the nation's first psychiatric hospital devoted exclusively to children and adolescents; Bradley is a Lifespan partner and a teaching hospital for The Warren Alpert Medical School of Brown University. Bradley Hospital has established itself as the national center for training and research in child and adolescent psychiatry. The purpose of the visit would be to highlight and learn about how Rhode Island's Executive Office of Health and Human Services (EOHHS) has been leading a statewide strategic conversation to implement a comprehensive system of care for children's behavioral health. RI's current system is siloed, with responsibility for children fragmented across different state agencies. The goal is to make coordinated services more accessible for families, creating a single point of access that streamlines the process and removes barriers to obtaining timely, necessary services and supports children, youth and families. This will require patient-centered coordination and electronic referral management software to build a coordinated continuum of care network of health and social service providers in RI. The system will include care coordination, intensive home and community-based services, transition-age youth and young adult services, as well as prevention services. (*Located in Providence, in the 1st Congressional district.*)

Event 2. A health equity zone (HEZ) visit that would also include attention to Covid vaccine equity. Rhode Island's Health Equity Zones (HEZ), led by the RI Department of Health, use a social determinants of health framework to decrease family poverty across communities. These community collaborations braid federal/state funding, including Medicaid and public health dollars to link health, social services,

families, education and neighborhoods. Through a collaborative, community-led process, each HEZ conducted a needs assessment and implemented a data-driven plan of action to address conditions that are preventing people from being as healthy as possible. As just one example of this initiative's success through improved community health outcomes, in the Pawtucket/Central Falls HEZ in 2019, the area saw a 63% decrease in elementary school absenteeism, a 44% drop in childhood lead poisoning, and a 24% decrease in teen pregnancy. When COVID-19 hit, the Tri-County HEZ leveraged community voice to build resilience and increase awareness and compliance with mitigation guidelines in the three communities served. (*Locoted in the 2nd Congressional district, and alsa proximate to the TF Green Airport, for departure.)*

Molly Doris-Pierce, she/her
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On Jul 8, 2021, at 7:34 PM, Rainer, Melanie Fontes (OS/IOS) <Melanie.Rainer@hhs.gov>wrote:

CCIIO can help connect but in RH they have a state-run exchange. And they do really good work, so would be good to do something with them and/or navigators/ community health center.

Sent from my iPhone

On Jul 8, 2021, at 7:23 PM, Lovenheim, Sarah (HHS/ASPA) <Sarah.Lovenheim@hhs.gov>wrote:

Desired press conference will focus on new special enrollment data coming so any location that could support that type of announcement would be great (a community health center or clinic, for example).

On Jul 8, 2021, at 6:59 PM, Palafox, Cynthia (HHS/IOS) <Cynthia.Palafox@hhs.gov>wrote:

Hi folks,

Checking-in on the draft sketches for the trips. Attached are the outlines that Ben &Laurence put together. Any updates on potential sites for each of the states?

Thanks,
Cynthia

From: Zelenko, Leslie (HHS/ASL) <Leslie.Zelenko@hhs.gov>
Sent: Thursday, July 8, 2021 3:22 PM
To: Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>; Pugh, Carrie (OS/IEA) <Carrie.Pugh@hhs.gov>; Doris-Pierce, Molly (OS/IEA) <Molly.Doris-pierce@hhs.gov>; Wilson, Laurence (OS/IOS) <Laurence.Wilson@hhs.gov>; Lovenheim, Sarah (HHS/ASPA) <Sarah.Lovenheim@hhs.gov>
Cc: Hild, Jeff (HHS/ASL) <Jeff.Hild@hhs.gov>; Scott, Benjamin (OS/IOS) <Benjamin.Scott@hhs.gov>; Palafox, Cynthia (HHS/IOS) <Cynthia.Palafox@hhs.gov>; Orozco, Esmeralda (HHS/IOS)

<Esmeralda.Orozco@hhs.gov>; Lopez, Steven (HHS/OS/IOS) <Steven.Lopez@hhs.gov>; Jones, Kamara (HHS/ASPA) <Kamara.Jones@hhs.gov>; Despres, Sarah (HHS/IOS) <Sarah.Despres@hhs.gov>; Figueroa, Marvin (HHS/IEA) <Marvin.Figueroa@hhs.gov>; Espinosa, Kimberly (HHS/ASL) <Kimberly.Espinosa@hhs.gov>; Villanueva, Josie (OS/IOS) <Josie.Villanueva@hhs.gov>; Rainer, Melanie Fontes (OS/IOS) <Melanie.Rainer@hhs.gov>; Cha, Stephen (HHS/IOS) <Stephen.Cha@hhs.gov>; Arguello, Andres (OS/IOS) <Andres.Arguello@hhs.gov>; Schechter, Alia (OS/IOS) <Alia.Schechter@hhs.gov>; Seshasai, Karuna (HHS/IOS) <Karuna.Seshasai@hhs.gov>; Zardeneta, Lizeth (HHS/OS/IOS) <Lizeth.Zardeneta@hhs.gov>; Jee, Lauren (HHS/ASL) <Lauren.Jee@hhs.gov>; Friedman, Jennifer (OS/IOS) <Jennifer.Friedman@hhs.gov>; Reid, Anne (OS/IOS) <Anne.Reid@hhs.gov>; Higgins, Sean (HHS/ASPA) <Sean.Higgins@hhs.gov>
Subject: RE: Confirmed Travel: Manchester, NH and Rhode Island

Another quick update from ASL:

New Hampshire: Senator Hassan's office said that depending on when the last votes in the Senate end on Thursday, she may be able to make it back for an event in the afternoon.

Rhode Island: Both Members (Rep. Cicilline &Rep. Langevin) will be in the State and look forward to joining the Secretary for his trip. We discussed possible events focused on AFP's HCBS and child care investments. Said I would loop back with more details when I had it from our end.

Thanks!

From: Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>
Sent: Thursday, July 8, 2021 1:55 PM
To: Pugh, Carrie (OS/IEA) <Carrie.Pugh@hhs.gov>; Doris-Pierce, Molly (OS/IEA) <Molly.Doris-pierce@hhs.gov>; Wilson, Laurence (OS/IOS) <Laurence.Wilson@hhs.gov>; Lovenheim, Sarah (HHS/ASPA) <Sarah.Lovenheim@hhs.gov>
Cc: Zelenko, Leslie (HHS/ASL) <Leslie.Zelenko@hhs.gov>; Hild, Jeff (HHS/ASL) <Jeff.Hild@hhs.gov>; Scott, Benjamin (OS/IOS) <Benjamin.Scott@hhs.gov>; Palafox, Cynthia (HHS/IOS) <Cynthia.Palafox@hhs.gov>; Orozco, Esmeralda (HHS/IOS) <Esmeralda.Orozco@hhs.gov>; Lopez, Steven (HHS/OS/IOS) <Steven.Lopez@hhs.gov>; Jones, Kamara (HHS/ASPA) <Kamara.Jones@hhs.gov>; Despres, Sarah (HHS/IOS) <Sarah.Despres@hhs.gov>; Figueroa, Marvin (HHS/IEA) <Marvin.Figueroa@hhs.gov>; Espinosa, Kimberly (HHS/ASL) <Kimberly.Espinosa@hhs.gov>; Villanueva, Josie (OS/IOS) <Josie.Villanueva@hhs.gov>; Rainer, Melanie Fontes (OS/IOS) <Melanie.Rainer@hhs.gov>; Cha, Stephen (HHS/IOS) <Stephen.Cha@hhs.gov>; Arguello, Andres (OS/IOS) <Andres.Arguello@hhs.gov>; Schechter, Alia (OS/IOS) <Alia.Schechter@hhs.gov>; Seshasai, Karuna (HHS/IOS) <Karuna.Seshasai@hhs.gov>; Zardeneta, Lizeth (HHS/OS/IOS) <Lizeth.Zardeneta@hhs.gov>; Jee, Lauren (HHS/ASL) <Lauren.Jee@hhs.gov>; Friedman, Jennifer (OS/IOS) <Jennifer.Friedman@hhs.gov>; Reid, Anne (OS/IOS) <Anne.Reid@hhs.gov>; Higgins, Sean (HHS/ASPA) <Sean.Higgins@hhs.gov>
Subject: RE: Confirmed Travel: Manchester, NH and Rhode Island

Hello all,

A couple thoughts on events. If we are interested, Tom Coderre, Principle Deputy Assistant Secretary at SAMHSA, can facilitate any/all.

Thanks,
Rachel

In both states

Secretary Becerra could visit/do an event at a Certified Community Behavioral Health Clinic (CCBHC's). This is a huge program for many members on the Hill. NH and RI both have grantees and over $1 billion dollars have been invested in this program in the last year, $420 million from the American Rescue Plan. If this direction is of interest, we can track down the best site.

New Hampshire:

If you want to get Hassan's attention in NH, perhaps we should set up some visits to see how the state is spending their SOR grant money. We would have to navigate the state politics on this carefully as Sen. Hassan and Governor Sununu could be opponents next year (https://www.vnews.com/Many-factors-could-influence-a-Sununu-Senate-run-40918649). The state has used a majority of the money to stand up a Sununu priority for addiction treatment called The Doorway, a hub and spoke model. There are nine Doorway locations, providing single points of entry for people seeking help for substance use, whether they need treatment, support, or resources for prevention and awareness. The regional Doorways ensure that help is always less than an hour away. In addition, 24/7 access to services is also available by dialing 211. https://www.thedoorway.nh.gov/home

In addition to treatment, NH has great prevention and recovery programs as well. Safe Stations was started in Manchester (https://www.manchesternh.gov/Departments/Fire/Safe-Station). Governor Sununu started the first and most robust statewide Recovery Friendly Workplace program, visits to model employers is a possibility (https://www.recoveryfriendlyworkplace.com/). NH has a Recovery HUB with lots of recovery community centers and other programs which make for excellent visits (https://www.dhhs.nh.gov/dcbcs/bdas/recovery.htm).

Looks like Hassan is working with neighbor Collins on workforce issues: https://www.seacoastonline.com/story/opinion/columns/guest/2021/03/18/collins-and-hassan-crisis-within-crisis/4715260001/. We could arrange something around this if you think the Secretary would find it interesting.

Rhode Island:

If you want to focus on **youth BH**, then Bradley Hospital is probably the best option. It's the nation's first psychiatric hospital devoted exclusively to children and adolescents. It's a Lifespan partner and a teaching hospital for The Warren Alpert Medical School of Brown University. Bradley Hospital has established itself as the national center for training and research in child and adolescent psychiatry. Bradley Hospital is a private, not-for-profit hospital. https://www.lifespan.org/locations/bradley-hospital/about-bradley-hospital

There is also BH Link. BH Link's mission is to ensure all Rhode Islanders 18+ experiencing mental health and substance use crises receive the appropriate services they need as quickly as possible in an environment that supports their recovery. https://www.bhlink.org/ This could be a good place to talk about crisis grant announcement and the building of crisis services in anticipation of 988. There is also a Kids Link, that I think Bradley manages.

There are a lot of options for recovery support and overdose related work – 5-6 recovery centers throughout the state (https://bhddh.ri.gov/substance-useaddiction/recovery-services), recovery coaches in ED's, Providence Safe (Fire) Stations (https://pvdsafestations.com/), and a recovery friendly workplace program (https://recoveryfriendlyri.com/). Rhode Island also has a renowned MAT behind the walls program, the only statewide program in the nation to offer all three FDA approved medications for OUD (https://www.statnews.com/2018/02/14/medication-assisted-treatment-inmates/). Dr. Nicole Alexander Scott is the Director of the Department of Health and co-chairs the Governor's Overdose Prevention Task Force, I would suggest including her in some way.

The legislative session just concluded and it was a good one for drug policy. Caution though, the state passed and today the Governor signed a bill legalizing the first Safe Injection Facility. The state also reclassified drug crimes as misdemeanors and decriminalized possession of buprenorphine. This article references Secretary Becerra's support for SIF's when he was AG in CA: https://www.providencejournal.com/story/news/courts/2021/07/03/ri-could-first-state-in-nation-to-legalize-safe-injection-sites-for-opioid-addicts/7840401002/

From: Pugh, Carrie (OS/IEA) <Carrie.Pugh@hhs.gov>
Sent: Thursday, July 8, 2021 11:46 AM
To: Doris-Pierce, Molly (OS/IEA) <Molly.Doris-pierce@hhs.gov>; Wilson, Laurence (OS/IOS) <Laurence.Wilson@hhs.gov>; Lovenheim, Sarah (HHS/ASPA) <Sarah.Lovenheim@hhs.gov>
Cc: Zelenko, Leslie (HHS/ASL) <Leslie.Zelenko@hhs.gov>; Hild, Jeff (HHS/ASL) <Jeff.Hild@hhs.gov>; Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>; Scott, Benjamin (OS/IOS) <Benjamin.Scott@hhs.gov>; Palafox, Cynthia (HHS/IOS) <Cynthia.Palafox@hhs.gov>; Orozco, Esmeralda (HHS/IOS) <Esmeralda.Orozco@hhs.gov>; Lopez, Steven (HHS/OS/IOS) <Steven.Lopez@hhs.gov>; Jones, Kamara (HHS/ASPA) <Kamara.Jones@hhs.gov>; Despres, Sarah (HHS/IOS) <Sarah.Despres@hhs.gov>; Figueroa, Marvin (HHS/IEA) <Marvin.Figueroa@hhs.gov>; Espinosa, Kimberly (HHS/ASL) <Kimberly.Espinosa@hhs.gov>; Villanueva, Josie (OS/IOS) <Josie.Villanueva@hhs.gov>; Rainer, Melanie Fontes (OS/IOS) <Melanie.Rainer@hhs.gov>; Cha, Stephen (HHS/IOS) <Stephen.Cha@hhs.gov>; Arguello, Andres (OS/IOS) <Andres.Arguello@hhs.gov>; Schechter, Alia (OS/IOS) <Alia.Schechter@hhs.gov>; Seshasai, Karuna (HHS/IOS) <Karuna.Seshasai@hhs.gov>; Zardeneta, Lizeth (HHS/OS/IOS) <Lizeth.Zardeneta@hhs.gov>; Jee, Lauren (HHS/ASL) <Lauren.Jee@hhs.gov>; Friedman, Jennifer (OS/IOS) <Jennifer.Friedman@hhs.gov>; Reid, Anne (OS/IOS) <Anne.Reid@hhs.gov>; Higgins, Sean (HHS/ASPA) <Sean.Higgins@hhs.gov>
Subject: RE: Confirmed Travel: Manchester, NH and Rhode Island

Good flag – thanks.

