UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF RHODE ISLAND

STATE OF NEW YORK, et al., Plaintiffs, v. ROBERT F. KENNEDY, JR., in his official capacity as SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., Defendants.	Case No. 1:25-cv-00196-MRD-PAS

DECLARATION OF ANDRES IVAN NAVEDO

ANDRES IVAN NAVEDO, an attorney admitted to practice before this Court and admitted to practice before the Courts of New York, does hereby state the following under penalty of perjury, pursuant to 28 U.S.C. § 1746:

1. I am an Assistant Attorney General in the Office of the Attorney General for the State of New York, and I appear on behalf of the State of New York in this action and am a member in good standing of the bar of the State of New York. I am admitted to appear in the United States District Court for the Districts of Kansas and Rhode Island, pursuant to this Court's Text Order from May 6, 2025.

2. I submit this Declaration and its attached Exhibits in support of Plaintiff States' Motion for a Preliminary Injunction, pursuant to Federal Rule of Civil Procedure 65.

3. I make the following statements on the basis of my own knowledge or a review of files in my possession.

4. Secretary Kennedy sat for a video-recorded interview with Dr. Jon LaPook of CBS News, that was published on April 10, 2025. A recording of that interview is available at https://youtu.be/o2U0csKvqMY?si=FLaUg8QmmPwLNSWB. Beginning at 17m05s in the published recording, Dr. LaPook asked the following questions, and Secretary Kennedy gave the following answers:

> "Q: But a lot of people were fired then rehired. Right? So the, I'm just wondering, you know, as like, I'm just trying to imagine, you know, and I've also, you know, run a company in the past. You know. Wouldn't it have been better or was thought given to say before firing them, going through and saying 'Hm. What is that job? What is that job?' Line by line by line and saying, 'I think that person's job, maybe, isn't needed.' You know? This has to be eliminated—
>
> A: That would've been another approach and it's the approach that has been, has failed for sixty years.
>
> Q: Because you mean it takes too long?
>
> A: It takes too long and you lose political momentum. You need to do—
>
> Q: But there are some casualties, the 20%—
>
> A: There is, yeah, and there is going to be, there are going to be casualties and there are going to be mistakes. And what our job is as we reconstitute this agency is to make sure that, you know, those mistakes are rectified."

5. Attached as Exhibit 1 is a true and accurate copy of *HHS Announces Transformation to Make America Healthy Again*, Dep't of Health & Human Servs. (Mar. 27, 2025), https://www.hhs.gov/about/news/hhs-restructuring-doge.html.

6. Attached as Exhibit 2 is a true and accurate copy of *Fact Sheet: HHS' Transformation to Make America Healthy Again*, Dep't of Health & Human Servs. (last reviewed Apr. 2, 2025), https://www.hhs.gov/about/news/hhs-restructuring-doge-fact-sheet.html.

7. Attached as Exhibit 3 is a true and accurate copy of a Glossary of Acronyms that was attached to the Complaint, ECF No. 1-3, in this matter, that was prepared by counsel for the plaintiffs for the Court's convenience.

8. Attached as Exhibit 4 is a true and accurate copy of a news publication by Alexander Tin, *RFK Jr. says 20% of health agency layoffs could be mistake*s, CBS News (Apr. 3, 2025, 7:12 PM EDT), https://www.cbsnews.com/news/rfk-jr-hhs-job-cuts-doge-mistakes/.

9. Attached as Exhibit 5 is a true and accurate copy of a portion of *About the Division of State Systems*, Children's Bureau, Off. of the Adm. for Children & Families (current as of June 30, 2024), https://acf.gov/cb/training-technical-assistance/state-tribal-info-systems/about-dss.

10. Attached as Exhibit 6 is a true and accurate copy of a news publication by Lorena O'Neil, *How Trump's CDC Purge Will Affect Reproductive Health: 'Women Will Die'*, Rolling Stone (Apr. 5, 2025), https://www.rollingstone.com/politics/politics-features/cdc-hhs-layoffs-impact-women-1235310574/.

11. Attached as Exhibit 7 is a true and accurate copy of a Notice of Award, dated April 8, 2025, from Centers for Disease Control and Prevention (CDC) to be received by Health Research Inc.

12. Attached as Exhibit 8 is a true and accurate copy of a Notice of Award, dated April 10, 2025, from CDC to be received by the Oregon Health Authority.

13. Attached as Exhibit 9 is a true and accurate copy of an email correspondence which began on April 1, 2025, between Meghan Joiner, Senior Associate General Counsel for Xcaliber International, and Ruth Hayes, Office on Smoking and Health, CDC, at the email address nccdoshfclaa@cdc.gov.

14. Attached as Exhibit 10 is a true and accurate copy of materials describing the Head Start program, *Head Start Approach*, Headstart.gov, (last visited May 9, 2025), https://www.headstart.gov/programs/article/head-start-approach.

15. Attached as Exhibit 11 is a true and accurate copy of *Frequently Asked Questions Related to the Poverty Guidelines and Poverty*, Off. of the Assistant Sec'y for Plan. & Evaluation (last visited May 9, 2025), https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines/frequently-asked-questions-related-poverty-guidelines-poverty.

16. Attached as Exhibit 12 is a true and accurate copy of a news article by Arthur Allen, *Trump HHS Eliminates Office That Sets Poverty Levels Tied to Benefits for at Least 80 Million People*, KFF Health News (Apr. 11, 2025), https://kffhealthnews.org/news/article/aspe-hhs-federal-poverty-guidelines-level-team-fired-medicaid-snap-wic/.

17. Attached as Exhibit 13 is a true and accurate copy of a news article by Rob Stein, *With Trump coming into power, the NIH is in the crosshairs*, NPR (Nov. 12, 2024, 1:16 PM ET), https://www.npr.org/transcripts/nx-s1-5183014.

18. Attached as Exhibit 14 is a true and accurate copy of a news article by Katherine Fung, *Everything RFK Jr. Has Said About What He'll Do if Named Trump Health Czar*, Newsweek (Nov. 5, 2024, 11:46 AM EST), https://www.newsweek.com/rfk-public-health-vaccines-flouride-drinking-water-1979990.

19. Attached as Exhibit 15 is a true and accurate copy of *Tobacco Ingredient and Nicotine Reporting*, CDC (last visited May 9, 2025), https://www.cdc.gov/tobacco/php/state-and-community-work/reporting.html.

20. Attached as Exhibit 16 is a true and accurate copy of *Poverty Guidelines*, Off. of the Assistant Sec'y for Plan. & Evaluation (last visited May 9, 2025), https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines.

21. Attached as Exhibit 17 is a true and accurate copy of a screenshot of a website hosted by USAspending.gov that contains a high-level summary of budget and obligated funding at the Department of Health and Human Services (last visited May 9, 2025), https://www.usaspending.gov/agency/department-of-health-and-human-services?fy=2024.

22. Attached as Exhibit 18 is a true and accurate copy of a news article by Julianne McShane, *Inside the "Vital" Office for Reproductive Health Gutted by Mass HHS Firings*, Mother Jones (April 4, 2025).

23. Attached as Exhibit 19 is a true and accurate copy of a news article by Moriah Balingit, *Mass layoffs rattle Head Start leaders already on edge over funding problems*, Associated Press (Apr. 2, 2025), https://apnews.com/article/head-start-office-closures-hhs-trump-00b1a6b33ef918cb66e59b7ffb07ac13.

24. Attached as Exhibit 20 is a true and accurate copy of the Declaration of Leonard F. Peruski, PhD, Director of the Wadsworth Center of the New York State Department of Health.

25. Attached as Exhibit 21 is a true and accurate copy of the Declaration of Wendy Underwood, Deputy Commissioner of the Minnesota Department of Health.

26. Attached as Exhibit 22 is a true and accurate copy of the Declaration of Gregory Hovan, Laboratory Director of the Delaware State Public Health Laboratory.

27. Attached as Exhibit 23 is a true and accurate copy of the Declaration of Glen R. Gallagher, PhD, Director of the Division of Rhode Island State Health Laboratories.

28. Attached as Exhibit 24 is a true and accurate copy of the Declaration of Jerome Larkin, M.D., Director of the Rhode Island Department of Health.

29. Attached as Exhibit 25 is a true and accurate copy of the Declaration of Eli S. Rosenberg, PhD, Director of the Office of Science at the New York State Department of Health.

30. Attached as Exhibit 26 is a true and accurate copy of the Declaration of Jeffrey A. Brown, Acting Commissioner of the New Jersey Department of Health.

31. Attached as Exhibit 27 is a true and accurate copy of the Declaration of Katie Eilers, Director of the Office of Family and Community Health Improvement at the Washington State Department of Health.

32. Attached as Exhibit 28 is a true and accurate copy of the Declaration of Naomi Biggs, Public Health Director of the Oregon Health Authority.

33. Attached as Exhibit 29 is a true and accurate copy of the Declaration of Jennifer Epstein, Deputy Director of the Illinois Department of Public Health.