From: Doris-Pierce, Molly (OS/IEA) <Molly.Doris-pierce@hhs.gov>
Sent: Thursday, July 8, 2021 11:12 AM
To: Wilson, Laurence (OS/IOS) <Laurence.Wilson@hhs.gov>; Lovenheim, Sarah (HHS/ASPA) <Sarah.Lovenheim@hhs.gov>
Cc: Zelenko, Leslie (HHS/ASL) <Leslie.Zelenko@hhs.gov>; Hild, Jeff (HHS/ASL) <Jeff.Hild@hhs.gov>; Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>; Scott, Benjamin (OS/IOS) <Benjamin.Scott@hhs.gov>; Palafox, Cynthia (HHS/IOS) <Cynthia.Palafox@hhs.gov>; Orozco, Esmeralda (HHS/IOS) <Esmeralda.Orozco@hhs.gov>; Lopez, Steven (HHS/OS/IOS) <Steven.Lopez@hhs.gov>; Jones, Kamara (HHS/ASPA) <Kamara.Jones@hhs.gov>; Despres, Sarah (HHS/IOS) <Sarah.Despres@hhs.gov>; Figueroa, Marvin (HHS/IEA) <Marvin.Figueroa@hhs.gov>; Espinosa, Kimberly (HHS/ASL)

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Subject: RE: Confirmed Travel: Manchester, NH and Rhode Island

Wanted to flag for this group that he will be in NH, but we declined the ME opioid summit in person request and pre-recorded. I don't think it's an issue, but did want to flag the date overlap.

Molly Doris-Pierce, *she/her*
Special Assistant
Office of Intergovernmental and External Affairs, U.S. Dept. of Health and Human Services
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From: Wilson, Laurence (OS/IOS) <Laurence.Wilson@hhs.gov>
Sent: Wednesday, July 7, 2021 9:45 PM
To: Lovenheim, Sarah (HHS/ASPA) <Sarah.Lovenheim@hhs.gov>
Cc: Zelenko, Leslie (HHS/ASL) <Leslie.Zelenko@hhs.gov>; Hild, Jeff (HHS/ASL) <Jeff.Hild@hhs.gov>; Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>; Scott, Benjamin (OS/IOS) <Benjamin.Scott@hhs.gov>; Palafox, Cynthia (HHS/IOS) <Cynthia.Palafox@hhs.gov>; Orozco, Esmeralda (HHS/IOS) <Esmeralda.Orozco@hhs.gov>; Lopez, Steven (HHS/OS/IOS) <Steven.Lopez@hhs.gov>; Jones, Kamara (HHS/ASPA) <Kamara.Jones@hhs.gov>; Despres, Sarah (HHS/IOS) <Sarah.Despres@hhs.gov>; Figueroa, Marvin (HHS/IEA) <Marvin.Figueroa@hhs.gov>; Espinosa, Kimberly (HHS/ASL) <Kimberly.Espinosa@hhs.gov>; Villanueva, Josie (OS/IOS) <Josie.Villanueva@hhs.gov>; Rainer, Melanie Fontes (OS/IOS) <Melanie.Rainer@hhs.gov>; Cha, Stephen (HHS/IOS) <Stephen.Cha@hhs.gov>; Pugh, Carrie (OS/IEA) <Carrie.Pugh@hhs.gov>; Arguello, Andres (OS/IOS) <Andres.Arguello@hhs.gov>; Schechter, Alia (OS/IOS) <Alia.Schechter@hhs.gov>; Seshasai, Karuna (HHS/IOS) <Karuna.Seshasai@hhs.gov>; Zardeneta, Lizeth (HHS/OS/IOS) <Lizeth.Zardeneta@hhs.gov>; Doris-Pierce, Molly (OS/IEA) <Molly.Doris-pierce@hhs.gov>; Jee, Lauren (HHS/ASL) <Lauren.Jee@hhs.gov>; Friedman, Jennifer (OS/IOS) <Jennifer.Friedman@hhs.gov>; Reid, Anne (OS/IOS) <Anne.Reid@hhs.gov>; Higgins, Sean (HHS/ASPA) <Sean.Higgins@hhs.gov>
Subject: Re: Confirmed Travel: Manchester, NH and Rhode Island

Resending New Hampshire sketch as additional folks have been added.

Best,

Laurence J. Wilson
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U.S. Department of Health &Human Services
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On Jul 7, 2021, at 7:49 PM, Lovenheim, Sarah (HHS/ASPA) <Sarah.Lovenheim@hhs.gov>wrote:

+ Sean H, who will be our ASPA POC.

On Jul 7, 2021, at 5:18 PM, Zelenko, Leslie (HHS/ASL) <Leslie.Zelenko@hhs.gov>wrote:

Hi folks,

Quick update for New Hampshire:

Congressman Chris Pappas will not be in town on the 15th, his office asked if there was any flexibility on the date, I'm guessing there's not but just wanted to see.

Senator Shaheen was hoping to get more details on the events of the day, I said I would share when I have them. Her Chief flagged that the Senate is in session next week, which may make it difficult.

Thanks!
Leslie

From: Hild, Jeff (HHS/ASL) <Jeff.Hild@hhs.gov>
Sent: Wednesday, July 7, 2021 2:15 PM
To: Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>; Scott, Benjamin (OS/IOS) <Benjamin.Scott@hhs.gov>; Wilson, Laurence (OS/IOS) <Laurence.Wilson@hhs.gov>; Palafox, Cynthia (HHS/IOS) <Cynthia.Palafox@hhs.gov>; Zelenko, Leslie (HHS/ASL) <Leslie.Zelenko@hhs.gov>
Cc: Orozco, Esmeralda (HHS/IOS) <Esmeralda.Orozco@hhs.gov>; Lopez, Steven (HHS/OS/IOS) <Steven.Lopez@hhs.gov>; Jones, Kamara (HHS/ASPA) <Kamara.Jones@hhs.gov>; Despres, Sarah (HHS/IOS) <Sarah.Despres@hhs.gov>; Lovenheim, Sarah (HHS/ASPA) <Sarah.Lovenheim@hhs.gov>; Figueroa, Marvin (HHS/IEA) <Marvin.Figueroa@hhs.gov>; Espinosa, Kimberly (HHS/ASL) <Kimberly.Espinosa@hhs.gov>; Villanueva, Josie (OS/IOS) <Josie.Villanueva@hhs.gov>; Rainer, Melanie Fontes (OS/IOS) <Melanie.Rainer@hhs.gov>; Cha, Stephen (HHS/IOS) <Stephen.Cha@hhs.gov>; Pugh, Carrie (OS/IEA) <Carrie.Pugh@hhs.gov>; Arguello, Andres (OS/IOS) <Andres.Arguello@hhs.gov>; Schechter, Alia (OS/IOS) <Alia.Schechter@hhs.gov>; Seshasai, Karuna (HHS/IOS) <Karuna.Seshasai@hhs.gov>; Zardeneta, Lizeth (HHS/OS/IOS) <Lizeth.Zardeneta@hhs.gov>; Doris-Pierce, Molly (OS/IEA) <Molly.Doris-pierce@hhs.gov>; Jee, Lauren (HHS/ASL) <Lauren.Jee@hhs.gov>; Friedman, Jennifer (OS/IOS) <Jennifer.Friedman@hhs.gov>; Reid, Anne (OS/IOS) <Anne.Reid@hhs.gov>
Subject: RE: Confirmed Travel: Manchester, NH and Rhode Island

+ Leslie who is helping to coordinate with the Congressional offices.

From: Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>
Sent: Wednesday, July 7, 2021 1:22 PM
To: Scott, Benjamin (OS/IOS) <Benjamin.Scott@hhs.gov>; Wilson, Laurence (OS/IOS) <Laurence.Wilson@hhs.gov>; Palafox, Cynthia (HHS/IOS) <Cynthia.Palafox@hhs.gov>

Cc: Orozco, Esmeralda (HHS/IOS) <Esmeralda.Orozco@hhs.gov>; Lopez, Steven (HHS/OS/IOS) <Steven.Lopez@hhs.gov>; Jones, Kamara (HHS/ASPA) <Kamara.Jones@hhs.gov>; Despres, Sarah (HHS/IOS) <Sarah.Despres@hhs.gov>; Lovenheim, Sarah (HHS/ASPA) <Sarah.Lovenheim@hhs.gov>; Figueroa, Marvin (HHS/IEA) <Marvin.Figueroa@hhs.gov>; Espinosa, Kimberly (HHS/ASL) <Kimberly.Espinosa@hhs.gov>; Hild, Jeff (HHS/ASL) <Jeff.Hild@hhs.gov>; Villanueva, Josie (OS/IOS) <Josie.Villanueva@hhs.gov>; Rainer, Melanie Fontes (OS/IOS) <Melanie.Rainer@hhs.gov>; Cha, Stephen (HHS/IOS) <Stephen.Cha@hhs.gov>; Pugh, Carrie (OS/IEA) <Carrie.Pugh@hhs.gov>; Arguello, Andres (OS/IOS) <Andres.Arguello@hhs.gov>; Schechter, Alia (OS/IOS) <Alia.Schechter@hhs.gov>; Seshasai, Karuna (HHS/IOS) <Karuna.Seshasai@hhs.gov>; Zardeneta, Lizeth (HHS/OS/IOS) <Lizeth.Zardeneta@hhs.gov>; Doris-Pierce, Molly (OS/IEA) <Molly.Doris-pierce@hhs.gov>; Jee, Lauren (HHS/ASL) <Lauren.Jee@hhs.gov>; Friedman, Jennifer (OS/IOS) <Jennifer.Friedman@hhs.gov>; Reid, Anne (OS/IOS) <Anne.Reid@hhs.gov>
Subject: RE: Confirmed Travel: Manchester, NH and Rhode Island

We have a lot of HCBS and SUD opportunity in both NH and RI- pulling some good programs now- thanks, Rachel

---

From: Scott, Benjamin (OS/IOS) <Benjamin.Scott@hhs.gov>
Sent: Wednesday, July 7, 2021 1:03 PM
To: Wilson, Laurence (OS/IOS) <Laurence.Wilson@hhs.gov>; Palafox, Cynthia (HHS/IOS) <Cynthia.Palafox@hhs.gov>
Cc: Orozco, Esmeralda (HHS/IOS) <Esmeralda.Orozco@hhs.gov>; Lopez, Steven (HHS/OS/IOS) <Steven.Lopez@hhs.gov>; Jones, Kamara (HHS/ASPA) <Kamara.Jones@hhs.gov>; Despres, Sarah (HHS/IOS) <Sarah.Despres@hhs.gov>; Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>; Lovenheim, Sarah (HHS/ASPA) <Sarah.Lovenheim@hhs.gov>; Figueroa, Marvin (HHS/IEA) <Marvin.Figueroa@hhs.gov>; Espinosa, Kimberly (HHS/ASL) <Kimberly.Espinosa@hhs.gov>; Hild, Jeff (HHS/ASL) <Jeff.Hild@hhs.gov>; Villanueva, Josie (OS/IOS) <Josie.Villanueva@hhs.gov>; Rainer, Melanie Fontes (OS/IOS) <Melanie.Rainer@hhs.gov>; Cha, Stephen (HHS/IOS) <Stephen.Cha@hhs.gov>; Pugh, Carrie (OS/IEA) <Carrie.Pugh@hhs.gov>; Arguello, Andres (OS/IOS) <Andres.Arguello@hhs.gov>; Schechter, Alia (OS/IOS) <Alia.Schechter@hhs.gov>; Seshasai, Karuna (HHS/IOS) <Karuna.Seshasai@hhs.gov>; Zardeneta, Lizeth (HHS/OS/IOS) <Lizeth.Zardeneta@hhs.gov>; Doris-Pierce, Molly (OS/IEA) <Molly.Doris-pierce@hhs.gov>; Jee, Lauren (HHS/ASL) <Lauren.Jee@hhs.gov>; Friedman, Jennifer (OS/IOS) <Jennifer.Friedman@hhs.gov>; Reid, Anne (OS/IOS) <Anne.Reid@hhs.gov>
Subject: RE: Confirmed Travel: Manchester, NH and Rhode Island

Folks – find incredibly draft version of sketch for Rhode Island attached. Will start a new Rhode Island only thread once we identify staff. Thanks!!

Ben

Benjamin Scott
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From: Wilson, Laurence (OS/IOS) <Laurence.Wilson@hhs.gov>
Sent: Wednesday, July 7, 2021 11:50 AM
To: Palafox, Cynthia (HHS/IOS) <Cynthia.Palafox@hhs.gov>
Cc: Orozco, Esmeralda (HHS/IOS) <Esmeralda.Orozco@hhs.gov>; Lopez, Steven (HHS/OS/IOS) <Steven.Lopez@hhs.gov>; Jones, Kamara (HHS/ASPA) <Kamara.Jones@hhs.gov>; Despres, Sarah (HHS/IOS) <Sarah.Despres@hhs.gov>; Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>; Lovenheim, Sarah (HHS/ASPA) <Sarah.Lovenheim@hhs.gov>; Figueroa, Marvin (HHS/IEA) <Marvin.Figueroa@hhs.gov>; Espinosa, Kimberly (HHS/ASL) <Kimberly.Espinosa@hhs.gov>; Hild, Jeff (HHS/ASL) <Jeff.Hild@hhs.gov>; Villanueva, Josie (OS/IOS) <Josie.Villanueva@hhs.gov>; Rainer, Melanie Fontes (OS/IOS) <Melanie.Rainer@hhs.gov>; Cha, Stephen (HHS/IOS) <Stephen.Cha@hhs.gov>; Pugh, Carrie (OS/IEA) <Carrie.Pugh@hhs.gov>; Scott, Benjamin (OS/IOS) <Benjamin.Scott@hhs.gov>; Arguello, Andres (OS/IOS) <Andres.Arguello@hhs.gov>; Schechter, Alia (OS/IOS) <Alia.Schechter@hhs.gov>; Seshasai, Karuna (HHS/IOS) <Karuna.Seshasai@hhs.gov>; Zardeneta, Lizeth (HHS/OS/IOS) <Lizeth.Zardeneta@hhs.gov>; Doris-Pierce, Molly (OS/IEA) <Molly.Doris-pierce@hhs.gov>; Jee, Lauren (HHS/ASL) <Lauren.Jee@hhs.gov>; Friedman, Jennifer (OS/IOS) <Jennifer.Friedman@hhs.gov>; Reid, Anne (OS/IOS) <Anne.Reid@hhs.gov>
Subject: Re: Confirmed Travel: Manchester, NH and Rhode Island

Thanks, Cynthia! Will do.

Best,

Laurence J. Wilson
Advance Representative
Office of the Secretary
U.S. Department of Health &Human Services
202-(b)(6)
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On Jul 7, 2021, at 10:22 AM, Palafox, Cynthia (HHS/IOS) <Cynthia.Palafox@hhs.gov>wrote:

Hi team,

The Secretary approved the travel to Manchester, NH on Thursday, July 15 and to Rhode Island on Friday, July 16. We also received confirmation from ASL on RI availability, so we fully locked-in for that trip. And although we are still working on clarifying a few pieces with ethics, I would like to see a **draft sketch of both trips by COB tomorrow**. And as we have before, it would great to continue to highlight the AFP and vaccine confidence (if appropriate) as well as care economy in RI.

Below is the tentative schedule I created for both days based on potential arrival and departure times. Although we don't yet know where the Secretary will be needed first in RI, I am having him travel to Providence from Manchester, NH, but that can be changed.