34. Attached as Exhibit 30 is a true and accurate copy of the Declaration of Steven Blessing, Director of the Delaware Division of Public Health. For clarity, Mr. Blessing submitted two declarations in support of Plaintiff States' Motion for a Preliminary Injunction (see Exhibit 53 below).

35. Attached as Exhibit 31 is a true and accurate copy of the Declaration of Christopher Simpson, Director of the Northwest Center for Occupational Health and Safety and the Deputy Director for the Pacific Northwest Agricultural Safety and Health Center at the University of Washington.

36. Attached as Exhibit 32 is a true and accurate copy of the Declaration of David Bonauto, Research Director at the State of Washington, Department of Labor & Industries.

37. Attached as Exhibit 33 is a true and accurate copy of the Declaration of Christina Tan, State Epidemiologist and Assistant Commissioner of the Division of Epidemiology, Environmental, and Occupational Health at the New Jersey Department of Health.

38. Attached as Exhibit 34 is a true and accurate copy of the Declaration of Arthur Miller, retired Senior Research Engineer of the National Institute for Occupational Safety and Health.

39. Attached as Exhibit 35 is a true and accurate copy of the Declaration of Margaret Leland, Policy Director at the State of Washington, Department of Labor & Industries.

40. Attached as Exhibit 36 is a true and accurate copy of the Declaration of Eric Berg, Deputy Chief of Health for California's Division of Occupational Safety and Health at the Department of Industrial Relations.

41. Attached as Exhibit 37 is a true and accurate copy of the Declaration of Michelle Davis, Deputy Commissioner of the Office of Public Health within New York State Department of Health.

42. Attached as Exhibit 38 is a true and accurate copy of the Declaration of Stephen Propheter, Director of the Early Education Division at the California Department of Education.

43. Attached as Exhibit 39 is a true and accurate copy of the Declaration of Elana Marton, Deputy Director and Counsel of the New York State Council on Children and Families.

44. Attached as Exhibit 40 is a true and accurate copy of the Declaration of Karen Pascale, the Head Start Collaboration Office Director for the Connecticut Office of Early Childhood.

45. Attached as Exhibit 41 is a true and accurate copy of the Declaration of Angela Rodgers, Deputy Director of Programs for the Arizona Department of Economic Security.

46. Attached as Exhibit 42 is a true and accurate copy of the Declaration of Peter Hadler, Deputy Commissioner of the Connecticut Department of Social Services.

47. Attached as Exhibit 43 is a true and accurate copy of the Declaration of Lisa A. Schieffert, Deputy Cabinet Secretary of the Delaware Department of Health and Social Services.

48. Attached as Exhibit 44 is a true and accurate copy of the Declaration of Sarah Adelman, Commissioner of the New Jersey Department of Human Services.

49. Attached as Exhibit 45 is a true and accurate copy of the Declaration of Brice Montgomery, Director of the Community Services Division of the Washington State Department of Social and Health Services.

50. Attached as Exhibit 46 is a true and accurate copy of the Declaration of John Doe 1, a former employee at the Division of Environmental Health Science and Practice, part of the National Center for Environmental Health within the Centers for Disease Control and Prevention.

51. Attached as Exhibit 47 is a true and accurate copy of the Declaration of John Doe 2, an employee at the National Institute for Occupational Safety and Health.

52. Attached as Exhibit 48 is a true and accurate copy of the Declaration of Sara Gagne-Holmes, Commissioner of the State of Maine Department of Health and Human Services.

53. Attached as Exhibit 49 is a true and accurate copy of the Declaration of Alyssa Chatterjee, Early Learning System Director of the Oregon Department of Early Learning and Care.

54. Attached as Exhibit 50 is a true and accurate copy of the Declaration of Debra Standridge, Deputy Secretary of the Wisconsin Department of Health Services.

55. Attached as Exhibit 51 is a true and accurate copy of the Declaration of Jennie Cunico, MC, Deputy Director of Public Health Operations and Licensing of the Arizona Department of Health Services.

56. Attached as Exhibit 52 is a true and accurate copy of the Declaration of Kristin J. Cummings, MD, MPH, ATSF, Branch Chief of the Occupational Health Branch at the California Department of Public Health.

57. Attached as Exhibit 53 is a true and accurate copy of the Declaration of Steven Blessing, Director of the Delaware Division of Public Health. For clarity, Mr. Blessing submitted two declarations in support of Plaintiff States' Motion for a Preliminary Injunction (see Exhibit 30 above).

58. Attached as Exhibit 54 is a true and accurate copy of the Declaration of Lauren E. Gilwee, Policy Director of the Maryland Department of Labor, Division of Workforce Development and Adult Learning.

59. Attached as Exhibit 55 is a true and accurate copy of the Declaration of Sarah Neville-Morgan, Assistant State Superintendent of the Division of Early Childhood at the Maryland State Department of Education.

60. Attached as Exhibit 56 is a true and accurate copy of the Declaration of Phillip A. Sanchez, Director of the Alcoholic Beverage Control Division of the New Mexico Regulation and Licensing Department.

61. Attached as Exhibit 57 is a true and accurate copy of the Declaration of Rajni Chawla, Executive Deputy Commissioner of the New York State Office of Temporary and Disability Assistance.

62. Attached as Exhibit 58 is a true and accurate copy of the Declaration of Manoj Verma, Comprehensive Child Welfare Information System Director for the Washington State Department of Children, Youth, and Families.

63. Attached as Exhibit 59 is a true and accurate copy of the Declaration of Elizabeth Hertel, Director of the Michigan Department of Health and Human Services.

64. Attached as Exhibit 60 is a true and accurate copy of the Declaration of Valerie M. Kato, First Deputy Director of the Hawai‘i State Department of Health.

65. Attached as Exhibit 61 is a true and accurate copy of *CDC Publishes New HIV Surveillance Reports*, CDC (May 21, 2024) https://www.cdc.gov/nchhstp/director-letters/cdc-publishes-new-hiv-surveillance-reports.html.

66. Attached as Exhibit 62 is a true and accurate copy of the Declaration of Manisha Juthani M.D., Commissioner of the State of Connecticut Department of Public Health.

67. Attached as Exhibit 63 is a true and accurate copy of a news article by Sarah Todd, *Why CDC cuts are being called 'the greatest gift to tobacco industry in the last half-century'*, Statnews (Apr. 14, 2025), https://www.statnews.com/2025/04/14/cdc-closing-office-smoking-health-called-gift-to-big-tobacco-by-former-osh-director/.

68. Attached as Exhibit 64 is a true and accurate copy of a news article by Rachel Cohrs Zhang, *RFK Jr. Ousts Top Officials in Bid to Overhaul US Health Agency Overhaul*, Bloomberg (Apr. 1, 2025), https://www.bloomberg.com/news/articles/2025-04-01/us-health-agency-mass-firings-begin-as-kennedy-orders-10-000-cut?utm_source=website&utm_medium=share&utm_campaign=copy.

69. Attached as Exhibit 65 is a true and accurate copy of a news article by Adam Cancryn & Lauren Gardner, *The FDA fired its tobacco enforcers. Now it wants them back.*,

Politico (Apr. 14, 2025), https://www.politico.com/news/2025/04/14/fda-fired-tobacco-enforcers-asked-return-00289985.

Dated: New York, New York
May 9, 2025

/s/ Andres Ivan Navedo
Andres Ivan Navedo
Assistant Attorney General
Office of the Attorney General
Of the State of New York

EXHIBIT 1

An official website of the United States government

U.S. Department of Health and Human Services
Enhancing the health and well-being of all Americans

FOR IMMEDIATE RELEASE
March 27, 2025

Contact: HHS Press Office
202-690-6343
Submit a Request for Comment <https://hhscewp.my.site.com/aspapublic/s for-comment>

HHS Announces Transformation to Make America Healthy Again

Washington, D.C. — March 27, 2025 — Today, the U.S. Department of Health and Human Services (HHS) announced a dramatic restructuring in accordance with President Trump's Executive Order, “Implementing the President’s ‘Department of Government Efficiency’ Workforce Optimization Initiative.”

The restructuring will address this and serve multiple goals without impacting critical services. First, it will save taxpayers $1.8 billion per year through a reduction in workforce of about 10,000 full-time employees who are part of this most recent transformation. When combined with HHS’ other efforts, including early retirement and Fork in the Road, the restructuring results in a total downsizing from 82,000 to 62,000 full-time employees.

Secondly, it will streamline the functions of the Department. Currently, the 28 divisions of the HHS contain many redundant units. The restructuring plan will consolidate them into 15 new divisions, including a new Administration for a Healthy America, or AHA, and will centralize

core functions such as Human Resources, Information Technology, Procurement, External Affairs, and Policy. Regional offices will be reduced from 10 to 5.

Third, the overhaul will implement the new HHS priority of ending America's epidemic of chronic illness by focusing on safe, wholesome food, clean water, and the elimination of environmental toxins. These priorities will be reflected in the reorganization of HHS.