Thursday, July 15, 2021
10:00am ET Wheels Down Manchester, NH

10:30am ET (30 min) HOLD for potential press
11:00am ET (60 min) CTC Press Conference (location: at a park – exact location TBD)
12:00pm ET Travel to lunch
12:15pm ET (60 min) Lunch
1:15pm ET Travel to site #2
1:30pm ET (90 min) Site #2
3:00pm ET Travel to site #3
3:15pm ET (90 min) Site #3
4:45pm ET Depart Manchester, NH and **drive** to Providence, RI
7:00pm ET Arrive at Providence RI
RON: Hotel in Providence, RI (location TBD)

Friday, July 16, 2021
9:00am ET Hold for press
9:30am ET Travel to site #1
10:00am ET (60 min) Site #1
11:00am ET Travel to site #2
11:30pm ET (60 min) Site #2
12:30pm ET (30 min) Lunch
 Depart for site #3
1:30pm ET (60 min) Site #3
2:30pm ET Depart for airport
4:00pm ET Arrive at airport
4:45pm ET Wheels-up Providence, RI

ASPA team – Sarah requested that we try and proactively hold time for press during each trip. Please let me know what time would work best. I'm currently holding time first thing in the morning but let me know if that doesn't work on your end.

ASL team – please confirm the Secretary's participation and let us know what they have in mind, especially for RI

IEA team – please confirm the Secretary's travel with regional office and keep us all posted on potential sites. Also, let me know if the time I've allocated is not enough – we could try to play round with timing based on the locations.

Counselors – please let us know if there's any specific policy and/or topics that the team should be aware of when building out the trip.

Ben – I know you are in Charlotte at the moment, but when you're free, can you please start creating the full sketch for RI?

Laurence – can you please start creating the sketch for Manchester, NH?

Thank you all!

Cynthia

Cynthia Palafox
Director of Scheduling &Advance
U.S. Department of Health and Human Services
202 (b)(6) cell)
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<7.15.21 Manchester, New Hampshire Trip Sketch v1.docx>
<Rhode Island - Sketch - v1.docx>

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Sent Date: 2021/07/08 21:17:17

Delivered Date: 2021/07/08 21:17:19

Enable access to mifepristone and tele-MAB through two different efforts: (a) Launching a public awareness campaign; and (b) Participating in litigation challenging state laws under preemption.

(a) Launch a public awareness campaign to help people safely access medication abortion throughout the country

The federal government, most likely through HHS, can launch a widespread public awareness campaign to ensure that people throughout the United States have access to accurate information and are able to safely access medication abortion. This could be akin to similar successful efforts in Uruguay[1] and leading global health organizations such as The World Health Organization[2] and Doctors without Borders.[3]

Importantly this will both help increase education and awareness about medication abortion as an option and help address misinformation. There is a tremendous amount of misinformation on medication abortion and on self-managed abortion more generally, which can be difficult to navigate for anyone, and particularly for people with lower health literacy and less experience navigating online resources. People are undoubtedly going to seek information on accessing medication abortion, both legally and illicitly. Even before Texas almost entirely eliminated access to legal abortion in the state, increasing numbers of people were seeking information online about how to safely end a pregnancy.[4] More recently, "in the first week after SB 8 went into effect, average daily requests [through Aid Access] from Texas increased by almost twelve-fold."[5] If they are unable to easily access accurate information, they may go without care at all or attempt methods which are much more harmful.

But there is no need for that in an era when medication abortion is safe, effective and available from a variety of sources. "Harm reduction is a strategy that aims to reduce adverse consequences of a target behavior when complete abstinence from or elimination of that behavior is not a realistic or desirable goal. In countries where abortion is illegal or severely restricted, health care providers have implemented harm reduction strategies after witnessing

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[1] https://www.nytimes.com/2016/06/28/opinion/from-uruguay-a-model-for-making-abortion-safer.html; https://www.sciencedirect.com/science/article/pii/S002072921630248X.
[2] "WHO recommendations on self-care interventions." World Health Organization. https://apps.who.int/iris/rest/bitstreams/1280116/retrieve
[3] "How to have a safe self-managed abortion." Doctors Without Borders. November 2021. https://www.doctorswithoutborders.org/latest/how-have-safe-self-managed-abortion
[4] See Jones R, Donovan M. Self-managed abortion may be on the rise, but probably not a significant driver of the overall decline in abortion. Guttmacher 2019. https://www.guttmacher.org/article/2019/11/self-managed-abortion-may-be-rise-probably-not-significant-driver-overall-decline.
[5] Carrie Baker. Online Abortion Pill Orders Surged After Texas Ban. Researchers Say This Is Only the Beginning. Ms. Magazine. Feb. 28, 2022. https://msmagazine.com/2022/02/28/online-abortion-pill-orders-telemedicine-texas-ban-sb8-researchers/; see also Aiken ARA, Starling JE, Scott JG, Gomperts R. Association of Texas Senate Bill 8 With Requests for Self-managed Medication Abortion. JAMA Netw Open. 2022. https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2789428.

the consequences of unsafe illegal abortion."[6] This was one of the asks for the administration as part of the Blueprint for Sexual and Reproductive Health, Rights & Justice[7] and is all that much more critical now.

The federal government has launched similar harm reduction campaigns to, for example, ensure that people who are using illicit drugs are able to do so safely. Earlier this year, the White House launched an initiative to address the overdose epidemic.[8] Among other initiatives, this strategy makes "harm reduction services – which include naloxone, fentanyl test strips, and syringe service programs – are a federal drug policy priority." Federal agencies have provided guidance on harm reduction strategies, such as this resource from Indian Health Services[9] and the CDC provides technical assistance,[10] which is funded as part of CDC's Injury Prevention Fund,[11] currently about $700k per year. State and local governments have taken additional actions. New York City recently launched overdose prevention centers,[12] where people can safely use drugs.

While private entities are working to disseminate information, such as this campaign in New York,[13] they do not have the resources, clout or reach of a federal government backed campaign, especially with individuals and communities that need this information the most. The administration has also provided funding for community-based harm reduction strategies.[14]

There is an even stronger argument to be made here that people have a right to this information and that failing to provide it not only violates their rights to medical care and bodily autonomy, but their right to be free from gender-based violence and discrimination.

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[6] Tasset J, Harris LH. Harm Reduction for Abortion in the United States. Obstet Gynecol. 2018 Apr;131(4):621-624. https://pubmed.ncbi.nlm.nih.gov/29528924/.

[7] Materials for pregnant people, created or supported by HHS, should include information about how self-managed abortion with pills works, what the common side effects are, and under what conditions a person may need to seek medical help following a medication abortion or miscarriage. Blueprint for Sexual and Reproductive Health, Rights, and Justice. 2019. https://reproblueprint.org/wp-content/uploads/2019/07/BlueprintPolicyAgenda-v14-PR-All-1.pdf

[8] "Fact sheet: Addressing Addiction and the Overdose Epidemic." March 2022. https://www.whitehouse.gov/briefing-room/statements-releases/2022/03/01/fact-sheet-addressing-addiction-and-the-overdose-epidemic/

[9] "Harm Reduction." Opioids. https://www.ihs.gov/opioids/harmreduction/

[10] "NHRTAC." Centers for Disease Control and Prevention. https://harmreductionhelp.cdc.gov/s/.

[11] "NCIPC Budget & Impact." Center for Disease Control and Prevention. https://www.cdc.gov/injury/budget/funding.html

[12] "Mayor De Blasio Announces Nation's First Overdose Prevention Center Services to Open in New York City." NYC.gov, November 2021. https://www1.nyc.gov/office-of-the-mayor/news/793-21/mayor-de-blasio-nation-s-first-overdose-prevention-center-services-open-new-york.

[13] "250 Ads for Self-Managed Abortion Pill Info Launch in NYC Subway System." Ms. Magazine. April 2022. https://msmagazine.com/2022/04/15/self-managed-abortion-pill-ads-nyc-subway-plan-c-medication-abortion/

[14] "Unprecedented $30 Million Harm Reduction Grant Funding Opportunity to Help Address the Nation's Substance Use and Overdose Epidemic." SAMHSA. December 2021. https://www.samhsa.gov/newsroom/press-announcements/202112081000

In the vein of harm reduction and combatting misinformation, the Federal Trade Commission (FTC) should investigate and take needed action against entities like crisis pregnancy centers that post false information about the safety of medication abortion online. This would be similar to what they have done to combat misinformation about COVID.[15] While FTC was given specific authority to combat COVID misinformation through the COVID-19 Consumer Protection Act of 2020,[16] the FTC also has general consumer protection authority[17] that it should utilize to combat misinformation in this area.[18]

(b) Support efforts to strengthen preemption arguments

The administration can file statements of interest in any case that reproductive health organizations (i.e. Planned Parenthood or other organizations) bring to challenge state laws that impose greater restrictions than the REMS for mifepristone.

Aside from participating in litigation, a public statement in any way (either informally or through agency guidance or other policy) stating that the REMS preempt state law is not likely to be helpful, and could be harmful. Such a statement could have the potential to make the argument seem political, rather than based entirely on the science, and could weaken the argument in future litigation.

The legal argument to make in litigation is that Congress created the REMS so that the FDA could balance the important goals associated with drug safety and drug access, and thus states' laws that balance these goals differently thwart this purpose. In regards to mifepristone, this comes into play in two ways: First, because the federal government has restricted access to mifepristone for two decades under the FDA Risk Evaluation and Mitigation System (REMS), there is a good argument that FDA has already preempted state law to impose additional restrictions on the drug. Indeed, in imposing a REMS for mifepristone, the FDA has chosen to exercise more control over the drug than it does for the 95% of approved drugs that are not subject to a REMS. Second, in the process of revising the REMS, the FDA has made specific scientific findings about the drug's safety and efficacy and updated the requirements. If a state chooses to impose greater restrictions, such as including banning abortion, imposing in-person requirements or physician-only restrictions, or limiting the drug to an earlier phase in pregnancy than 10 weeks, these restrictions would be in conflict with FDA's scientific findings and preempted by FDA law. In other words, state laws that overregulate medication abortion purport to reach scientific conclusions that are directly at odds with those that Congress required the FDA to make when issuing the REMS.

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[15] "Coronavirus Response: Enforcement Actions." Federal Trade Commission, February 2022. https://www.ftc.gov/news-events/features/coronavirus/enforcement.
[16] Pub. L. No. 116-260, 134 Stat. 1182, Division FF, Title XIV, § 1401.
[17] "Bureau of Consumer Protection." Federal Trade Commission, December 2021. https://www.ftc.gov/about-ftc/bureaus-offices/bureau-consumer-protection.
[18] 15 U.S.C. Sec. 57b-1; see also, A Brief Overview of the Federal Trade Commission's Investigative, Law Enforcement, and Rulemaking Authority, https://www.ftc.gov/about-ftc/mission/enforcement-authority.

Provide transportation funding, vouchers, and other support for people who need to travel to nearby states by using the Bus and Bus Facilities Competitive Grant Program to fund transportation services.[19]

The federal government through this program in the Federal Transit Administration (which is part of DOT) issues discretionary grants to "State or local governmental entities that operate fixed route bus service," who may in turn allocate part of the grant to subrecipients, including nonprofits.[20]

Approximately $372 million in total grants will be available through this program for FY2022,[21] and FTA has awarded numerous multi-million dollar grants through the program in the recent past.[22] (A related discretionary-grant program is also available for projects involving low- or no-emission buses and supporting facilities, and over $1 billion is available through that program.[23]

This program is an intriguing candidate for transportation funding for two reasons: First, DOT does not appear to be limited by the Hyde Amendment: The agency falls under Division L of the 2022 Appropriations Act, and there is no Hyde Amendment for Division L. For that reason, it would be unnecessary for the agency to obtain a legal opinion from the Office of Legal Counsel on the applicability of the Hyde Amendment before awarding such a grant (like this one,[24] for example), which would allow for a more streamlined process. Second, this program could conceivably be used to cover a significant portion of the costs of providing transportation services along a fixed bus route from, say, the southeastern United States to California.

There are some limitations.The grants covers only[25] "capital projects to replace, rehabilitate, and purchase buses, vans, and related equipment, and to construct bus-related facilities."[26] That includes leasing power sources and incidental costs, but not preventative maintenance and operating expenses (e.g., fuel, staffing, and administrative costs).[27] Nor would it include the costs of meals or lodging, though it might be possible to purchase buses that would allow passengers to comfortably sleep while on the bus.

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[19] *See* 49 U.S.C. § 5339(b); Listing 20.526.
[20] 49 U.S.C. §§ 5339(a)(4)(A), (B).
[21] See 87 Fed. Reg. 12,528-01 (Mar. 4, 2022).
[22] "Fiscal Year 2020 Buses and Bus Facilities Projects." Federal Transit Administration. https://www.transit.dot.gov/funding/grants/fiscal-year-2020-buses-and-bus-facilities-projects
[23] See 49 U.S.C. 5339(c), 87 Fed. Reg. 12528-01.)
[24] "Application of the Hyde Amendment to Federal Student-Aid Programs." The U.S. Department of Justice. https://www.justice.gov/sites/default/files/opinions/attachments/2021/01/17/2021-01-16-hyde-amdt.pdf
[25] "Grants for Buses and Bus Facilities Program." Federal Transit Administration. https://www.transit.dot.gov/bus-program
[26] See also 49 U.S.C. 5339(b) (explaining that the grants may be used to "assist in the financing of buses and bus facilities capital projects, including (A) replacing, rehabilitating, purchasing, or leasing buses or related equipment; and (B) rehabilitating, purchasing, constructing, or leasing bus-related facilities").
[27] "Low or No Emission Grant & Grants for Buses and Bus Facilities Competitive Program." Federal Transit Administration. https://www.transit.dot.gov/sites/fta.dot.gov/files/2022-03/FY22-Low-No-Bus-Public-Webinar.pdf

Another limitation is that the grant does not cover 100% of the eligible costs. Rather, it covers only 80% of the eligible costs (a portion that, if the vehicles comply with the Clean Air Act and Americans with Disabilities Act, can be increased to 85% of the cost of purchasing/leasing low or no-emission buses and 90% of the cost of procuring equipment and facilities for low or no-emission buses). This means that the remaining costs would have to be borne by the state designated as the grant recipient, or else by the subrecipient nonprofit or a third party.

In addition, because the recipient would have to be a state, the bus route would presumably have to take passengers specifically to that state, even if other states were closer. And the relevant state agency would have to apply for the grant itself.