Finally, the restructuring will improve Americans' experience with HHS by making the agency more responsive and efficient, while ensuring that Medicare, Medicaid, and other essential health services remain intact.

"We aren't just reducing bureaucratic sprawl. We are realigning the organization with its core mission and our new priorities in reversing the chronic disease epidemic," HHS Secretary Robert F. Kennedy, Jr. said. "This Department will do more – a lot more – at a lower cost to the taxpayer."

The specific contents of the restructuring plan that have been announced so far are as follows:

- Creation of the Administration for a Healthy America (AHA), which will combine multiple agencies — the Office of the Assistant Secretary for Health (OASH), Health Resources and Services Administration (HRSA), Substance Abuse and Mental Health Services Administration (SAMHSA), Agency for Toxic Substances and Disease Registry (ATSDR), and National Institute for Occupational Safety and Health (NIOSH) — into a new, unified entity. This centralization will improve coordination of health resources for low-income Americans and will focus on areas including, Primary Care, Maternal and Child Health, Mental Health, Environmental Health, HIV/AIDS, and Workforce development. Transferring SAMHSA to AHA will increase operational efficiency and assure programs are carried out because it will break down artificial divisions between similar programs.
- Strengthening the Centers for Disease Control and Prevention (CDC): the Administration for Strategic Preparedness and Response (ASPR), responsible for national disaster and public health emergency response, will transfer to the CDC, reinforcing its core mission to protect Americans from health threats.
- New Assistant Secretary for Enforcement: HHS will create a new Assistant Secretary for Enforcement to oversee the Departmental Appeals Board (DAB), Office of Medicare Hearings and Appeals (OMHA), and Office for Civil Rights (OCR) to combat waste, fraud, and abuse in federal health programs.
- Research and Evaluation for Health Policy: HHS will merge the Assistant Secretary for Planning and Evaluation (ASPE) with the Agency for Healthcare Research and Quality (AHRQ) to create the Office of Strategy to enhance research that informs the Secretary's policies and improves the effectiveness of federal health programs.

- Reorganization of the Administration for Community Living (ACL): Critical programs that support older adults and people with disabilities will be integrated into other HHS agencies, including the Administration for Children and Families (ACF), ASPE, and the Centers for Medicare and Medicaid Services (CMS). This reorganization will not impact Medicare and Medicaid services.

“Over time, bureaucracies like HHS become wasteful and inefficient even when most of their staff are dedicated and competent civil servants,” Secretary Kennedy said. “This overhaul will be a win-win for taxpayers and for those that HHS serves. That’s the entire American public, because our goal is to Make America Healthy Again.”

For more detailed information, please visit our fact sheet </about/news/hhs-restructuring-doge-fact-sheet.html>.

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Note: All HHS press releases, fact sheets and other news materials are available at https://www.hhs.gov/about/news/index.html </about/news/index.html>.
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Last revised: March 27, 2025

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Secretary Kennedy Renews Public Health Emergency Declaration to Address National Opioid Crisis </about/news/secretary-kennedy-opiod-crisis-emergency-declaration.html>

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HHS, FDA Announce Operation Stork Speed to Expand Options for Safe, Reliable, and Nutritious Infant Formula for American Families </about/news/operation-stork-speed.html>

MARCH 18, 2025 | PRESS RELEASE

Content created by ASPA Press Office
Content last reviewed March 27, 2025

EXHIBIT 2

Fact Sheet: HHS' Transformation to Make America Healthy Again

hhs.gov/about/news/hhs-restructuring-doge-fact-sheet.html

March 27, 2025

Official websites use .gov
A **.gov** website belongs to an official government organization in the United States.

Secure .gov websites use HTTPS
A **lock** (🔒) or **https://** means you've safely connected to the .gov website. Share sensitive information only on official, secure websites.

The restructuring of HHS is proceeding in accordance with President Trump's Executive Order, "Implementing the President's 'Department of Government Efficiency' Workforce Optimization Initiative." Over the past four years, during the Biden administration, HHS's budget increased by 38% and its staffing increased by 17%.

1. The plan combines personnel cuts, centralization of functions, and consolidation of HHS divisions, including:
    - The current 82,000 full-time employees will be reduced to 62,000
    - 28 divisions will be consolidated to 15
    - 10 regional offices will become 5
    - Human Resources, Information Technology, Procurement, External Affairs, and Policy will be centralized.

2. Regarding FDA, CDC, NIH, and CMS:
    - FDA will decrease its workforce by approximately 3,500 full-time employees, with a focus on streamlining operations and centralizing administrative functions. This reduction will not affect drug, medical device, or food reviewers, nor will it impact inspectors.
    - The CDC will decrease its workforce by approximately 2,400 employees, with a focus on returning to its core mission of preparing for and responding to epidemics and outbreaks. This includes moving ASPR under CDC to enhance coordination of response efforts. NOTE: The “CDC” decrease would only be 1,400 if you included the individuals coming over from ASPR (approx. 1,000 individuals).
    - The NIH will decrease its workforce by approximately 1,200 employees by centralizing procurement, human resources, and communications across its 27 institutes and centers.
    - CMS will decrease its workforce by approximately 300 employees, with a focus on reducing minor duplication across the agency. This reorganization will not impact Medicare and Medicaid services.
3. The consolidation and cuts are designed not only to save money, but to make the organization more efficient and more responsive to Americans’ needs, and to implement the Make America Healthy Again goal of ending the chronic disease epidemic.
4. No additional cuts are currently planned, but the Department will continue to look for further ways to streamline its operations and agencies.
5. A new Administration for a Healthy America (AHA) will consolidate the OASH, HRSA, SAMHSA, ATSDR, and NIOSH, so as to more efficiently coordinate chronic care and disease prevention programs and harmonize health resources to low-income Americans. Divisions of AHA include Primary Care, Maternal and Child Health, Mental Health, Environmental Health, HIV/AIDS, and Workforce, with support of the U.S. Surgeon General and Policy team.
6. HHS will have a new Assistant Secretary for Enforcement to provide oversight of the Departmental Appeals Board (DAB), Office of Medicare Hearings and Appeal (OMHA), and the Office for Civil Rights (OCR) to combat waste, fraud, and abuse.
7. HHS will combine the Assistant Secretary for Planning and Evaluation (ASPE) and Agency for Healthcare Research and Quality (AHRQ) into the Office of Strategy to conduct research that informs the Secretary’s policies and evaluates the effectiveness of the Department’s programs for a healthier America.
8. The critical programs within the Administration for Community Living (ACL) that support older adults and people of all ages with disabilities will be split across the Administration for Children and Families (ACF), Assistant Secretary for Planning and Evaluation (ASPE), and Centers for Medicare and Medicaid Services (CMS).

Content created by Assistant Secretary for Public Affairs (ASPA)
Content last reviewed March 27, 2025

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For more information on HHS's web notification policies, see Website Disclaimers.

EXHIBIT 3

Glossary of Acronyms

Acronym	Term
ACF	Administration for Children and Families
ACL	Administration for Community Living
AHA	Administration for a Healthy America (a new operating agency within HHS)
AHRQ	Agency for Health Care Research and Quality (an operating division within HHS)
ASPE	Office of the Assistant Secretary for Planning and Evaluation (an administrative office)
ASPR	Administration for Strategic Preparedness and Response
ATSDR	Agency for Toxic Substances and Disease Registry
CBER	Center for Biologics Evaluation and Research (sits within FDA)
CDC	Centers for Disease Control and Prevention
CDER	Center for Drug Evaluation and Research (sits within FDA)
CMS	Centers for Medicare & Medicaid Services
CTP	Center for Tobacco Products (sits within FDA)
CVM	Center for Veterinary Medicine (sits within FDA)

Acronym	Term
CWHSP	Coal Workers' Health Surveillance Program (a program administered by NIOSH)
DEHSP	Division of Environmental Health Science and Practice (sits within NCEH)
DHP	Division of HIV Prevention (sits within CDC)
DRH	Division of Reproductive Health (sits within NCCDPHP)
DSTDP	Division of Sexually Transmitted Disease Prevention (sits within NCHHSTP)
DVH	Division of Viral Hepatitis (sits within NCHHSTP)
EHDI	Early Hearing Detection and Intervention Programs (a program administered by NCBDDD)
EHE	Ending the HIV/AIDS Epidemic (a program administered by OIDP)
ERC	Education and Resource Centers (a program administered by NIOSH)
FDA	Food and Drug Administration
FFFIPP	Fire Fighter Fatality Investigation and Prevention Program (a program administered by NIOSH)
GHC	Global Health Center (sits within CDC)
HEW	Department of Health, Education, and Welfare (a former cabinet-level agency created by Congress in 1953)
HHE	Health Hazard Evaluation (a program administered by NIOSH)