Use disaster relief authorities in three ways to provide support to states and providers

(a) **FEMA:** Approve state governor requests to use the federal disaster relief authority under FEMA.[28]

Under FEMA, states supportive of access to abortion could request federal funding to meet the needs of the public health disaster they will likely face because of the increased demand/traffic from out of state individuals. For example, these states could set up mobile clinics near the border line, so out of state people can access abortion more conveniently.[29]

The Federal Emergency Management Agency (FEMA), under the Department of Homeland Security, coordinates the federal government's preparedness for, response to, and recovery from all domestic disasters.[30] The Robert T. Stafford Disaster Relief and Emergency Assistance Act[31] (Stafford Act) grants the statutory authority for most Federal disaster response activities, particularly as related to FEMA.[32] The Stafford Act delineates the formal process for requesting a declaration by the President "that a major disaster exists."[33] FEMA has codified and further elaborated on this process at 44 C.F.R. Part § 206, Subpart B.[34] There are two critical components to securing an emergency declaration that would authorize federal assistance: first, the state governor must submit a request for a declaration from the President, and second, the President, who maintains discretion over such a determination, must accept or reject the request. Although not explicitly stated in such terms in the statute nor the relevant regulation, FEMA indicates that "[a]ll emergency and major disaster declarations are made solely at the discretion of the President of the United States."[35]

The Stafford Act provides for two types of disaster declarations: emergency declarations and major disaster declarations. It is likely that the emergency declaration authority, which applies to state and local needs "'to save lives and to protect property and public health and safety, or to lessen or avert the threat of catastrophe" applies here.[36]

The following are certain types of assistance provided under FEMA once the disaster declaration is approved by the President that seem most relevant to this situation. There are no abortion restrictions on DHS/FEMA appropriations, meaning that the funding could be utilized

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[28] "How a Disaster Gets Declared." FEMA. https://www.fema.gov/disaster/how-declared
[29] "Federally Supported Community Vaccination Centers." FEMA. https://www.fema.gov/disaster/coronavirus/vaccine-support/vaccine-center
[30] Federal Register, *Federal Emergency Management Agency*, Nat. Archives (Apr. 04. 2022) https://www.federalregister.gov/agencies/federal-emergency-management-agency
[31] 42 U.S.C. § 5121 et seq.
[32] https://www.fema.gov/disaster/stafford-act
[33] Title IV – Major Disaster Assistance Program § 401, 42 U.S.C. 5170, https://www.fema.gov/sites/default/files/documents/fema_stafford_act_2021_vol1.pdf
[34] https://www.ecfr.gov/current/title-44/chapter-I/subchapter-D/part-206/subpart-B
[35] *How a Disaster Gets Declared*, FEMA (Apr. 3, 2022) https://www.fema.gov/disaster/how-declared
[36] Stafford Act, 42 U.S.C. 5122 §102, https://www.fema.gov/sites/default/files/documents/fema_stafford_act_2021_vol1.pdf.

for anything related to abortion provision in response to the emergency, so long as it complied with the other requirements of FEMA.

1. Public Assistance Program: Assistance to State, Local and Tribal Governments and CBOs

Under the Public Assistance Fund, private nonprofit organizations that operate a facility providing critical services, such as emergency medical care, or essential social services, such as health and safety services, may be eligible for aid. Funding is provided for Emergency Work, which includes "emergency protective measures."[37] The work must be needed because of the declared disaster, it must be located within the designated disaster area, and it must be the legal responsibility of an eligible applicant.

Eligible emergency protective measures include those that "eliminate or lessen immediate threats to lives, public health, or safety."[38] Federal or local government officials may need to certify that such a threat exists. An immediate threat is the "threat of additional damage or destruction from an event which can reasonably be expected to occur within five years."[39] Eligible emergency protective measures include medical care and transport, childcare, and transportation and pre-positioning of equipment for response. FEMA may provide funds for extraordinary costs for providing temporary facilities for emergency medical care in situations where the emergency medical delivery system within the disaster area is destroyed, compromised, or overwhelmed. Aid for medical care under the public assistance program seems to be restricted to emergency care.

2. Individuals and Households Program: Medical Assistance to Individuals

FEMA may provide financial assistance for medical and dental expenses "to meet the disaster-related necessary expenses and serious needs of individuals and households."[40] An applicant seeking this assistance does not need to live in the declared disaster area. The medical injury or expense must be a direct result of the disaster, which must be attested to by the applicant or medical provider. Documentation includes itemized bills or estimates from the medical provider or pharmacy and "a written and signed statement from a medical or dental provider, including the date of disaster-caused injury and expenses necessary for recovery."[41]

3. Individuals and Households Program: Child Care Assistance to Individuals

FEMA will provide a one-time payment covering up to eight cumulative weeks of expenses for a household's increased financial burden in caring for children aged 13 and under; and/or children

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[37] https://www.fema.gov/sites/default/files/documents/fema_pappg-v4-updated-links_policy_6-1-2020.pdf pg. 51
[38] https://www.fema.gov/sites/default/files/documents/fema_pappg-v4-updated-links_policy_6-1-2020.pdf pg.110
[39] 44 CFR § 206.221 - Definitions.
[40] 44 CFR § 206.119 - Financial assistance to address other needs.
[41] https://www.fema.gov/sites/default/files/documents/fema_iappg-1.1.pdf pg. 154

up to 21 years of age with a disability needing assistance with daily living as defined by federal law.[42] In order to be eligible, either the applicant's gross household income must have decreased directly due to the disaster, or the applicant's child care expenses must have increased directly due to the disaster. An applicant must certify that they cannot use child care services provided by another source such as other federal assistance or private employer-provided services.

(b) **NDMS:** Invoke the National Disaster Medical System (42 U.S.C. § 300hh-11) to provide federal health care workers to address the crisis.[43,44]

The Secretary for Health and Human Services is authorized to activate the National Disaster Medical System.[45] Per 42 USC 300hh-11(a)(3)(a), the Secretary may activate the NDMS to:

> (i) provide health services, health-related social services, other appropriate human services, and appropriate auxiliary services to respond to the needs of victims of a public health emergency, including at-risk individuals as applicable (whether or not determined to be a public health emergency under s.247d of this title); or
>
> (ii) be present at locations, and for limited periods of time, specified by the Secretary on the basis that the Secretary has determined that a location is at risk of a public health emergency during the time specified, or there is significant potential for a public health emergency.

While NDMS can be funded through the Public Health Emergency Fund, currently funding for the NDMS comes primarily through the Labor, Health and Human Services, and Education (LHHS) Appropriations Bill. The Pandemic And All-Hazards Preparedness and Advancing Innovation Act 2019, Title III, § 301 (4) authorized $57,400,000 for NDMS' operation each fiscal year between and including 2019 and 2023.[46] And it is currently funded at $63 million per year; although the President requested more than twice that in his recent budget request. Because it is funded through LHHS, the Hyde Amendment attaches to this funding.

Health care providers can apply to join the NDMS and be called upon in medical and public health emergencies similar to the National Guard.[47] Therefore, invoking NDMS would call upon a cadre of health care providers that are already part of the system.

This option is most pertinent in states with only civil penalties. Intermittent personnel appointed

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[42] https://www.fema.gov/sites/default/files/2020-07/fema_individuals-households-program_fact-sheet.pdf pg. 3

[43] "The National Disaster Medical System (NDMS) and the COVID-19 Pandemic." KFF. April 2020. https://www.kff.org/coronavirus-covid-19/issue-brief/the-national-disaster-medical-system-ndms-and-the-covid-19-pandemic/

[44] 42 U.S.C. § 300hh-11 - National Disaster Medical System

[45] 42 U.S.C. § 201(c).

[46] See 42 U.S.C. § 300hh-11(g).

[47] https://www.phe.gov/Preparedness/responders/ndms/Pages/join-ndms.aspx.

by the Secretary of Health and Human Services pursuant to the NDMS are considered employees of the Public Health Service "performing medical, surgical, dental or related functions" for liability purposes.[48] Accordingly, under 42 U.S.C. § 233, Public Health Service employees are indemnified for actions taken in the scope of their employment. Civil actions brought in those circumstances therefore become actions against the United States, which "[t]he Attorney General shall defend." These statutes suggest that, were the NDMS deployed for abortion provision, those health care personnel would be indemnified in any civil action brought under an SB 8-style enforcement mechanism. Moreover, in a Bivens style action involving constitutional claims, *Hui v. Castaneda*, the Supreme Court held that § 233 immunity applied and is absolute "for actions arising out of the performance of medical or related functions within the scope of their employment."[49] Because Hui's rationale applies also to cases alleging violations of statutes, § 233 immunity should also attach in cases asserting violation of SB 8.

Another provision of the Public Health Service statutes could similarly provide assistance in states without criminal abortion bans. Health care providers responding to a health emergency as members of the Medical Reserve Corps or Emergency System for Advance Registration of Volunteer Health Professionals "shall be subject only to the State liability laws of the State in which such act or omission occurred, in the same manner and to the same extent as a similar health care professional who is a resident of such State would be subject to such State laws."[50] The same exception to liability as discussed above also applies. Thus, a health care professional providing abortion care or assistance to Missouri women in Illinois, for example, would potentially be subject only to Illinois law; not the Missouri law attempting to have extraterritorial effect.[51] However, section 234 only applies when providers are responding to a public health emergency (as declared by the Secretary, due to "a disease or disorder present[ing] a public health emergency" or a determination that "a public health emergency . otherwise exists"[52] during the initial period of not more than 90 days of the public health emergency, or to a major disaster or an emergency as declared by the President at the request of a state Governor (42 U.S.C. § 5170), also during the initial period.[53]

(c) **PHE:** Declare a Public Health Emergency (PHE) and use authority from that to exercise other federal authorities and free funding sources, including under the NDMS.

The Secretary for Health and Human Services can declare a public health emergency after determining that a "disease or disorder presents a public health emergency" or that "a public health emergency, including significant outbreaks of infectious diseases or bioterrorist attacks,

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[48] 42 U.S.C. § 300hh-11(c)(2).
[49] 559 U.S. 799, 806 (2010).
[50] 42 U.S.C. § 234(a).
[51] See also id. § 234(c) ("This section shall supersede the laws of any State that would subject a health care professional described in subsection (a) to the liability laws of any State other than the State liability laws to which such individual is subject pursuant to such subsection").
[52] 42 U.S.C. § 247d).
[53] Id. § 234(a)(1).

otherwise exists."[54] The public health emergency terminates either when the Secretary determines that it no longer exists, or on the expiry of the 90-day period beginning on the date on which the determination is made by the Secretary, whichever occurs first. During a PHE, the Secretary may "take such action as may be appropriate to respond to the public health emergency, including making grants, providing awards for expenses, and entering into contracts and conducting and supporting investigations into the cause, treatment or prevention of disease or disorder." The Secretary may use these funds to support initial emergency operations and assets related to the preparation and deployment of disaster response personnel under the National Disaster Medical System. The Public Health Emergency Fund (established in the Treasury) may only be accessed if either a Public Health Emergency has been declared, or the Secretary determines that there is significant potential for a public health emergency.[55]

[54] 42 U.S.C. § 247(d).
[55] Id. § 247(d)(b)(1).

These ideas are grounded in a "harm reduction" strategy and are consistent with many other areas of health care policy that intersect with legal restrictions, such as opioid use harm reduction strategies. At first blush, they may seem unorthodox, but they are in the same vein as clean needle exchange programs or wide distribution of naloxone. In other words, any way to increase abortion access, especially in the face of severe and harmful restrictions, is harm reduction.

No matter the policy solutions pursued, we know that there is broad support for abortion rights and voters do not want to see access rolled back.

Key Polling and Findings

- Washington Post-ABC poll: **75%** say decisions on abortion should be left to the woman and her doctor, including 95% of Democrats, 81% of independents and 53% of Republicans.[56]
- CNN (Conducted Jan. 13-18, 2022): Nearly **70%** of Americans do not want the Supreme Court to overturn *Roe v. Wade*. 85% of Democrats, 72% of Independents, and 44% of Republicans do not want the Supreme Court to overturn Roe.[57]
- Fox News (Conducted Dec. 15, 2021): **Nearly two-thirds** (65%) want Roe to remain the law of the land. Over half of Republicans (53%) joined majorities of Democrats (77%) and independents (64%) in saying Roe should remain the law of the land.**Seven in 10** white Catholics (72%) and about half of white evangelical Christians (49%) also said the decision should stand.[58]
- Marquette (Conducted Sept. 2021): Voters oppose overturning Roe by a **30 point margin**.[59]
- Gallup Poll (Conducted May 3-18, 2021): **80%** of the American public think abortion should be legal.
- Polling from Planned Parenthood Action Fund, EMILY's List, and American Bridge 21st Century indicating that support for abortion rights is a winning issue heading into the 2022 midterm elections.[60]
    - Among the top findings are:
        - Eighty percent of voters surveyed said they were more likely to vote for a Democrat who favors leaving abortion decisions up to pregnant people and their doctors, and only 9 percent were more likely to support a Republican who favors making abortion illegal, including in early pregnancy

[56] https://www.washingtonpost.com/politics/2021/11/16/post-abc-poll-abortion-supreme-court/
[57] https://www.cnn.com/2022/01/21/politics/cnn-poll-abortion-roe-v-wade/index.html
[58] https://www.foxnews.com/politics/abortion-roe-v-wade-polling-where-americans-stand
[59] https://www.marquette.edu/news-center/2021/new-marquette-law-poll-finds-sharp-decline-in-public-opinion-of-the-supreme-court-s-job-performance.php
[60] https://news.gallup.com/poll/1576/abortion.aspx

        - Seventy-one percent of women and 64 percent of men in the group said Republicans were "out of step with their own views" on abortion — more so than on guns, immigration, taxes or health care.
        - Support for Roe v. Wade increased to 87 percent once voters were told the case established a constitutional right for an individual to "decide for herself whether to have an abortion and limited the circumstances under which the government could restrict this right."
- Lake Research and Emerson College (September 22-24): Black women (57% oppose), Latinas (52% oppose), and Asian American/Pacific Islander women (64% oppose) all oppose S.B. 8 by wide margins.[61]
    - The law that bans most abortions in Texas makes over half (59%) of people more interested in voting in the 2022 elections, with nearly a third (32%) who are much more interested.
        - A solid majority of Black women (58% more interested, 39% much more interested), Latinas (64% more interested, 37% much more interested), and Asian American/Pacific Islander women (63% more interested, 33% much more interested) are more interested in the 2022 elections because of the Texas law that bans abortion.
        - The Texas ban makes Democrats (68% more interested, 38% much more interested) more interested than Independents (48% more interested, 24% much more interested) or Republicans (52% more interested, 28% much more interested) to vote in the 2022 elections.
- PerryUndem Post-election Polling 2020: Latino voters are twice as likely to vote for a candidate for political office who supports abortion rights and access (46%) than one who opposes abortion (23%). 30% say abortion doesn't make a difference in their vote. For voters overall: 42% v. 26% v. 30%
    - Among Latino Biden voters, 56% are more likely to vote for pro-choice candidate: 10% are more likely to vote for anti-abortion candidate; 32% say no difference

Policy Areas Pros and Cons

Medication Abortion Pros and Cons

- Pros:
    - These are BOLD and SPECIFIC responses to the abortion health crisis.
    - They have the potential to solve the practical access issue for many people who will be harmed by abortion bans by creating a safe access up to 10/11 weeks of pregnancy.
- Cons:
    - This doesn't help people In abortion ban states who need abortion after 10/11 weeks of pregnancy.
    - Implementation is critical -- pregnant people need to know about these resources in order to access them. And implementation is always hardest to achieve for those who are most marginalized by our health care system and/or have the least personal resources because they are often the hardest to reach.