Acronym	Term
HHS	Department of Health and Human Services
HRSA	Health Resources and Services Administration
HSP	Office of Human Services Policy (an administrative office)
IHS	Indian Health Service
LIHEAP	Low-Income Home Energy Assistance Program (a program administered by ACF)
MMRC	Maternal Mortality Review Committee (multidisciplinary committees formed at the state or local level to review pregnancy-related deaths, a program administered by DRH)
MSHA	Mine Health Safety Administration (sits within Department of Labor)
NCBDDD	National Center on Birth Defects and Developmental Disabilities (sits within CDC)
NCCDPHP	National Center for Chronic Disease Prevention and Health Promotion (sits within CDC)
NCEH	National Center for Environmental Health (sits within CDC)
NCHHSTP	National Center for HIV, Viral Hepatitis, STD, and Tuberculosis Prevention (sits within CDC)
NCIPC	National Center for Injury Prevention and Control (sits within CDC)
NIH	National Institutes of Health (an operating division within HHS)

Acronym	Term
NIOSH	National Institute for Occupational Safety and Health (sits within CDC)
NORA	National Occupational Research Agenda (a program administered by NIOSH)
NPPTL	National Personal Protective Technology Laboratory (a program administered by NIOSH)
NSDUH	National Survey on Drug Use and Health (a program administered by SAMHSA)
NTCP	National and State Tobacco Control Program (a program administered by OSH)
NVP	National Vaccine Program (a program administered by OIDP)
NYTS	National Youth Tobacco Survey (a program administered within OSH)
OASH	Office of the Assistant Secretary for Health (an administrative office)
OIDP	Office of Infectious Disease and HIV/AIDS Policy (an administrative office)
OMHA	Office of Medicare Hearings and Appeals (an administrative office)
OSH	Office of Smoking and Health (sits within NCCDPHP)
PHS	Public Health Service (led by the Surgeon General)
PRAMS	Pregnancy Risk Assessment Monitoring System (a program administered by DRH)
PRNS	Mental Health Programs of Regional and National Significance

Acronym	Term
SAMHSA	Substance Abuse and Mental Health Services Administration (an operating division within HHS)
SCBA	Self-Contained Breathing Apparatus
SPHL	State Public Health Laboratory
TANF	Temporary Assistance for Needy Families (a program administered by ACF)
WTCHP	World Trade Center Health Program (a program administered NIOSH)

EXHIBIT 4

RFK Jr. says 20% of health agency layoffs could be mistakes

cbsnews.com/news/rfk-jr-hhs-job-cuts-doge-mistakes

Alexander Tin April 3, 2025

HealthWatch

Health and Human Services Secretary Robert F. Kennedy Jr. suggested Thursday that around 20% of the job cuts by the Trump administration's Department of Government Efficiency will be wrong and need to be corrected.

Around 10,000 employees were laid off from the Department of Health and Human Services on Tuesday, as part of a restructuring architected by Kennedy and Elon Musk's DOGE task force. But Kennedy acknowledged they didn't get everything right the first time.

"Personnel that should not have been cut, were cut. We're reinstating them. And that was always the plan. Part of the — at DOGE, we talked about this from the beginning, is we're going to do 80% cuts, but 20% of those are going to have to be reinstated, because we'll make mistakes," Kennedy said, speaking to reporters at a stop in Virginia.

Kennedy said that the elimination of the Centers for Disease Control and Prevention's entire Lead Poisoning Prevention and Surveillance Branch was among the mistakes.

It is unclear which other programs Kennedy may be planning to restore. The department did not immediately provide a response for a request for comment.

Multiple CDC officials said they had so far not heard of plans to reinstate the lead poisoning program.

Among the immediate impacts of eliminating its work was an outstanding request from Milwaukee's health department for help responding to lead in water, which had stalled, multiple CDC officials said.

Known as an "Epi-Aid," or investigation into a public health problem, the CDC assistance "will not be able to continue due to the loss of subject matter experts," agency officials had said internally this week.

Elsewhere in the department, a handful of employees who got termination notices at the Food and Drug Administration have already been asked back to work temporarily, multiple FDA officials said.

Among those asked to work for a few more weeks before they are cut include teams in the agency's inspections and investigations office, two officials said, after the agency's office lost around 170 employees. The office has been planning for cuts to routine inspections of drugmakers and food producers because of the layoffs.

More from CBS News

In:

- United States Department of Health and Human Services
- Robert F. Kennedy Jr.

Alexander Tin
Alexander Tin is a digital reporter for CBS News based in the Washington, D.C. bureau. He covers federal public health agencies.

Twitter

EXHIBIT 5

An official website of the United States government Here's how you know

About the Division of State Systems (DSS)

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Current as of: June 30, 2024

DSS supports state and tribal title IV-E agencies in developing and operating child welfare information systems.

The following are DSS's key responsibilities:

- Support state and tribal child welfare agencies in the development, maintenance, and operations of their information systems through partnerships, collaborative efforts , and technical assistance activities
- Provide guidance on and respond to Advance Planning Documents (APDs) and procurement documents, such as requests for proposals and contracts
- Coordinate the development and implementation of strategies and policies related to child welfare information technology for the Administration for Children and Families
- Conduct assessments and ongoing reviews of child welfare information systems
- Provide relevant training and technical assistance

State and Tribal Assignments

Each state, territory, or tribe with a title IV-E agency works with an assigned DSS analyst who responds to questions, provides technical assistance, and serves as the primary contact for APD submissions.

EXHIBIT 6

RollingStone

‘OBLITERATED’

HOW TRUMP’S CDC PURGE WILL AFFECT REPRODUCTIVE HEALTH: ‘WOMEN WILL DIE’

CDC staffers and medical experts sound the alarm on how gutting the federal health agencies will put women’s lives at risk

By LORENA O'NEIL

APRIL 5, 2025

Former federal workers protest against Trump administration policies in front of the Hubert Humphrey Health and Human Services building.

DOMINIC GWINN/MIDDLE EAST IMAGES/AFP/GETTY IMAGES

The consequences of the Trump administration's purge of **thousands of federal workers** from the Department of **Health** and Human Services on April 1 are so enormous, they can be difficult to grasp. But the impacts won't be abstract — experts say the destruction of critical departments could put women's lives at risk.

On Tuesday morning, more than 7,000 federal employees across the Centers for Disease Control and Prevention, the National Institutes of Health, the Food and Drug Administration, and the Centers for Medicare and Medicaid Services were placed on administrative leave. The cuts — part of **Donald Trump** and **Elon Musk**'s broader purge of the federal workforce — were widespread and erased entire departments, without regard to experience. Two of the three branches in the **CDC**'s Division of Reproductive Health were eliminated, as

was their leadership, leaving only the Maternal and Infant Health branch. "We got obliterated," says Taylor, who received a reduction in force (RIF) letter on Tuesday. (They asked to use a pseudonym to avoid retribution.) The Division of Violence Prevention was similarly affected, with three of the four branches cut. Only its leadership and a surveillance branch remain.

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The firings led to more confusion when Robert F. Kennedy Jr., the vaccine skeptic made head of the **HHS**, said on Thursday about 20 percent of the cuts could be mistakes — and that they need to be corrected. The chaos and uncertainty left many working for the department and those who rely on their life-saving research concerned about those who will be disproportionately impacted by these changes — women.

When the Supreme Court overturned *Roe v. Wade* in June 2022, ending federal protection for **abortion** rights, reproductive health experts sounded the alarm on how it would be catastrophic for women's health. And now,

especially in states where abortion is banned, the collection and interpretation of data around reproductive health is crucial, as is medical research on IVF, contraception, and high-risk pregnancies. With the layoffs at the Reproductive Health and Violence Prevention divisions, a lot of research and programs that focused on women have been gutted. The repercussions will be far-reaching, as violence against women and pregnancy are linked. In fact, the leading cause of death for pregnant people is homicide. And the groups that are the most vulnerable to both violence and maternal health mortalities are Black women and communities of color. This is in addition to the risks this lack of resources poses for domestic abuse and rape victims because the teams studying how to prevent this type of violence have been decimated.

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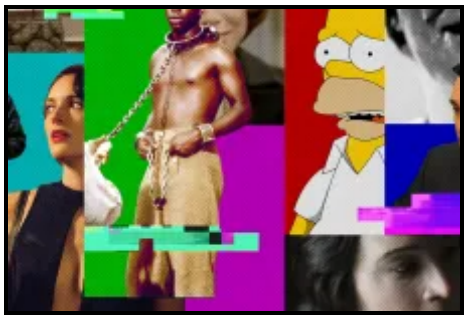
EDITOR'S PICKS



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The CDC's Division of Reproductive Health team that focused on emergency preparedness for pregnant and postpartum women and infants was also slashed this week. Those staffers were responsible for responding to how pandemics like Covid-19 can impact pregnant women and making sure to include them in their health response plans. The entire Pregnancy Risk Assessment Monitoring System (PRAMS) team was laid off. That program was

developed to identify women and infants at high risk of health problems, with the goal of reducing infant mortality and morbidity.