[61] https://aitogether.org/september-2021-poll/

- The legal foundation is unlikely to achieve results in hostile courts.
- In the absence of relief in the courts, providers may not be willing to take the risk to prescribe and send Mife if they are afraid of being penalized.

Transportation Grants Pros and Cons

- Pros:
  - This is ready to go -- it's an existing program, existing authority, existing resources.
  - This is an immediate opportunity for abortion destination states.
  - This is an easy to understand policy for the general public.
  - It also highlights the hoops the restrictions have imposed.
- Cons:
  - This is happening NOW -- will be the tip of the spear and will attract a ton of opposition
  - The deadline to apply for funding is May 1, so states will need to work quickly to apply.

Disaster/Public Health Emergency Pros and Cons

- Pros:
  - This meets the moment. This IS a public health emergency.
  - This is a good path to make federal funds available to help abortion destination states.
- Cons:
  - This is an aggressive and novel use of the Stafford Act.
  - Workability is a challenge -- this only works in states willing to request an emergency declaration (ie without bans).

From: Ltd.DIBOHF23SPDLT)/CN=RECIPIENTS/CN=161E6A3E157B42FB9F2C27260D697A79-WILSON, LAU <Laurence.Wilson@hhs.gov>

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Figueroa, Marvin (HHS/IEA) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=4a287d28c5d248d2a21ad454649a7f7e-Figueroa, M <Marvin.Figueroa@hhs.gov>;
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Higgins, Sean (HHS/ASPA) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=12cc04e1cb0147408f56f9efac699715-Higgins, Se <Sean.Higgins@hhs.gov>

Subject: RE: Confirmed Travel: Manchester, NH and Rhode Island

Date: 2021/07/12 15:54:06

Priority: Normal

Type: Note

Team,

Please find attached version 3 of the New Hampshire sketch.

From: Palafox, Cynthia (HHS/IOS) <Cynthia.Palafox@hhs.gov>
Sent: Monday, July 12, 2021 1:07 PM
To: Zelenko, Leslie (HHS/ASL) <Leslie.Zelenko@hhs.gov>; Doris-Pierce, Molly (OS/IEA) <Molly.Doris-pierce@hhs.gov>; Wilson, Laurence (OS/IOS) <Laurence.Wilson@hhs.gov>; Scott, Benjamin (OS/IOS) <Benjamin.Scott@hhs.gov>; Rainer, Melanie Fontes (OS/IOS) <Melanie.Rainer@hhs.gov>; Jee, Lauren (HHS/ASL) <Lauren.Jee@hhs.gov>
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Subject: RE: Confirmed Travel: Manchester, NH and Rhode Island

Leslie – thank you for the update.

IEA &ASL – do we have confirmation on the site locations for each of the events? I can't really make a determination on whether we can push the start time on site #1 until we know what travel time will look like.

@Scott, Benjamin (OS/IOS)and @Wilson, Laurence (OS/IOS) – can you each pls send an updated sketch of each location based on the info that has been presented? Please also highlight what information is still outstanding.

Also Laurence – please make sure you update the NH sketch with the information we learned in today's call with the organizers of the 11am event.

Thanks,
Cynthia

From: Zelenko, Leslie (HHS/ASL) <Leslie.Zelenko@hhs.gov>
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Subject: RE: Confirmed Travel: Manchester, NH and Rhode Island

Molly &I connected offline. No changes to NH sketch, just affirming we'll check with Sen. Hassan on any SUD event/location.

Updated the RI Sketch v3 (attached).

@Palafox, Cynthia (HHS/IOS) One thing Rep. Cicilline's office asked was whether the first event's start time in RI could be pushed to 10:30 (right now it is at 10 am). I believe this may allow the Congressman to join for the first event (which will now be the HCBS roundtable). I said I would check in on that.

Thanks all, have a great weekend!

Leslie

New Hampshire
Site #1 – CTC Press Conference in the Park (still waiting on WH's park recommendation)
Site #2 – Council for Thriving Children Roundtable on Early Childhood

Site #3 – SUD-related event ***note, we are still waiting to finalize the location and whatever we plug in here it is requested we run by Sen. Hassan's office.**

Rhode Island
Site #1: Disability/HCBS focused event in CD 2 with Rep. Langevin &Governor on investments from AFP for HCBS. Waiting on location from Rep. Langevin's office.
Site #2: Blackstone Community Health Center Tour, Roundtable/Press Conference (CD1)

- • This CHC is in Pawtucket and came from as a recommendation of Rep. Cicilline.

Site #3: Bradley Hospital Site Visit on Child and Adolescent Behavioral Health (CD1)

From: Doris-Pierce, Molly (OS/IEA) <Molly.Doris-pierce@hhs.gov>
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Subject: RE: Confirmed Travel: Manchester, NH and Rhode Island

Leslie – for awareness, we're already working on locking in a different site for the ACA/SEP event – it would be first of the day, then Bradley, then HCBS. Would this work for the Reps?

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Thanks everyone. I shared the updated sketches and have some more feedback from the Rhode Island Member offices. Here is our updated sketch for RI below.

Site #1: Disability/HCBS focused event in CD 2 with Rep. Langevin &Governor on investments from AFP for HCBS.

- • They are working with Tina Spears of the Community Provider Network of RI is currently looking for possible sites.
- • Format: Tour &host a roundtable discussion with providers/patients.
- • Time: 60-75 minutes
- • NOTE: Cicilline has a conflict in the morning due to a previously scheduled event around Transportation with both Senators.

Site #2: Blackstone Community Health Center Tour, Roundtable/Press Conference in CD1

- • This CHC is in Pawtucket and came from a recommendation of Rep. Cicilline.
- • Attendees: Both RI Members of Congress (Senators will be invited too).
- • Format: Tour and press conference on the SEP data &ACA
- • Time: 90 minutes

Site #3: Bradley Hospital Site Visit on Child and Adolescent Behavioral Health (CD1)

- • Format: Tour &standing/seated discussion on MH investments.
- • Attendees: Both RI Members of Congress (Senators will be invited too).
- • Time: 60 minutes
- • Note: Rep. Langevin's team flagged a prior issue Bradley had with medical records, but I am getting clarification from them on what it is. They were fine with having an event there but wanted to flag in case press were invited and it came up. I did some searching and found this article on the possible issue: https://www.jdsupra.com/legalnews/lifespan-pays-1m-to-settle-hipaa-case-22313/.

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Subject: RE: Confirmed Travel: Manchester, NH and Rhode Island

Good morning Everyone and Happy Friday! New Hampshire sketch v2 is attached.

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Subject: RE: Confirmed Travel: Manchester, NH and Rhode Island

Thanks, folks! See updated draft sketch attached. Latest version is v2.

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Thanks, Molly! Let me check-in with the WH on the park and I'll get back to the group.

@Scott, Benjamin (OS/IOS)and @Wilson, Laurence (OS/IOS) – can you please add these sites to the sketch and send it back around?

From: Doris-Pierce, Molly (OS/IEA) <Molly.Doris-pierce@hhs.gov>
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Based on folks input this is what I'm tracking as a potential sketch:

New Hampshire
Site #1 – CTC Press Conference in the Park (@Palafox, Cynthia (HHS/IOS) does the WH have a preferred park or should we pick?)
Site #2 – Council for Thriving Children Roundtable on Early Childhood

Site #3 – SUD-related event

Rhode Island
Site #1 – Community Health Center and Navigator Roundtable
Note: This would be for the presser on SEP data and the ACA
Site #2 – Bradley Hospital Site Visit on child and adolescent BH
Site #3 – HCBS Roundtable in the 2nd CD

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Subject: Re: Confirmed Travel: Manchester, NH and Rhode Island

Hi all,

Apologies for the delay here. Below are the recommendations from the region. Note the overlap on the BH Hospital with Rachel's suggestion, so we feel confident about locking that in.

Additionally; we are planning on working with our ASL counterparts on swapping one event in RI to one about home and community based services based on the Members' recommendations. Appreciate your patience as we work that out!

Cynthia, if it makes sense for IEA to winnow down all the recs on this chain for the Secretary to review - let me know!

Thank you!

MDP

Suggestions for New Hampshire Events, Thursday 7/15/21

Press Conference TBD

Event 1: Roundtable meeting with Council for Thriving Children. This state early childhood council is managed cross-agency by the NH Department of Education and the Department of Health and Human Services in cross-sector partnership with the University of New Hampshire. Adopting a social determinants of health framework, the Council strives to meet the educational and health needs of children. With a two-generation lens, membership includesparent leaders, as well as state child care leaders, healthcare experts, businesses and legislators. Pulling a group together would not be difficult.

Event 2: New Hampshire Equity Group could lead a discussion on their Covid vaccine equity strategy with a roundtable of discussants/leaders from faith organizations, FQHCs, CBOs and philanthropies. The focus will be how the state is working to further improve vaccination coverage in BIPOC communities between now and September, as well as a broader discussion of (a) integration with flu vaccination, (b) Covid booster vaccination campaigns into the fall and winter, (c) the state's plan for addressing the EUA which will authorize vaccination of 5-12 year olds later this year and (d) the state's strategy for re-opening schools for the next academic year.

Suggestions for Rhode Island events, Friday 7/16/21

Press Conference TBD

Event 1: Roundtable on Pathways out of Poverty. Secretary Womazetta Jones and/or Dr. Nicole Alexander-Scott would lead a family poverty-reduction focused roundtable on pathways out of poverty. Topics to include a) how to keep the family in the center, b) child care access, c) equity and access of key services and opportunities d) social determinants of health as a primary way of practice e) the child care tax credit f) pilot Universal Basic Income (UBI) work in Providence and other cities. Participants could include community agencies, interfaith leaders, parents, state government. (*Located in Providence, in the 1st Congressional district.*)

Alternate suggestion for Event 1: Covid vaccine equity roundtable

Dr. Nicole Alexander-Scott, Rhode Island's public health commissioner, could lead a discussion on RI's Covid vaccine equity strategy with a roundtable of discussants/leaders from faith organizations, FQHCs, CBOs and philanthropies. The focus will be how the state is working to further improve vaccination coverage in BIPOC communities between now and September, as well as a broader discussion of (a) integration with flu vaccination, (b) Covid booster vaccination campaigns into the fall and winter, (c) the state's plan for addressing the EUA which will authorize vaccination of 5-12 year olds later this year and (d) the state's strategy for re-opening schools for the next academic year.

Event 2. A visit to Bradley Hospital, the nation's first psychiatric hospital devoted exclusively to children and adolescents; Bradley is a Lifespan partner and a teaching hospital for The Warren Alpert

Medical School of Brown University. Bradley Hospital has established itself as the national center for training and research in child and adolescent psychiatry. The purpose of the visit would be to highlight and learn about how Rhode Island's Executive Office of Health and Human Services (EOHHS) has been leading a statewide strategic conversation to implement a comprehensive system of care for children's behavioral health. RI's current system is siloed, with responsibility for children fragmented across different state agencies. The goal is to make coordinated services more accessible for families, creating a single point of access that streamlines the process and removes barriers to obtaining timely, necessary services and supports children, youth and families. This will require patient-centered coordination and electronic referral management software to build a coordinated continuum of care network of health and social service providers in RI. The system will include care coordination, intensive home and community-based services, transition-age youth and young adult services, as well as prevention services. (*Located in Providence, in the 1st Congressional district.*)

Event 2. A health equity zone (HEZ) visit that would also include attention to Covid vaccine equity. Rhode Island's Health Equity Zones (HEZ), led by the RI Department of Health, use a social determinants of health framework to decrease family poverty across communities. These community collaborations braid federal/state funding, including Medicaid and public health dollars to link health, social services, families, education and neighborhoods. Through a collaborative, community-led process, each HEZ conducted a needs assessment and implemented a data-driven plan of action to address conditions that are preventing people from being as healthy as possible. As just one example of this initiative's success through improved community health outcomes, in the Pawtucket/Central Falls HEZ in 2019, the area saw a 63% decrease in elementary school absenteeism, a 44% drop in childhood lead poisoning, and a 24% decrease in teen pregnancy. When COVID-19 hit, the Tri-County HEZ leveraged community voice to build resilience and increase awareness and compliance with mitigation guidelines in the three communities served. (*Located in the 2nd Congressional district, and also proximate to the TF Green Airport, for departure.)*

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On Jul 8, 2021, at 7:34 PM, Rainer, Melanie Fontes (OS/IOS) <Melanie.Rainer@hhs.gov>wrote:

CCIIO can help connect but in RH they have a state-run exchange. And they do really good work, so would be good to do something with them and/or navigators/ community health center.

Sent from my iPhone

On Jul 8, 2021, at 7:23 PM, Lovenheim, Sarah (HHS/ASPA) <Sarah.Lovenheim@hhs.gov>wrote:

Desired press conference will focus on new special enrollment data coming so any location that could support that type of announcement would be great (a community health center or clinic, for example).

On Jul 8, 2021, at 6:59 PM, Palafox, Cynthia (HHS/IOS) <Cynthia.Palafox@hhs.gov>wrote:

Hi folks,

Checking-in on the draft sketches for the trips. Attached are the outlines that Ben &Laurence put together. Any updates on potential sites for each of the states?

Thanks,
Cynthia

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Subject: RE: Confirmed Travel: Manchester, NH and Rhode Island

Another quick update from ASL:

New Hampshire: Senator Hassan's office said that depending on when the last votes in the Senate end on Thursday, she may be able to make it back for an event in the afternoon.

Rhode Island: Both Members (Rep. Cicilline &Rep. Langevin) will be in the State and look forward to joining the Secretary for his trip. We discussed possible events focused on AFP's HCBS and child care investments. Said I would loop back with more details when I had it from our end.

Thanks!

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Sent: Thursday, July 8, 2021 1:55 PM
To: Pugh, Carrie (OS/IEA) <Carrie.Pugh@hhs.gov>; Doris-Pierce, Molly (OS/IEA) <Molly.Doris-pierce@hhs.gov>; Wilson, Laurence (OS/IOS) <Laurence.Wilson@hhs.gov>; Lovenheim, Sarah (HHS/ASPA) <Sarah.Lovenheim@hhs.gov>
Cc: Zelenko, Leslie (HHS/ASL) <Leslie.Zelenko@hhs.gov>; Hild, Jeff (HHS/ASL) <Jeff.Hild@hhs.gov>; Scott, Benjamin (OS/IOS) <Benjamin.Scott@hhs.gov>; Palafox, Cynthia (HHS/IOS) <Cynthia.Palafox@hhs.gov>; Orozco, Esmeralda (HHS/IOS) <Esmeralda.Orozco@hhs.gov>; Lopez, Steven (HHS/OS/IOS) <Steven.Lopez@hhs.gov>; Jones, Kamara (HHS/ASPA) <Kamara.Jones@hhs.gov>; Despres, Sarah

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Subject: RE: Confirmed Travel: Manchester, NH and Rhode Island

Hello all,

A couple thoughts on events. If we are interested, Tom Coderre, Principle Deputy Assistant Secretary at SAMHSA, can facilitate any/all.

Thanks,
Rachel

In both states

Secretary Becerra could visit/do an event at a Certified Community Behavioral Health Clinic (CCBHC's). This is a huge program for many members on the Hill. NH and RI both have grantees and over $1 billion dollars have been invested in this program in the last year, $420 million from the American Rescue Plan. If this direction is of interest, we can track down the best site.

New Hampshire:
If you want to get Hassan's attention in NH, perhaps we should set up some visits to see how the state is spending their SOR grant money. We would have to navigate the state politics on this carefully as Sen. Hassan and Governor Sununu could be opponents next year (https://www.vnews.com/Many-factors-could-influence-a-Sununu-Senate-run-40918649). The state has used a majority of the money to stand up a Sununu priority for addiction treatment called The Doorway, a hub and spoke model. There are nine Doorway locations, providing single points of entry for people seeking help for substance use, whether they need treatment, support, or resources for prevention and awareness. The regional Doorways ensure that help is always less than an hour away. In addition, 24/7 access to services is also available by dialing 211. https://www.thedoorway.nh.gov/home

In addition to treatment, NH has great prevention and recovery programs as well. Safe Stations was started in Manchester (https://www.manchesternh.gov/Departments/Fire/Safe-Station). Governor Sununu started the first and most robust statewide Recovery Friendly Workplace program, visits to model employers is a possibility (https://www.recoveryfriendlyworkplace.com/). NH has a Recovery HUB with lots of recovery community centers and other programs which make for excellent visits (https://www.dhhs.nh.gov/dcbcs/bdas/recovery.htm).

Looks like Hassan is working with neighbor Collins on workforce issues: https://www.seacoastonline.com/story/opinion/columns/guest/2021/03/18/collins-and-hassan-crisis-within-crisis/4715260001/. We could arrange something around this if you think the Secretary would find it interesting.

Rhode Island:
If you want to focus on **youth BH**, then Bradley Hospital is probably the best option. It's the nation's first psychiatric hospital devoted exclusively to children and adolescents. It's a Lifespan partner and a teaching hospital for The Warren Alpert Medical School of Brown University. Bradley Hospital has established itself as the national center for training and research in child and adolescent psychiatry. Bradley Hospital is a private, not-for-profit hospital. https://www.lifespan.org/locations/bradley-hospital/about-bradley-hospital

There is also BH Link. BH Link's mission is to ensure all Rhode Islanders 18+ experiencing mental health and substance use crises receive the appropriate services they need as quickly as possible in an environment that supports their recovery. https://www.bhlink.org/ This could be a good place to talk about crisis grant announcement and the building of crisis services in anticipation of 988. There is also a Kids Link, that I think Bradley manages.

There are a lot of options for recovery support and overdose related work – 5-6 recovery centers throughout the state (https://bhddh.ri.gov/substance-useaddiction/recovery-services), recovery coaches in ED's, Providence Safe (Fire) Stations (https://pvdsafestations.com/), and a recovery friendly workplace program (https://recoveryfriendlyri.com/). Rhode Island also has a renowned MAT behind the walls program, the only statewide program in the nation to offer all three FDA approved medications for OUD (https://www.statnews.com/2018/02/14/medication-assisted-treatment-inmates/). Dr. Nicole Alexander Scott is the Director of the Department of Health and co-chairs the Governor's Overdose Prevention Task Force, I would suggest including her in some way.

The legislative session just concluded and it was a good one for drug policy. Caution though, the state passed and today the Governor signed a bill legalizing the first Safe Injection Facility. The state also reclassified drug crimes as misdemeanors and decriminalized possession of buprenorphine. This article references Secretary Becerra's support for SIF's when he was AG in CA: https://www.providencejournal.com/story/news/courts/2021/07/03/ri-could-first-state-in-nation-to-legalize-safe-injection-sites-for-opioid-addicts/7840401002/

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Sent: Thursday, July 8, 2021 11:46 AM
To: Doris-Pierce, Molly (OS/IEA) <Molly.Doris-pierce@hhs.gov>; Wilson, Laurence (OS/IOS) <Laurence.Wilson@hhs.gov>; Lovenheim, Sarah (HHS/ASPA) <Sarah.Lovenheim@hhs.gov>
Cc: Zelenko, Leslie (HHS/ASL) <Leslie.Zelenko@hhs.gov>; Hild, Jeff (HHS/ASL) <Jeff.Hild@hhs.gov>; Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>; Scott, Benjamin (OS/IOS) <Benjamin.Scott@hhs.gov>; Palafox, Cynthia (HHS/IOS) <Cynthia.Palafox@hhs.gov>; Orozco, Esmeralda (HHS/IOS) <Esmeralda.Orozco@hhs.gov>; Lopez, Steven (HHS/OS/IOS) <Steven.Lopez@hhs.gov>; Jones, Kamara (HHS/ASPA) <Kamara.Jones@hhs.gov>; Despres, Sarah (HHS/IOS) <Sarah.Despres@hhs.gov>; Figueroa, Marvin (HHS/IEA) <Marvin.Figueroa@hhs.gov>; Espinosa, Kimberly (HHS/ASL) <Kimberly.Espinosa@hhs.gov>; Villanueva, Josie (OS/IOS) <Josie.Villanueva@hhs.gov>; Rainer, Melanie Fontes (OS/IOS) <Melanie.Rainer@hhs.gov>; Cha, Stephen (HHS/IOS) <Stephen.Cha@hhs.gov>; Arguello, Andres (OS/IOS) <Andres.Arguello@hhs.gov>; Schechter, Alia (OS/IOS) <Alia.Schechter@hhs.gov>; Seshasai, Karuna (HHS/IOS) <Karuna.Seshasai@hhs.gov>; Zardeneta, Lizeth (HHS/OS/IOS) <Lizeth.Zardeneta@hhs.gov>; Jee, Lauren (HHS/ASL) <Lauren.Jee@hhs.gov>; Friedman, Jennifer (OS/IOS) <Jennifer.Friedman@hhs.gov>; Reid, Anne (OS/IOS) <Anne.Reid@hhs.gov>; Higgins,

Sean (HHS/ASPA) <Sean.Higgins@hhs.gov>
Subject: RE: Confirmed Travel: Manchester, NH and Rhode Island

Good flag – thanks.

From: Doris-Pierce, Molly (OS/IEA) <Molly.Doris-pierce@hhs.gov>
Sent: Thursday, July 8, 2021 11:12 AM
To: Wilson, Laurence (OS/IOS) <Laurence.Wilson@hhs.gov>; Lovenheim, Sarah (HHS/ASPA) <Sarah.Lovenheim@hhs.gov>
Cc: Zelenko, Leslie (HHS/ASL) <Leslie.Zelenko@hhs.gov>; Hild, Jeff (HHS/ASL) <Jeff.Hild@hhs.gov>; Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>; Scott, Benjamin (OS/IOS) <Benjamin.Scott@hhs.gov>; Palafox, Cynthia (HHS/IOS) <Cynthia.Palafox@hhs.gov>; Orozco, Esmeralda (HHS/IOS) <Esmeralda.Orozco@hhs.gov>; Lopez, Steven (HHS/OS/IOS) <Steven.Lopez@hhs.gov>; Jones, Kamara (HHS/ASPA) <Kamara.Jones@hhs.gov>; Despres, Sarah (HHS/IOS) <Sarah.Despres@hhs.gov>; Figueroa, Marvin (HHS/IEA) <Marvin.Figueroa@hhs.gov>; Espinosa, Kimberly (HHS/ASL) <Kimberly.Espinosa@hhs.gov>; Villanueva, Josie (OS/IOS) <Josie.Villanueva@hhs.gov>; Rainer, Melanie Fontes (OS/IOS) <Melanie.Rainer@hhs.gov>; Cha, Stephen (HHS/IOS) <Stephen.Cha@hhs.gov>; Pugh, Carrie (OS/IEA) <Carrie.Pugh@hhs.gov>; Arguello, Andres (OS/IOS) <Andres.Arguello@hhs.gov>; Schechter, Alia (OS/IOS) <Alia.Schechter@hhs.gov>; Seshasai, Karuna (HHS/IOS) <Karuna.Seshasai@hhs.gov>; Zardeneta, Lizeth (HHS/OS/IOS) <Lizeth.Zardeneta@hhs.gov>; Jee, Lauren (HHS/ASL) <Lauren.Jee@hhs.gov>; Friedman, Jennifer (OS/IOS) <Jennifer.Friedman@hhs.gov>; Reid, Anne (OS/IOS) <Anne.Reid@hhs.gov>; Higgins, Sean (HHS/ASPA) <Sean.Higgins@hhs.gov>
Subject: RE: Confirmed Travel: Manchester, NH and Rhode Island

Wanted to flag for this group that he will be in NH, but we declined the ME opioid summit in person request and pre-recorded. I don't think it's an issue, but did want to flag the date overlap.

Molly Doris-Pierce, *she/her*
Special Assistant
Office of Intergovernmental and External Affairs, U.S. Dept. of Health and Human Services
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From: Wilson, Laurence (OS/IOS) <Laurence.Wilson@hhs.gov>
Sent: Wednesday, July 7, 2021 9:45 PM
To: Lovenheim, Sarah (HHS/ASPA) <Sarah.Lovenheim@hhs.gov>
Cc: Zelenko, Leslie (HHS/ASL) <Leslie.Zelenko@hhs.gov>; Hild, Jeff (HHS/ASL) <Jeff.Hild@hhs.gov>; Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>; Scott, Benjamin (OS/IOS) <Benjamin.Scott@hhs.gov>; Palafox, Cynthia (HHS/IOS) <Cynthia.Palafox@hhs.gov>; Orozco, Esmeralda (HHS/IOS) <Esmeralda.Orozco@hhs.gov>; Lopez, Steven (HHS/OS/IOS) <Steven.Lopez@hhs.gov>; Jones, Kamara (HHS/ASPA) <Kamara.Jones@hhs.gov>; Despres, Sarah (HHS/IOS) <Sarah.Despres@hhs.gov>; Figueroa, Marvin (HHS/IEA) <Marvin.Figueroa@hhs.gov>; Espinosa, Kimberly (HHS/ASL) <Kimberly.Espinosa@hhs.gov>; Villanueva, Josie (OS/IOS) <Josie.Villanueva@hhs.gov>; Rainer, Melanie Fontes (OS/IOS) <Melanie.Rainer@hhs.gov>; Cha, Stephen (HHS/IOS) <Stephen.Cha@hhs.gov>; Pugh, Carrie (OS/IEA) <Carrie.Pugh@hhs.gov>; Arguello, Andres (OS/IOS) <Andres.Arguello@hhs.gov>; Schechter, Alia (OS/IOS) <Alia.Schechter@hhs.gov>; Seshasai, Karuna (HHS/IOS) <Karuna.Seshasai@hhs.gov>; Zardeneta, Lizeth (HHS/OS/IOS) <Lizeth.Zardeneta@hhs.gov>; Doris-Pierce, Molly (OS/IEA) <Molly.Doris-pierce@hhs.gov>; Jee, Lauren (HHS/ASL) <Lauren.Jee@hhs.gov>;

Friedman, Jennifer (OS/IOS) <Jennifer.Friedman@hhs.gov>; Reid, Anne (OS/IOS) <Anne.Reid@hhs.gov>; Higgins, Sean (HHS/ASPA) <Sean.Higgins@hhs.gov>
Subject: Re: Confirmed Travel: Manchester, NH and Rhode Island

Resending New Hampshire sketch as additional folks have been added.

Best,

Laurence J. Wilson
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Office of the Secretary
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On Jul 7, 2021, at 7:49 PM, Lovenheim, Sarah (HHS/ASPA) <Sarah.Lovenheim@hhs.gov>wrote:

+ Sean H, who will be our ASPA POC.

On Jul 7, 2021, at 5:18 PM, Zelenko, Leslie (HHS/ASL) <Leslie.Zelenko@hhs.gov>wrote:

Hi folks,

Quick update for New Hampshire:

Congressman Chris Pappas will not be in town on the 15th, his office asked if there was any flexibility on the date, I'm guessing there's not but just wanted to see.

Senator Shaheen was hoping to get more details on the events of the day, I said I would share when I have them. Her Chief flagged that the Senate is in session next week, which may make it difficult.

Thanks!
Leslie

From: Hild, Jeff (HHS/ASL) <Jeff.Hild@hhs.gov>
Sent: Wednesday, July 7, 2021 2:15 PM
To: Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>; Scott, Benjamin (OS/IOS) <Benjamin.Scott@hhs.gov>; Wilson, Laurence (OS/IOS) <Laurence.Wilson@hhs.gov>; Palafox, Cynthia (HHS/IOS) <Cynthia.Palafox@hhs.gov>; Zelenko, Leslie (HHS/ASL) <Leslie.Zelenko@hhs.gov>
Cc: Orozco, Esmeralda (HHS/IOS) <Esmeralda.Orozco@hhs.gov>; Lopez, Steven (HHS/OS/IOS) <Steven.Lopez@hhs.gov>; Jones, Kamara (HHS/ASPA) <Kamara.Jones@hhs.gov>; Despres, Sarah (HHS/IOS) <Sarah.Despres@hhs.gov>; Lovenheim, Sarah (HHS/ASPA) <Sarah.Lovenheim@hhs.gov>; Figueroa, Marvin (HHS/IEA) <Marvin.Figueroa@hhs.gov>; Espinosa, Kimberly (HHS/ASL)

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Subject: RE: Confirmed Travel: Manchester, NH and Rhode Island

+ Leslie who is helping to coordinate with the Congressional offices.

From: Pryor, Rachel (HHS/OS/IOS) <Rachel.Pryor@hhs.gov>
Sent: Wednesday, July 7, 2021 1:22 PM
To: Scott, Benjamin (OS/IOS) <Benjamin.Scott@hhs.gov>; Wilson, Laurence (OS/IOS) <Laurence.Wilson@hhs.gov>; Palafox, Cynthia (HHS/IOS) <Cynthia.Palafox@hhs.gov>
Cc: Orozco, Esmeralda (HHS/IOS) <Esmeralda.Orozco@hhs.gov>; Lopez, Steven (HHS/OS/IOS) <Steven.Lopez@hhs.gov>; Jones, Kamara (HHS/ASPA) <Kamara.Jones@hhs.gov>; Despres, Sarah (HHS/IOS) <Sarah.Despres@hhs.gov>; Lovenheim, Sarah (HHS/ASPA) <Sarah.Lovenheim@hhs.gov>; Figueroa, Marvin (HHS/IEA) <Marvin.Figueroa@hhs.gov>; Espinosa, Kimberly (HHS/ASL) <Kimberly.Espinosa@hhs.gov>; Hild, Jeff (HHS/ASL) <Jeff.Hild@hhs.gov>; Villanueva, Josie (OS/IOS) <Josie.Villanueva@hhs.gov>; Rainer, Melanie Fontes (OS/IOS) <Melanie.Rainer@hhs.gov>; Cha, Stephen (HHS/IOS) <Stephen.Cha@hhs.gov>; Pugh, Carrie (OS/IEA) <Carrie.Pugh@hhs.gov>; Arguello, Andres (OS/IOS) <Andres.Arguello@hhs.gov>; Schechter, Alia (OS/IOS) <Alia.Schechter@hhs.gov>; Seshasai, Karuna (HHS/IOS) <Karuna.Seshasai@hhs.gov>; Zardeneta, Lizeth (HHS/OS/IOS) <Lizeth.Zardeneta@hhs.gov>; Doris-Pierce, Molly (OS/IEA) <Molly.Doris-pierce@hhs.gov>; Jee, Lauren (HHS/ASL) <Lauren.Jee@hhs.gov>; Friedman, Jennifer (OS/IOS) <Jennifer.Friedman@hhs.gov>; Reid, Anne (OS/IOS) <Anne.Reid@hhs.gov>
Subject: RE: Confirmed Travel: Manchester, NH and Rhode Island

We have a lot of HCBS and SUD opportunity in both NH and RI- pulling some good programs now- thanks, Rachel

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From: Scott, Benjamin (OS/IOS) <Benjamin.Scott@hhs.gov>
Sent: Wednesday, July 7, 2021 1:03 PM
To: Wilson, Laurence (OS/IOS) <Laurence.Wilson@hhs.gov>; Palafox, Cynthia (HHS/IOS) <Cynthia.Palafox@hhs.gov>
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Friedman, Jennifer (OS/IOS) <Jennifer.Friedman@hhs.gov>; Reid, Anne (OS/IOS) <Anne.Reid@hhs.gov>
Subject: RE: Confirmed Travel: Manchester, NH and Rhode Island

Folks – find incredibly draft version of sketch for Rhode Island attached. Will start a new Rhode Island only thread once we identify staff. Thanks!!