"We cannot understand factors associated with poor pregnancy outcomes without surveillance like PRAMs," Taylor says. The U.S. has the **highest maternal mortality rate** of all high-income countries, and experts fear that reducing research on prevention will make things even worse. "If we don't understand those factors, U.S. maternal morbidity and mortality will continue to worsen. This means more women will die."

"Black women in America are three times more likely to die from pregnancy-related causes than white women, we know this in large part because of the data collected and analyzed by the CDC," says Jennifer Driver, who runs the reproductive rights council at the State Innovation Exchange, a strategy center collaborating with state lawmakers on progressive public policy.

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Dr. Nicole Freehill is an OB-GYN in Louisiana, and many of her patients have high-risk pregnancies. She's not directly funded by these programs, but she and other doctors across the country will feel the impacts of these cuts. "Anything like PRAMS that's monitoring for pregnancies with adverse outcomes, even though [the CDC] didn't cut the maternal mortality branch, these things are intertwined," she says. "If you're potentially cutting services, monitoring, and research, how can we keep pregnancies healthy?"

Freehill also says she was concerned about how cuts to the Assisted Reproductive Technology (ART) team will affect fertility research. “That’s an ever-changing field, trying to find the best techniques to help patients get pregnant and stay pregnant,” she says. “A lot of these patients have tried for years, they want to be parents. If this administration is so pro-life, why are they cutting this?”

Among the employees who were cut were researchers who studied contraception, abortion, and fertility. For example, staffers would investigate success rates of IVF across clinics nationwide. The CDC is one of the only federal agencies tracking success rates and overseeing fertility clinics. The IVF cuts were especially ironic, considering Trump recently declared himself the “fertilization president’ at a Women’s History Month event at the White House on March 26 when talking about the **executive order** he signed pledging to expand access to fertility treatment.

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And for people who don’t want to get pregnant, the CDC cuts also pose challenges. In a state like Louisiana, where Freehill practices and abortion is banned, contraception is more important than ever. But, as *Rolling Stone* reported this week, the team that worked on the **contraception guidelines** at the CDC was also shuttered.

The guidelines, which provide recommendations for health care providers for safe use of contraception, are used as a standard of care by OB-GYNs, midwives, and primary care doctors. Freehill says she often checks them when patients who have specific medical conditions and are on medication come in and want to know which birth control option is safest and most effective for them. She is also worried about the gutting of the FDA, which releases guidelines on how many years IUDs can be effective, something that can be constantly updated with new research and data.

Trump and Kennedy's attacks on science have been rolled out in stages. One of the first ways the CDC was affected was after Trump's executive order in January claiming to "defend women from gender ideology extremism." CDC researchers had to change how they talked about gender, even when it was central to their work. For example, in January an agency website about violence had to **scrub** the term "gender-based violence," and a website about racism in health was removed.

"This will close a lot of doors for sexual assault survivors that relied on these programs."

– a health scientist on the violence prevention team

"The executive order drastically affected the way that we study, report, and all the different ways we can talk about violence against women because it is gender based," says Jordan, a CDC staffer who researches violence prevention and was sent a RIF letter on Tuesday. They also requested a pseudonym for fear of retribution. "Gender is associated with a likelihood of experiencing violence."

Intimate partner violence, for example, primarily affects women, and the Intimate Partner Violence Prevention team was dismantled. The team worked

with state and local domestic violence coalitions to put prevention strategies in place. All of the employees working on rape prevention education were also placed on leave. They'd funded and evaluated programs aimed at reducing sexual violence, especially in communities with marginalized individuals. They provided funding to state coalitions which distributed the money to rape crisis centers and local organizations and educated communities on resources they had available.

One program that was funded was a hotspot mapping app called "Like a Girl." If girls and women don't feel safe in a neighborhood they can mark the spot on the map and then that data can be used to target high-impact areas and see if there are improvements that can be made to the area, like adding streetlights or using other proven ways of reducing violence.

"This will close a lot of doors for sexual assault survivors that relied on these programs," says a health scientist on the violence prevention team who asked to remain anonymous.

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"When you experience violence, you are more likely to have mental health issues, to have physical health issues, you're more likely to live in poverty," Jordan says. "All of these things are related. If we can't work on preventing

violence, we can't work on preventing a whole wide range of health issues for women. You can't tease [these issues] apart and just work on one and not the other."

While the CDC's Division of Violence Prevention's leadership remains, its branches were almost entirely eliminated except for the surveillance team, which looks at data available across the states to see where violence happens, and where help is needed. Many of the positions eliminated were responsible for using this data from the field to determine which methods are successful in preventing violence.

"We're not just giving money to people and walking away; we connect national partners together and create guidance and technical assistance for local communities and states to implement violence prevention activities," Jordan says. "If those connections go away, and nobody's funding them, it's leaving these communities out to dry, especially in rural areas. They're going to be left with no resources."

They added, "If we can't track how and why and what to do about it, there's no point in knowing that [violence] is happening. We already know that."

As the massive layoffs have hit federal health agencies, reproductive health advocates are trying to amp up the involvement of state legislators. "States rely on [CDC] information to help them understand the gaps," says advocate Driver. "How can states address the racial disparities in maternal deaths if the data no longer exists? Erratic and wholesale elimination of programs has and will continue to harm people in the states."

The consequences could have reverberations far outside of the U.S., as well. Cutting funding to all of these agencies could create irreversible damage that trickles out to countries that rely on the U.S. for things like vaccine innovation,

detailed guidelines on medicine, and decades-long research on issues that harm people.

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"Research-cutting in any area of medicine is dangerous," Freehill says. "Currently, the United States is the world leader in medical research, and if that gets significantly cut, then I'm worried about what's going to happen with the overall health of our country — of the entire world."

IN THIS ARTICLE: ABORTION, CDC, DONALD TRUMP, ELON MUSK, HEALTH, HHS, RFK JR.

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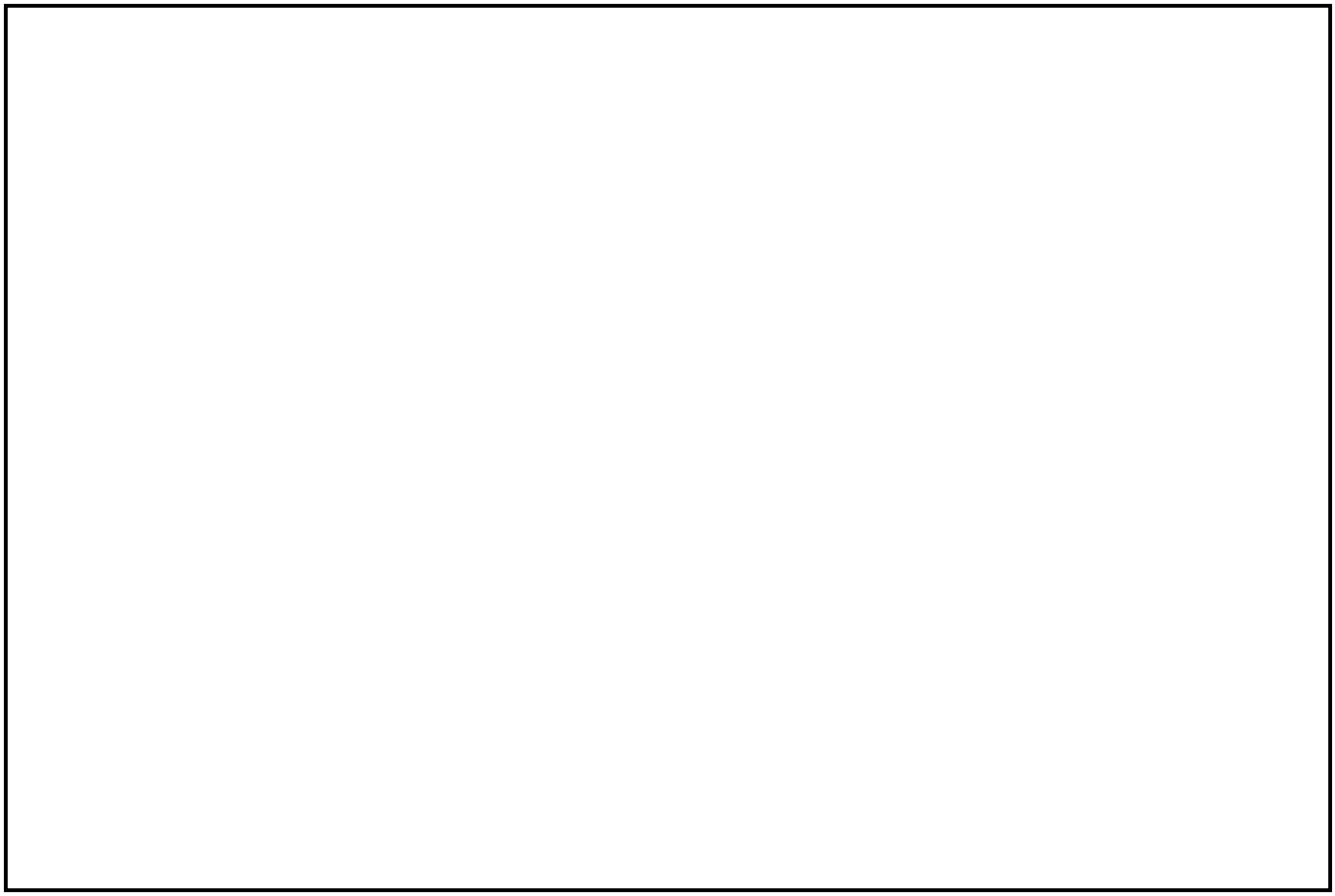

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By RYAN BORT

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By NIKKI MCCANN RAMIREZ

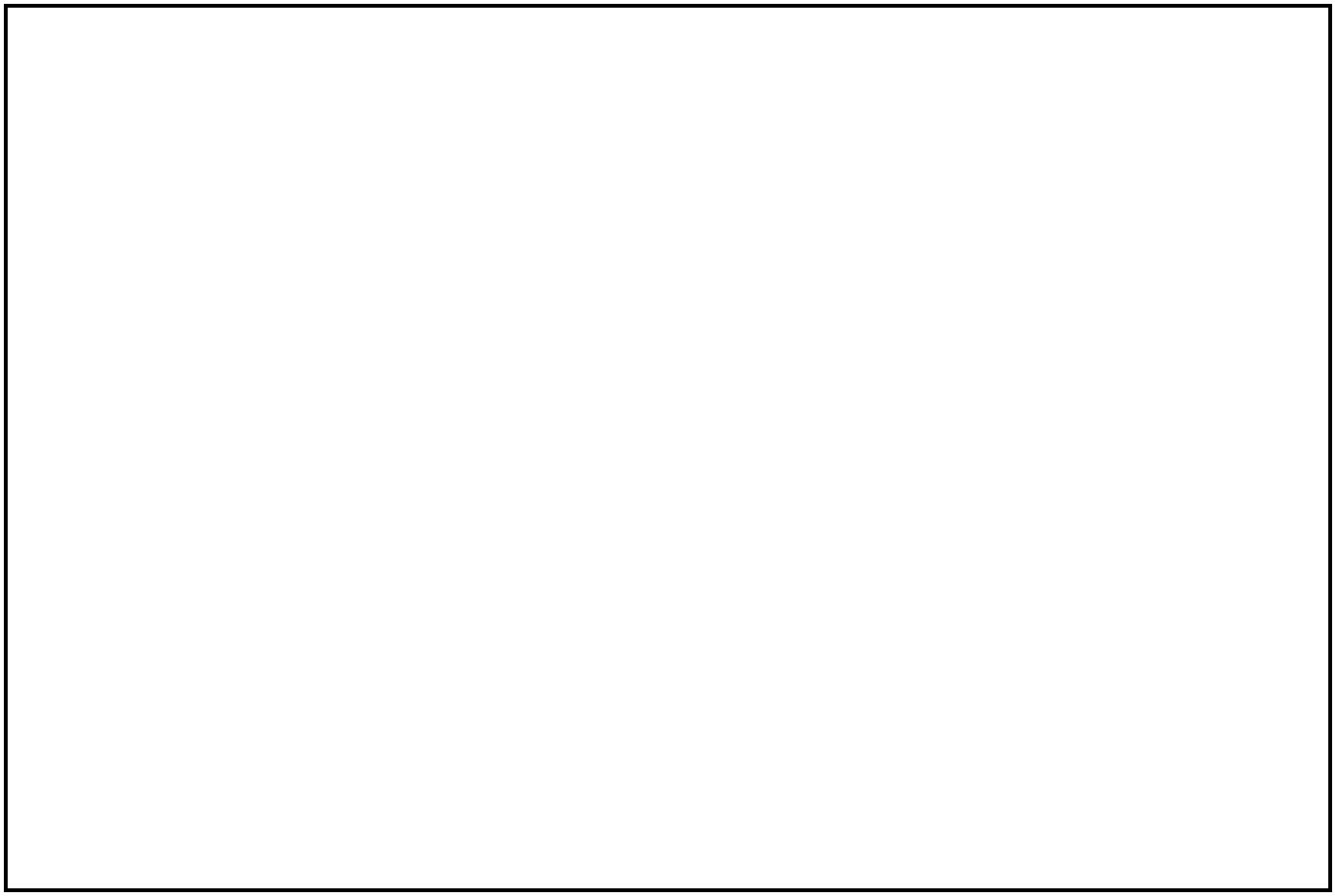

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EXHIBIT 7

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Notice of Award

Award# 5 U01DP006608-05-00
FAIN# U01DP006608
Federal Award Date: 04/08/2025

Recipient Information

1. Recipient Name
HEALTH RESEARCH, INC.
150 Broadway STE 280
Riverview Center
Health Research, Inc.
Menands, NY 12204-2732
[NO DATA]

2. Congressional District of Recipient
20

3. Payment System Identifier (ID)
1141402155A1

4. Employer Identification Number (EIN)
141402155

5. Data Universal Numbering System (DUNS)
153695809

6. Recipient's Unique Entity Identifier (UEI)
WJ37AD42G8A5

7. Project Director or Principal Investigator
Trang Q Nguyen
trang.nguyen@health.ny.gov
518-4742543

8. Authorized Official
Mr. Michael Saglimbeni
Director, Office of Sponsored Programs
HRINGA@healthresearch.org
(518) 431-1265

Federal Agency Information
CDC Office of Financial Resources

9. Awarding Agency Contact Information
Tracy Rice
Grants Management Specialist
tjn4@cdc.gov
678-475-4964

10.Program Official Contact Information
Mrs. Natalie Brown
Program Officer
fmc7@cdc.gov
404-639-4601

Federal Award Information

11. Award Number
5 U01DP006608-05-00

12. Unique Federal Award Identification Number (FAIN)
U01DP006608

13. Statutory Authority
Section 317K of the Public Health Service Act, [42 U.S.C. 247b-12], as amended

14. Federal Award Project Title
DP21-001 Pregnancy Risk Assessment Monitoring System (PRAMS)

15. Assistance Listing Number
93.946

16. Assistance Listing Program Title
Cooperative Agreements to Support State-Based Safe Motherhood and Infant Health Initiative Programs

17. Award Action Type
Non-Competing Continuation

18. Is the Award R&D?
Yes

Summary Federal Award Financial Information

19.	**Budget Period Start Date** 05/01/2025 **- End Date** 04/30/2026	
20.	**Total Amount of Federal Funds Obligated by this Action**	$175,000.00
	20a. Direct Cost Amount	$151,978.00
	20b. Indirect Cost Amount	$23,022.00
21.	Authorized Carryover	$0.00
22.	Offset	$0.00
23.	Total Amount of Federal Funds Obligated this budget period	$0.00
24.	**Total Approved Cost Sharing or Matching, where applicable**	$0.00
25.	**Total Federal and Non-Federal Approved this Budget Period**	$175,000.00
26.	**Period of Performance Start Date** 05/01/2021 **- End Date** 04/30/2026	
27.	Total Amount of the Federal Award including Approved Cost Sharing or Matching this Period of Performance	$845,040.00

28. Authorized Treatment of Program Income
ADDITIONAL COSTS

29. Grants Management Officer – Signature
Ms. Manal Ali
Grants Management Specialist / Officer

30. Remarks

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Notice of Award

Award# 5 U01DP006608-05-00
FAIN# U01DP006608
Federal Award Date: 04/08/2025

Recipient Information

Recipient Name
HEALTH RESEARCH, INC.
150 Broadway STE 280
Riverview Center
Health Research, Inc.
Menands, NY 12204-2732
[NO DATA]

Congressional District of Recipient
20

Payment Account Number and Type
1141402155A1

Employer Identification Number (EIN) Data
141402155

Universal Numbering System (DUNS)
153695809

Recipient's Unique Entity Identifier (UEI)
WJ37AD42G8A5

31. Assistance Type
Cooperative Agreement

32. Type of Award
Research

33. Approved Budget
(Excludes Direct Assistance)

I. Financial Assistance from the Federal Awarding Agency Only
II. Total project costs including grant funds and all other financial participation

a. Salaries and Wages	$85,188.00
b. Fringe Benefits	$33,479.00
c. Total Personnel Costs	$118,667.00
d. Equipment	$0.00
e. Supplies	$1,419.00
f. Travel	$2,814.00
g. Construction	$0.00
h. Other	$29,078.00
i. Contractual	$0.00
j. TOTAL DIRECT COSTS	$151,978.00
k. INDIRECT COSTS	$23,022.00
l. TOTAL APPROVED BUDGET	$175,000.00
m. Federal Share	$175,000.00
n. Non-Federal Share	$0.00