Ben

Benjamin Scott
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Subject: Re: Confirmed Travel: Manchester, NH and Rhode Island

Thanks, Cynthia! Will do.

Best,

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On Jul 7, 2021, at 10:22 AM, Palafox, Cynthia (HHS/IOS) <Cynthia.Palafox@hhs.gov>wrote:

Hi team,

The Secretary approved the travel to Manchester, NH on Thursday, July 15 and to Rhode Island on Friday, July 16. We also received confirmation from ASL on RI availability, so we fully locked-in for that trip. And although we are still working on clarifying a few pieces with ethics, I would like to see a **draft sketch of both trips by COB tomorrow**. And as we have before, it would great to continue to highlight the AFP and vaccine confidence (if appropriate) as well as care economy in RI.

Below is the tentative schedule I created for both days based on potential arrival and departure times. Although we don't yet know where the Secretary will be needed first in RI, I am having him travel to Providence from Manchester, NH, but that can be changed.

Thursday, July 15, 2021

10:00am ET Wheels Down Manchester, NH
10:30am ET (30 min) HOLD for potential press
11:00am ET (60 min) CTC Press Conference (location: at a park – exact location TBD)
12:00pm ET Travel to lunch
12:15pm ET (60 min) Lunch
1:15pm ET Travel to site #2
1:30pm ET (90 min) Site #2
3:00pm ET Travel to site #3
3:15pm ET (90 min) Site #3
4:45pm ET Depart Manchester, NH and **drive** to Providence, RI
7:00pm ET Arrive at Providence RI
RON: Hotel in Providence, RI (location TBD)

Friday, July 16, 2021

9:00am ET Hold for press
9:30am ET Travel to site #1
10:00am ET (60 min) Site #1
11:00am ET Travel to site #2
11:30pm ET (60 min) Site #2
12:30pm ET (30 min) Lunch
1:00pm ET Depart for site #3
1:30pm ET (60 min) Site #3
2:30pm ET Depart for airport
4:00pm ET Arrive at airport
4:45pm ET Wheels-up Providence, RI

ASPA team – Sarah requested that we try and proactively hold time for press during each trip. Please let me know what time would work best. I'm currently holding time first thing in the morning but let me know if that doesn't work on your end.

ASL team – please confirm the Secretary's participation and let us know what they have in mind, especially for RI

IEA team – please confirm the Secretary's travel with regional office and keep us all posted on potential sites. Also, let me know if the time I've allocated is not enough – we could try to play round with timing based on the locations.

Counselors – please let us know if there's any specific policy and/or topics that the team should be aware of when building out the trip.

Ben – I know you are in Charlotte at the moment, but when you're free, can you please start creating the full sketch for RI?

Laurence – can you please start creating the sketch for Manchester, NH?

Thank you all!

Cynthia

Cynthia Palafox
Director of Scheduling &Advance
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<7.15.21 Manchester, New Hampshire Trip Sketch v1.docx>
<Rhode Island - Sketch - v1.docx>

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Zelenko, Leslie (HHS/ASL) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=b14d75b301ff4872beb48588e0ad4c8e-Zelenko, Le <Leslie.Zelenko@hhs.gov>;
Doris-Pierce, Molly (OS/IEA) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=319bffa9a39b432eb695810f0c3a7202-Doris-Pierc <Molly.Doris-pierce@hhs.gov>;
Scott, Benjamin (OS/IOS) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=78e801f602f54f21a59156d5b1cd26cc-Scott, Benj <Benjamin.Scott@hhs.gov>;
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(FYDIBOHF23SPDLT)/cn=Recipients/cn=12cc04e1cb0147408f56f9efac699715-Higgins, Se
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Sent Date: 2021/07/12 15:53:39

Delivered Date: 2021/07/12 15:54:06

February 25, 2022

Dr. Rahul Gupta
Director, Office of National Drug Control Policy
1800 G Street NW
Washington, DC 20006

Xavier Becerra
Secretary, U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: Stimulant Harm Reduction Supplies, SAMHSA Grants, and Federal Approach to Harm Reduction

To the Honorable Director Rahul Gupta and the Honorable Secretary Xavier Becerra:

We, the signers of this letter, are members of the Substance Abuse and Mental Health Services Administration (SAMHSA) Steering Committee on Harm Reduction, assembled as a follow-up to the joint Centers for Disease Control and Prevention (CDC), Office of National Drug Control Policy (ONDCP), and SAMHSA convening, *Field Views on Harm Reduction: A National Summit*. We write to protest in the strongest terms the statement by Department of Health and Human Services (HHS) Secretary Xavier Becerra and the Director of ONDCP, Dr. Rahul Gupta, that "no federal funding will be used directly or through subsequent reimbursement of grantees to put pipes in safe smoking kits" for people who smoke crack, methamphetamine, or other substances in order to reduce the risk of infectious disease transmission and engage clients in other healthcare and social services, including overdose prevention education and naloxone access. This statement contradicts the stated intention of "using our resources smartly to reduce harm and save lives" and reflects a fundamental misunderstanding of harm reduction philosophy, practice, and evidence.

We understand our current task to be to advise SAMHSA on a definition of harm reduction, its pillars, principles, and metrics, and to inform SAMHSA's implementation efforts to better serve people who use drugs (PWUD). We were nominated by our peers to this committee in recognition of our many years of individual and collective experience as harm reduction service providers in varying capacities. We are participating in this effort because we firmly believe that harm reduction is a just and scientific approach to reduce disease transmission, overdose death, and other potential harms associated with the use of substances. We urgently seek a change in the current approach to drug use, which is misguided, informed by rhetoric over evidence, and racist in its history, intent, and practice.

Much of the focus of harm reduction over its 30+ year history, particularly due to the HIV epidemic and increased risk for overdose, has understandably been on injection drug use and more specifically, on the provision of sterile syringes. But harm reduction is equally applicable to other routes of administration, including the smoking of substances such as crack cocaine and methamphetamine. Further, pipes can be provided to people who inject drugs as an alternative that can reduce the risk of fatal overdose. Providing pipes for someone who smokes is no different from providing syringes to someone who injects, and these practices are not mutually exclusive. Both strategies are grounded in evidence-based practice, compassion, and justice. They further facilitate education, trust-building, and linkage to care.

Undermining the funding of smoking kits, of which pipes are an essential element, robs us of a critical tool of engagement during a time when we have surpassed a devastating 100,000 overdose deaths in the last 12 months – overdoses increasingly seen in polydrug use as well as stimulant use impacted by the introduction of fentanyl and other novel psychoactive substances into the drug supply. Overdose deaths have surged among Black and Native American men in particular, despite 2019 SAMHSA data reflecting, with few exceptions, less lifetime and past-year use of stimulant drugs by communities of color compared to White Americans (regardless of the racist dog whistles of recent crack pipe panic). Recent data also show sharply rising cocaine- and opioid-related overdose deaths in Hispanic and Asian American and Pacific Islander communities, with Asian Americans demonstrating some of the highest respective increases in overdose deaths in some regions. To right this inequity and these alarming, rising rates of overdose-related deaths, we cannot pick and choose – we require all methods of harm reduction be available to impact morbidity and mortality associated with substance use.

Further, the COVID-19 pandemic has exacerbated health risks for people who use drugs and we see disproportionate fatalities among PWUD, particularly PWUD of color. In the past year, we have seen increased requests for safer smoking supplies at harm reduction and syringe services programs (SSPs) from PWUD attempting to prevent COVID-19 exposure and transmission. What's more, SSPs have emerged as a key venue to co-locate COVID prevention activities, including vaccination, targeting groups that experience vaccine hesitancy and mistreatment from traditional healthcare providers. Supporting SSPs in offering the widest range of supplies, including pipes, allows us to recruit a wider network of people into public health programming. Thus, recently, the distribution of pipes has become an even more urgent public health strategy.

Damaging outcomes of the Administration's refusal to counter and correct recent alarmist narratives are already apparent in Congress, namely with the swift introduction of the PIPES Act by Senators Joe Manchin (D-WV) and Marco Rubio (R-FL), as well as the CRACK Act by another contingent of Senate Republicans, led again by Senator Rubio. The PIPES Act further places sterile syringe access out of reach for the six states and four territories without a current CDC determination of need for syringe services. The statement by Secretary Becerra and Director Gupta has undermined the work of HHS agencies attempting to incorporate harm reduction, the work of this advisory body, and SAMHSA's future harm reduction grantees, and has given rise to doubt that HHS has a meaningful commitment to the implementation of harm reduction as a pillar of its overdose prevention strategy. Instead, it appears that HHS and ONDCP will be swayed from this critical charge by the clamor of ill-informed voices. Our communities deserve to have funded public health services that are unflinchingly rooted in evidence and compassion.

The Harm Reduction Steering Committee would like to request a meeting to discuss this matter at your earliest convenience. In the meantime, please find our recommendations below:

- Establish a plan to engage harm reduction experts on a consistent and ongoing basis, including in developing federal harm reduction programming, messaging, materials, grants (from RFPs to grant review), and optimal models of funding, as well as outcome metrics and indicators. This steering committee can advise that process, and we are available to develop a roster from the broader harm reduction pool of experts.
- Appoint a liaison at HHS for the Harm Reduction Steering Committee and other groups of harm reduction experts as noted above for ongoing dialogue regarding harm reduction optics, rollout strategy, messaging, etc.
- Instruct SAMHSA to widely disseminate clarification, particularly to applicants and reviewers, that applicants for FY22 Harm Reduction Program Grants (NOFO No. SP-22-001) who included references to

safer smoking program activities, including pipe distribution, or presence of smoking kits including pipes, in proposed budgets will not be penalized, sanctioned, dismissed, or poorly scored by grant reviewers solely for the references to these activities or materials, given that the Secretary and Director's statement occurred after the grant application period had closed.

- Improve access to essential subject matter expertise on harm reduction by establishing Intergovernmental Personnel Act (IPA) agreements with harm reduction organizations and drug user unions. Forging partnerships through IPA agreements would allow the federal government to retain the expertise of the knowledgeable, experienced, and often highly credentialed leadership within these organizations.
- Establish a harm reduction ombudsman position whose role is to ensure that harm reduction activities that are funded with taxpayer money are evidence-based and retain fidelity to evidence-based models.
- Given the retirement of community partners Tom Hill, former Senior Policy Advisor for ONDCP, and Captains Jeffrey Coady and Christopher Jones's interim roles as Acting Directors for the Center for Substance Abuse Prevention at SAMHSA and National Center for Injury Prevention and Control at CDC, respectively, provide opportunities to build upon existing momentum by appointing staff who appreciate the role of harm reduction in addressing substance use and facilitate relationship-building between new appointees and the harm reduction community.
- Via NIDA, fund effectiveness research on promising and emergent harm reduction practices whose evidence base could be strengthened or relies on international more than domestic evidence, including but not limited to: drug checking, safer smoking interventions, safer snorting interventions, safer supply, and overdose prevention sites. Privilege meaningful public health outcomes such as COVID-19 prevention or transition-from-injection as much as substance use-related outcomes such as Addiction Severity Index scores. Seek the expertise of the above-mentioned harm reduction body in developing said outcomes.
- Establish a plan to manage and respond to confusion, uncertainty, lack of familiarity, and objections to harm reduction, which is a new area of activity for the federal government. Consult with public servants who have been in similar positions at state and municipal levels, as well as the above-mentioned harm reduction expert body. Regarding state and municipal officials, this steering committee or other established body of harm reduction experts can advise that process and recommend relevant contacts.

Thank you for your time and attention.

Respectfully,

Hiawatha Collins
Community & Capacity Building Manager, National Harm Reduction Coalition
Board Chair, VOCAL-NY
Founder & Co-Director, Peer Network of New York

Maya Doe-Simkins
Co-Founder, Remedy Alliance

Mark Jenkins
Executive Director, Connecticut Harm Reduction Alliance

Charles King
Executive Director, Housing Works

Sherrine Peyton
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Marielle A. Reataza, MD, MS
Executive Director, National Asian Pacific American Families Against Substance Abuse

Christine Rodriguez, MPH
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Executive Director, The Missouri Network for Opiate Reform & Recovery

Anthony Salandy, PhD, MSc
Managing Director of Programs, National Harm Reduction Coalition

Caty Simon
Leadership Team Member, Urban Survivors Union
Founding Co-Organizer, Whose Corner Is It Anyway

Jess Tilley
Executive Director, New England Users Union
Co-Founder, HRH413

Rafael A. Torruella
Executive Director, Intercambios Puerto Rico

Louise Vincent
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Justine Waldman, MD, FACEP
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Alice Asher, RN, MS, PhD
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Captain Jeffrey Coady, Psy.D., ABPP
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Dr. Miriam E. Delphin-Rittmon
Assistant Secretary for Mental Health and Substance Use, Office of the Assistant, SAMHSA

Peter Gaumond
Senior Policy Analyst/Chief, Recovery Branch, ONDCP

Captain Christopher M. Jones, PharmD, DrPH, MPH
Acting Director, National Center for Injury Prevention and Control, CDC

Rochelle P. Walensky, MD, MPH
Director, CDC

From: Grant Smith <gsmith@drugpolicy.org>

To: Becerra, Xavier (OS/IOS) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=171a00a148784e8881fda2324d3f44e8-Becerra, Xa <Xavier.Becerra@hhs.gov>;
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Levine, Rachel (HHS/OASH) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=e691235ff2f3496e9b53eeb5f538b2f6-Levine, Rac <Rachel.Levine@hhs.gov>;
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Subject: Letter to Secretary Becerra and Director Gupta

Date: 2022/02/28 15:09:50

Priority: Normal

Type: Note

Dear Secretary Becerra and Director Gupta:

Please accept this letter on behalf of more than 260 organizations to express our concern regarding the Administration's response to media distortions leveled against the Notice of Funding Opportunity (NOFO) for the $30 million in SAMHSA harm reduction funding.