34. Accounting Classification Codes

FY-ACCOUNT NO.	DOCUMENT NO.	ADMINISTRATIVE CODE	OBJECT CLASS	ASSISTANCE LISTING	AMT ACTION FINANCIAL ASSISTANCE	APPROPRIATION
2-939ZRDR	21U01DP006608	DP	41.41	93.946	$0.00	75-22-0948
3-939ZRDR	21U01DP006608	DP	41.41	93.946	$0.00	75-23-0948
4-939ZRDR	21U01DP006608	DP	41.41	93.946	$0.00	75-24-0948
5-939ZRDH	21U01DP006608	DP	41.41	93.946	$175,000.00	75-25-0948

AWARD ATTACHMENTS

HEALTH RESEARCH, INC. 5 U01DP006608-05-00

1. Terms and Conditions dp006608

AWARD INFORMATION

Incorporation: In addition to the federal laws, regulations, policies, and CDC General Terms and Conditions for Research awards at https://www.cdc.gov/grants/federal-regulations-policies/index.html, the Centers for Disease Control and Prevention (CDC) hereby incorporates Notice of Funding Opportunity (NOFO) number **DP-21-001, entitled Pregnancy Risk Assessment Monitoring System (PRAMS)**, **award DP006608 – Health Research Inc., New York State Department of Health,** and application dated December 27, 2024, as may be, which are hereby made a part of this Research award hereinafter referred to as the Notice of Award (NOA).

Note: Due to grants management administration system parameters, the budget category names on Page 1 of this NOA may be altered from the budget categories submitted with the SF-424 Research and Related Budget application.

Applicability of 2 CFR 200 Provisions Beginning October 1, 2024
This award is subject to the requirements in 45 CFR Part 75, except as amendated by the following provisions of 2 CFR Part 200, which apply to new, continuation, and supplemental awards made on or after October 1, 2024.

- 2 CFR § 200.1. Definitions, "Modified Total Direct Cost", "Equipment", and "Supplies"
- 2 CFR § 200.313(e). Equipment, Disposition
- 2 CFR § 200.314(a). Supplies
- 2 CFR § 200.320. Procurement methods
- 2 CFR § 200.333. Fixed amount sub awards
- 2 CFR § 200.344. Closeout
- 2 CFR § 200.414(f). Indirect costs, De Minimis Rate
- 2 CFR § 200.501. Audit requirements

2 CFR 200 citation	**Replaces 45 CFR 75 citation**
2 CFR § 200.1. Definitions, *"Modified Total Direct Cost"*	45 CFR § 75.2. Definitions, *"Modified Total Direct Cost"*
2 CFR § 200.1. Definitions, *"Equipment"*	45 CFR § 75.2. Definitions, *"Equipment"*
2 CFR § 200.1. Definitions, *"Supplies"*	45 CFR § 75.2. Definitions, *"Supplies"*
2 CFR § 200.313(e). Equipment, *"Disposition"*	45 CFR § 75.320(e). Equipment, *Disposition"*
2 CFR § 200.314(a). Supplies	45 CFR § 75.321(a). Supplies
2 CFR § 200.320. Procurement methods	45 CFR § 75.329. Procurement procedures
2 CFR § 200.333. Fixed amount subawards	45 CFR § 75.353 Fixed amount subawards
2 CFR § 200.344. Closeout	45 CFR § 75.381 Closeout
2 CFR § 200.414(f). Indirect costs, De Minimis Rate	45 CFR § 75.414(f). Indirect (F&A) costs, De Minimis Rate
2 CFR § 200.501. Audit requirements	45 CFR § 75.501. Audit requirements

Total Approved Funding is included in Summary Federal Award Financial Information on page 1 of the NOA. All future year funding will be based on satisfactory programmatic progress and the availability of funds.

The federal award amount is subject to adjustment based on total allowable costs incurred and/or the value of any third-party in-kind contribution when applicable.

Note: Refer to the Payment Information section for draw down and Payment Management System (PMS) subaccount information.

Approved Component/Project Funding: The NOFO provides for the funding of multiple components under this award. The approved component funding levels for this notice of award are:

NOFO Component	Amount
Component A	$175,000
Total Approved Budget	$175,000

Recipients are to review the **Payment Management System (PMS) Subaccount** section in this document to determine the appropriate subaccount document number for the referenced Component. Program specific authorizing legislation, budgetary appropriations, or similar authority may require the creation of more than one subaccount document number per award.

Financial Assistance Mechanism: Cooperative Agreement

Substantial Involvement by CDC: It is anticipated that CDC will have substantial programmatic involvement after the award is made. Substantial involvement is in addition to all post-award monitoring, technical assistance, and performance reviews undertaken in the normal course of stewardship of federal funds.

CDC program staff will assist, coordinate, or participate in carrying out effort under the award, and recipients agree to the responsibilities as detailed in the NOFO and included below.

Component A:

1. Maintain CDC Institutional Review Board approvals as required when engaged in research involving human subjects.
2. Obtain Office of Management and Budget (0MB) approval in accordance with the PaperworkReduction Act (PRA), as required.
3. Provide model procedures and assist with development of jurisdiction-specific written procedures. Conduct periodic review of written procedures and provide recommendations for improvement if needed.
4. Provide CDC-provided software system for use in data collection procedures and monitoring of PRAMS operational data.
5. Provide training, operations management and ongoing technical support for CDC supported software.
6. Assist with the specification of variable descriptions and format layouts of all data files.
7. Assist with the development of computer programs for sampling and analysis.
8. Provide statistical guidance on development, implementation, and modification of sampling plan.
9. Provide technical assistance to resolve problems in data collection procedures.
10. Conduct regular operational evaluations and provide recommendations for improvements if needed.

11. Provide technical assistance for data editing.
12. Provide technical assistance on implementation of survey supplements to address emerging issues that may arise during the project.
13. Assist with implementation of a new version of the questionnaire (Phase 9) with potential adaptions to the existing PRAMS methodology (e.g. online data collection) in conjunction with awardees and stakeholders in maternal and infant health.
14. Provide awardees with epidemiologic technical assistance including identifying relevant data sources, developing descriptive analyses and preparing reports on a range of topics.
15. Conduct the statistical weighting and create annual data sets for awardees. Processing of data for weighted data sets by CDC is subject to awardees' adherence to protocol and meeting a minimum response rate target.
16. Assist awardee staff in obtaining training in software to analyze PRAMS data.
17. Facilitate the dissemination of weighted analytic datasets to researchers per data sharing agreement.
18. Facilitate dissemination and translation of findings for use in development and evaluation of MCH programs.
19. Organize on-going opportunities for exchange of information on challenges and best practices in establishing surveillance or other enhanced activities.
20. Participate with awardees in workshops, trainings, meetings, and coordinating committees to exchange information among awardees.
21. Coordinate and participate in PRAMS National Awardee Meetings.
22. Participate in the voluntary PRAMS Coordinating Committee comprised of CDC Project Scientists and awardees to promote exchange of information and best practices for program development and evaluation.
23. Assist awardee with complying with the CDC PRAMS Standard Data Management Plan for AR25 https://www.cdc.gov/grants/additionalrequirements/ar-25.html.

Additionally, an HHS/CDC Project Officer or other HHS/CDC staff will provide day-to-day programmatic, administrative, and fiscal management in support of the project as defined above.
Additionally, an HHS/CDC agency Program Official will be responsible for the normal scientific and programmatic stewardship of the award. The SPO will be:

- Named in the Notice of Grant Award (NGA) as the Program Official to provide oversight and assure overall scientific and programmatic stewardship of the award.
- Monitor performance against approved project objectives; and
- Assure assessment of the public health impact of the research conducted under this funding opportunity announcement and promote translation of promising practices, programs, interventions, and other results from the research.

Areas of Joint Responsibility include: Participation in the PRAMS Coordinating Committee:

- The PRAMS Coordinating Committee (CC) is comprised of CDC Project Scientists and the Awardee Working Group (AWG). This work group been established to help with project planning and to promote exchange of information and best practices for program development and evaluation. CDC Project Scientists and awardees meet to discuss a variety of programmatic, operational, and methodologic subjects. Topics include questionnaire revision, national meeting, training activities, software issues, alternative data collections methods, and others. The AWG consists of a primary and secondary representative from 7 defined regions.

• Primary representatives actively participate in calls and serve as the liaison between the AWG and the awardee in their assigned region as needed (i.e., take the lead in conveying or gathering information). Secondary representatives participate in calls and back up the primary representatives as needed. Representation rotates each year so that secondary representatives become primary representatives and each jurisdiction in the region has an opportunity to participate during the grant cycle. The AWG meets quarterly by phone. The frequency of the meetings is subject to change depending on the operational and methodologic issues underway.

Awardees and CDC Project Scientists are expected to participate in the following:

1 Routine conference calls to discuss operational and analytic activities at the jurisdiction-level.
2. All awardee calls to discuss emerging issues that affect all awardees; and
3. In-person awardee meetings.