We do appreciate the Administration's drug policy priorities, "Advancing racial equity issues in our approach to drug policy," and "Enhancing evidence-based harm reduction efforts" and we urge the Administration to keep working to implement these issues. We ask that harm reduction practitioners and people who use drugs continue to be a resource to you and hope that this letter will serve as a springboard for further discussion on how we can end the overdose crisis together. To that end we propose that the Administration meet directly with harm reduction programs engaged in safer smoking supplies distribution and outreach to people who smoke drugs, to share their insights and experiences with these harm reduction strategies and that you meet regularly with the Justice Roundtable Harm Reduction Working Group.

We look forward to hearing from you and thank you for considering the attached letter.

Sincerely,

Grant Smith
Co-Chair, Drug Policy Reform Working Group of the Justice Roundtable
Deputy Director, National Affairs, Drug Policy Alliance

Grant Smith | Deputy Director, National Affairs
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Drug Policy Alliance
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Delivered Date:	2022/02/28 15:09:50

February 28, 2022

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, N.W.
Washington, DC 20201

Director Rahul Gupta
Office of National Drug Control Policy
The White House
1600 Pennsylvania Avenue, N.W.
Washington, DC 20500

Dear Secretary Becerra and Director Gupta,

As you are well aware, the United States is in the midst of an unprecedented and horrific overdose crisis. Last year, more than 100,000 Americans lost their lives to overdose. At the same time, HIV transmissions among people who use drugs have risen over the past 5 years as HIV incidence has fallen across the general population, and rates of viral hepatitis transmission among people who inject drugs continue to skyrocket. We are in a state of crisis and our nation's response to the overdose epidemic must reflect this.

Given this public health emergency, we must express our deep concern regarding the Administration's response to media distortions leveled against the Notice of Funding Opportunity (NOFO) for the $30 million in SAMHSA harm reduction funding. The use of the term "crack pipe" is not a technical term but a racist trope specifically targeting Black people. We note that crystal methamphetamine, more associated with drug use among rural white people, is also used with a glass pipe but was not mentioned in the conservative media that chose the most stigmatizing language that they could, creating a racist dog whistle. Additionally, while white people have used crack cocaine at similar rates, demonization of crack use led to a 100-to-1 (now 18-to-1) federal sentencing disparity between crack and powder cocaine despite the fact these substances are chemically the same. Such stigmatizing terminology fails to reflect the science and lived experience that smoking cocaine, methamphetamine or other drugs is in and of itself less dangerous than injection drug use. Additionally, policies and laws continue to cause harm through racial disparities in the criminal legal system and reduced access to life-saving services, such as harm reduction and drug treatment, for Black people and other people of color who are disproportionately impacted by the overdose crisis.

The landscape of substance use in the US is constantly shifting, but one thing that we can be sure of is that the drug supply is getting progressively less stable. Adulterants are now appearing in all forms of illicit drugs, including smokable stimulants. Individuals using smokable stimulants often have no idea that their drugs may contain powerful manufactured opiates; some may not even be familiar with opioid overdose response or carry naloxone. For that

reason, among several others, it is critically important to ensure that targeted outreach to people who smoke stimulants is a major part of harm reduction programming and overdose response.

The harm reduction community has been encouraged by the support the Biden-Harris Administration has given to evidence-based approaches to addressing the overdose crisis. In particular, we appreciate the administration's stated drug policy priorities, "Advancing racial equity issues in our approach to drug policy," and "Enhancing evidence-based harm reduction efforts." We believe that these priorities have the potential to enhance the U.S. response to increasing overdoses. We were additionally pleased by the inclusion of $30 million of harm reduction funding in the American Rescue Plan Act. It is clear that this administration is serious about leading with science when confronting the overdose crisis, and that the punitive approaches of the failed war on drugs must be redirected.

We urge the Biden Administration to implement the following:

a) Remove the federal funding ban on purchasing syringes and other drug paraphernalia for the prevention of infectious disease and overdose deaths.
b) Invest in the types of evidence based harm reduction interventions that will curb the HIV, viral hepatitis, and overdose crises, beginning with a request in the FY23 Budget for $150 million to the CDC's Opioid Related Infectious Diseases Programs.
c) Reduce regulatory barriers to ensure increased access to buprenorphine and methadone as evidence-based treatments for opioid use disorder for all people who use drugs that want it.
d) Allow states and municipalities to operate life-saving Overdose Prevention Centers without interference from the federal government.

We urge the Biden-Harris Administration to pursue its public commitment to end the overdose crisis, advance racial equity and reduce stigma in its approach to drug policy and to enhance evidence-based harm reduction efforts that will save lives. We ask that the Administration work with people engaged in lifesaving harm reduction when the next media distortions emerge to set the record straight and to respond with greater nuance. People who use drugs and harm reductionists need the support of the Biden-Harris Administration to ensure that harm reduction is scaled up to fully respond to increasing overdoses and infectious disease transmission.

We ask finally that harm reduction practitioners and people who use drugs continue to be a resource to you and hope that this letter will serve as a springboard for further discussion on how we can end the overdose crisis together. Harm reductionists are fighting an uphill battle against an overdose crisis that shows little sign of abating soon with little funding and heavy hearts as our friends and family and colleagues are routinely taken from us. We ask the Administration to stand beside us to maintain its public commitment to advancing racial equity and reducing stigma in its approach to drug policy. We also must insist that the Administration not only trust the science of harm reduction but also pushes back when it is attacked with stigmatizing racist tropes rife with misinformation.

To that end, we request that you 1) meet directly with harm reduction programs engaged in safer smoking supplies distribution and outreach to people who smoke drugs, to share their insights and experiences with these harm reduction strategies and better inform the Administration's understanding of their role in public health and 2) that you meet regularly with the Justice Roundtable Harm Reduction Working Group and others. These meetings would foster understanding and alignment around harm reduction priorities, strategies, and messaging, including the vital challenge of resisting racialized stigma and fostering broader consensus across partisan lines.

Thank you for your commitment to working on these urgent issues impacting individuals, families and communities nationwide. If you have questions or need additional information please do not hesitate to contact William McColl, Chair of the Harm Reduction Working Group at 202-595-4167 at mccollbusiness@gmail.com.

Sincerely,

List of National Organizations:

A Little Piece of Light

Academy of Perinatal Harm Reduction

AIDS United

American Academy of HIV Medicine

amfAR, The Foundation for AIDS Research

AnKa Consulting LLC

Association for Ambulatory Behavioral Healthcare

Association of Asian Pacific Community Health Organizations (AAPCHO)

AVAC

Behavioral Health Leadership Institute

Best Practices Policy Project

Big Cities Health Coalition

Black AIDS Institute

Black Harm Reduction Network

Blacks in Law Enforcement of America

Blaque Women Rising

Broken No More

Caring Ambassadors Program

Center for Employment Opportunities

Center for LGBTQ Economic Advancement & Research (CLEAR)

Center for Popular Democracy

CenterLink: The Community of LGBT Centers

CHLP

Clergy For a New Drug Policy

Dave Purchase Project/NASEN

Defending Rights & Dissent

Drug Policy Alliance

Equality Federation

Fair and Just Prosecution

Faith in Harm Reduction

Faith in Public Life

Fast-Track Cities Institute

Funders Concerned About AIDS

GLMA: Health Professionals Advancing LGBTQ Equality

Global Liver Institute

Healing Equity and Liberation (HEAL)

HealthHIV

HIV Dental Alliance

In The Works

Incarcerated Nation Network

Institutes for Behavior Resources, Inc.

International Association of Providers of AIDS Care

InterReligious Task Force on Central America

John Snow, Inc.

Justice Strategies

Juvenile Law Center

Lambda Legal Defense & Education Fund, Inc.

Latino Commission on AIDS

Law Enforcement Action Partnership

Legal Action Center

MomsRising

Musicians For Overdose Prevention

NAADAC, the Association for Addiction Professionals

NASTAD

National Association of Addiction Treatment Providers

National Association of Criminal Defense Lawyers

National Center for Advocacy and Recovery for Behavioral Health

National Harm Reduction Coalition

National Health Care for the Homeless Council

National Health Law Program

National Pain Advocacy Center

National Viral Hepatitis Roundtable

National Working Positive Coalition

NETWORK Lobby for Catholic Social Justice

NEXT Distro

NMAC

Oasis Legal Services

PAIN

Partnership to End Addiction

People's Action

Positive Women's Network-USA

PrEP4All

Prevention Access Campaign - U=U

Reframe Health and Justice

Remedy Alliance

Sero Project

Stop Stigma Now

StoptheDrugWar.org

Students for Sensible Drug Policy

The AIDS Institute

The Hepatitis C Mentor and Support Group-HCMSG

Transforming Reentry Services/MWIPM

Transgender Law Center

Treatment Action Group

United Church of Christ, Justice and Local Church Ministries

URGE. Unite for Reproductive & Gender Equity

USU

Washington Office on Latin America (WOLA)

Women's Community Justice Association

Young People in Recovery

List of State Organizations:

Alabama

AIDS Alabama South, LLC.

Alabama Regional Medical Services

GoodWorks: North AL Harm Reduction

Arizona

Circle the City

Rooted Community Acupuncture & Holistic Care

Shot in the Dark

Southwest Recovery Alliance

California

APLA Health

Arlene & Michael Rosen Foundation

COVID Clinic, Inc.

DAP Health

Equality California

Face to Face/Sonoma County AIDS Network

Harm Reduction Coalition of San Diego ON POINT

Harm Reduction Services

HIV Education and Prevention Project of Alameda County

Homeless Health Care Los Angeles

MCAVHN Care and Prevention Network

San Francisco AIDS Foundation

San Francisco Department of Public Health

The Spahr Center/Syringe Access Program

Colorado

Boulder County AIDS Project (BCAP)

Colorado Coalition for the Homeless

Colorado Health Network

Colorado Individuals and Organizations Responding to HIV AIDS

Harm Reduction Action Center

One Colorado

District of Columbia

HIPS DC

Rebuilding Independence My Style

Florida

Florida Opiate Coalition

Florida Rising

Miami Coalition to Advance Racial Equity

NEU Health Solutions, Inc

Rad Heartstrings Florida, Inc

Southeast Florida Recovery Advocates, Inc

Georgia

Phoenix Transition Program

Hawaii

Drug Policy Forum of Hawai'i

Hep Free Hawaii

Kaipuokaualoku, LLC

Idaho

Idaho Harm Reduction Project

Iowa

Iowa Harm Reduction Coalition

Positive Iowans Taking Charge (PITCH)

Illinois

AIDS Foundation Chicago

Center for Housing & Health

Chicago Drug Users' Union

Drug Users Health Collective of Chicago

Duneys Defense

Heartland Alliance Health

Howard Brown Health

Illinois Harm Reduction and Recovery Coalition

Live4Lali, Inc.

Phoenix Center

Recovery Options Champaign

The Night Ministry

The Perfectly Flawed Foundation

Indiana

HIV Modernization Movement-Indiana

Holding Space Recovery Project

Hoosier Action

Indiana Recovery Alliance

Louisiana

CrescentCare

Trystereo/New Orleans Harm Reduction Collective

Massachusetts

Material Aid and Advocacy Program

New England Drug Users Union Eastern Massachusetts Branch

New England Users Union/HRH413

Smoke Works

Tapestry Health Systems Inc.

Whose Corner Is It Anyway

Maryland

Addiction Connections Resource

Advocacy and Training Center

AIDS Action Baltimore

Baltimore Harm Reduction Coalition

Communities United

Health Care for the Homeless (Baltimore)

MD Coalition of Families

Mental Health Association of Maryland

National Council on Alcoholism and Drug Dependence-Maryland

NCADD Maryland

Voices of Hope, Inc.

Maine

Amistad

Health Equity Alliance

Maine Access Points

Maine Council of Churches

Maine Drug Policy Lab at Colby College

Maine People's Alliance

Needlepoint Sanctuary

The REST Center

Michigan

Flint Rising

Harm Reduction Michigan

Michigan United

Minnesota

Augsburg University

Harm Reduction Sisters

Rural AIDS Action Network (RAAN)

Missouri

Communities Creating Opportunity

MO Network

North Carolina

Action Institute NC

ekiM For Change

Fruit of Labor Action Research & Technical Assistance, LLC

Holler Harm Reduction

NC Council of Churches

NC Survivors Union

North Carolina AIDS Action Network

North Carolina Harm Reduction Coalition

Opioid Data Lab at Univ. of North Carolina

Smoky Mountain Harm Reduction

Twin City Harm Reduction Collective

Wilkes Recovery Revolution, Inc.

New Hampshire

Rights and Democracy

New Jersey

New Jersey Harm Reduction Coalition

New Jersey Policy Perspective

Newark Community Street Team

NJ Hepatitis Coalition

Salvation and Social Justice

South Jersey AIDS Alliance

New Mexico

Casa de Salud

New Mexico DanceSafe

New Mexico Harm Reduction Collaborative inc

NM Integrative Wellness MRC

Santa Fe Community Services

Taos LEAD

The Mountain Center

Transgender Resource Center of New Mexico

Nevada

Make the Road Nevada

Prison Families Alliance

New York

Alliance for Positive Change

Callen-Lorde Community Health Center

Care For the Homeless

College & Community Fellowship

Community Action for Social Justice

GMHC

Housing Works, Inc.

NDRI Swan Project

Southern Tier AIDS Program

Unity Fellowship of Christ Church NYC

VOCAL-NY

Ohio

Community Medical Services

Equitas Health

Harm Reduction Ohio

Ohio Organizing Collaborative

OhioCAN (Change Addiction Now)

Opportunities People's Justice Leaders

Policy Matters Ohio

Project White Butterfly

River Valley Organizing

Say it Loud Columbus

Scioto county harm reduction

Showing Up for Racial Justice Ohio

Thrive Peer Recovery Services

United Returning Citizens

Writers in Residence

Oregon

Portland Drug Users Union

Pennsylvania

ACT UP Philadelphia (AIDS Coalition To Unleash Power)

Angels in Motion

Clean & Sober Greetings

Families & Youth Innovations +

Friends of Safehouse

Operation in My Back Yard

Philadelphia Overdose Prevention Network

Prevention Point Pittsburgh

Puerto Rico

Bill's Kitchen, Inc.

Coalición de Coaliciones Pro Personas sin Hogar de PR, Inc.

The Puerto Rico Project

Rhode Island

Project Weber/RENEW

Tennessee

Street Works

Texas

CURE (Citizens United for Rehabilitation of Errants)

Utah

Martindale Clinic

One Voice Recovery, Inc.

Virginia

Friends of Guest House

Washington

VOCAL-WA

West Virginia

Mountain State Harm Reduction

NAMI Huntington

West Virginia Hepatitis Academic Mentoring Partnership

WV Citizen Action Group

Wisconsin

FORGE, Inc.

Vivent Health