Technical Review Response: Any strengths and weaknesses of the proposal performance progress will be communicated via email directly from the CDC Scientific Program Officer/Program Official (SPO/PO) noted in the Staff Contacts section of this NOA. A response must be submitted via email to the SPO/PO by the due date of, June 1, 2025. Failure to respond will cause delay in programmatic progress and may adversely affect the future funding of this project.

Data Management Plan: As identified in the NOFO, a data management plan is required. The recipient is required to submit a Data Management Plan to the Scientific Program Official noted in the Staff Contacts section of this NOA, no later than 30 days from the budget period start date.

Expanded Authority: The recipient is permitted expanded authorities in the administration of the award.

The expanded authorities selected below apply to this NoA.

☒ Carryover of unobligated balances from one budget period to a subsequent budget period. Unobligated funds may be used for purposes within the scope of the project as originally approved. Recipients will report use, or intended use, of unobligated funds in Section 12 “Remarks” of the annual Federal Financial Report submitted in eRA Commons. If the GMO determines that some or all the unobligated funds are not necessary to complete the project, the GMO may restrict the recipient’s authority to automatically carry over unobligated balances in the future, use the balance to reduce or offset CDC funding for a subsequent budget period, or use a combination of these actions.

☒ Extension of final budget period of a period of performance without additional funds up to 12 months with no change in the scope of work to ensure adequate completion of the originally approved project or program. The recipient must notify the awarding office, in writing, of the extension 10 days before the expiration date of the period of performance. Upon notification, the awarding office will revise the period of performance ending date and provide an acknowledgement to the recipient.

Program Income: Any program income generated under this grant or cooperative agreement will be used in accordance with the Addition alternative.

Addition alternative: Under this alternative, program income is added to the funds committed to the project/program and is used to further eligible project/program objectives.

Certificate of Confidentiality: Institutions and investigators are responsible for determining whether research they conduct is subject to Section 301(d) of the Public Health Service (PHS) Act. Section 301(d), as amended by Section 2012 of the 21st Century Cures Act, P.L. 114-255 (42 U.S.C. 241(d)), states that the Secretary shall issue Certificates of Confidentiality (Certificates) to persons engaged in biomedical, behavioral, clinical, or other research activities in which identifiable, sensitive information is collected. In furtherance of this provision, CDC supported research commenced or ongoing after December 13, 2016 in which identifiable, sensitive information is collected, as defined by Section 301(d), is deemed issued a Certificate and therefore required to protect the privacy of individuals who are subjects of such research. Certificates issued in this manner will not be issued as a separate document but are issued by application of this term and condition to this award. See Additional Requirement 36 to ensure compliance with this term and condition. The link to the full text is at: https://www.cdc.gov/grants/additional-requirements/ar-36.html

Indirect Costs:

Indirect costs are approved based on the negotiated indirect cost rate agreement dated June 30, 2024, which calculates indirect costs as follows, a Provisional is approved at a rate of 19.4% of the base, which includes direct salaries and wages including all fringe benefits. The effective dates of this indirect cost rate are from April 1, 2024 to March 31, 2027.

REPORTING REQUIREMENTS

The CDC General Award Terms and Conditions include annual and final FFR, RPPR, FFATA, FISMA, and FAPIIS reporting requirements.

PAYMENT INFORMATION

Payment Management System Subaccount: Funds awarded in support of approved activities have been obligated in a newly established subaccount in the PMS, herein identified as the "P Account". Funds must be used in support of approved activities in the NOFO and the approved application. All award funds must be tracked and reported separately.

The grant document number identified on the bottom of page 2 of the NOA must be known to draw down funds.

Subaccount Title: 21U01DP006608

CLOSEOUT REQUIREMENTS

Standard closeout reporting requirements are identified in the General Terms and Conditions, which are published on the CDC website at https://www.cdc.gov/grants/federal-regulations-policies/index.html.

CDC STAFF CONTACTS

Grants Management Specialist: The GMS is the federal staff member responsible for the day-to-day management of grants and cooperative agreements. The GMS is the primary contact of recipients for business and administrative matters pertinent to grant awards. Many of the functions described in the GMO section are performed by the GMS, on behalf of the GMO.

Grants Management Specialist
Tracy Rice
Centers for Disease Control and Prevention
Office of Financial Resources (OFR)
Office of the Chief Operating Officer (OCOO)
Research Branch 2, Team 1
Tel: 678-475-4964
Email: tjn4@cdc.gov

Scientific Program Official/Project Officer: The SPO is the federal official responsible for monitoring the programmatic, scientific, and/or technical aspects of grants and cooperative agreements, as well as contributing to the effort of the award under cooperative agreements.

Programmatic Contact:
Natalie Brown
Extramural Research Program Operations and Services
Centers for Disease Control and Prevention
4770 Buford Highway
Atlanta, GA 30341
Tel: 770-488-5740
Email: fmc7@cdc.gov

Grants Management Officer: The GMO is the federal official responsible for the business and other non-programmatic aspects of grant awards. The GMO is the only official authorized to obligate federal funds and is responsible for signing the NOA, including revisions to the NOA that change the terms and conditions. The GMO serves as the counterpart to the business officer of the recipient organization.

Grants Management Officer
Ahmad Chabkoun
Centers for Disease Control and Prevention
Office of Financial Resources (OFR)
Office of the Chief Operating Officer (OCOO)
Research Branch 2, Team 1
Tel: 404-498-4164
Email:jwg6@cdc.gov

EXHIBIT 8

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Notice of Award

Award# 5 U01DP006605-05-00
FAIN# U01DP006605
Federal Award Date: 04/10/2025

Recipient Information

1. Recipient Name
OREGON HEALTH AUTHORITY
800 NE Oregon St
HST Section
Portland, OR 97232-2162
[NO DATA]

2. Congressional District of Recipient
03

3. Payment System Identifier (ID)
1936001752A1

4. Employer Identification Number (EIN)
936001752

5. Data Universal Numbering System (DUNS)
878144021

6. Recipient's Unique Entity Identifier (UEI)
HFJRBHKCBPR5

7. Project Director or Principal Investigator
Ms. Cate S. Wilcox2041117
Duplicate
cate.s.wilcox@oha.oregon.gov
971-673-0299

8. Authorized Official
Ms. Nadia Davidson
Authorized Representative
nadia.a.davidson@dhsoha.state.or.us
503-798-6020

Federal Agency Information
CDC Office of Financial Resources

9. Awarding Agency Contact Information
Tracy Rice
Grants Management Specialist
tjn4@cdc.gov
678-475-4964

10.Program Official Contact Information
Mrs. Natalie Brown
Program Officer
fmc7@cdc.gov
404-639-4601

Federal Award Information

11. Award Number
5 U01DP006605-05-00

12. Unique Federal Award Identification Number (FAIN)
U01DP006605

13. Statutory Authority
Section 317K of the Public Health Service Act, [42 U.S.C. 247b-12], as amended

14. Federal Award Project Title
DP21-001 Pregnancy Risk Assessment Monitoring Systems (PRAMS), Component A: Core Surveillance

15. Assistance Listing Number
93.946

16. Assistance Listing Program Title
Cooperative Agreements to Support State-Based Safe Motherhood and Infant Health Initiative Programs

17. Award Action Type
Non-Competing Continuation

18. Is the Award R&D?
Yes

Summary Federal Award Financial Information

19.	**Budget Period Start Date** 05/01/2025 **- End Date** 04/30/2026	
20.	**Total Amount of Federal Funds Obligated by this Action**	$175,000.00
	20a. Direct Cost Amount	$149,624.00
	20b. Indirect Cost Amount	$25,376.00
21.	Authorized Carryover	$0.00
22.	Offset	$0.00
23.	Total Amount of Federal Funds Obligated this budget period	$0.00
24.	**Total Approved Cost Sharing or Matching, where applicable**	$0.00
25.	**Total Federal and Non-Federal Approved this Budget Period**	$175,000.00
26.	**Period of Performance Start Date** 05/01/2021 **- End Date** 04/30/2026	
27.	Total Amount of the Federal Award including Approved Cost Sharing or Matching this Period of Performance	$845,040.00

28. Authorized Treatment of Program Income
ADDITIONAL COSTS

29. Grants Management Officer – Signature
Ms. Manal Ali
Grants Management Specialist / Officer

30. Remarks

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Notice of Award

Award# 5 U01DP006605-05-00
FAIN# U01DP006605
Federal Award Date: 04/10/2025

Recipient Information

Recipient Name
OREGON HEALTH AUTHORITY
800 NE Oregon St
HST Section
Portland, OR 97232-2162
[NO DATA]

Congressional District of Recipient
03

Payment Account Number and Type
1936001752A1

Employer Identification Number (EIN) Data
936001752

Universal Numbering System (DUNS)
878144021

Recipient's Unique Entity Identifier (UEI)
HFJRBHKCBPR5

31. Assistance Type
Cooperative Agreement

32. Type of Award
Research

33. Approved Budget
(Excludes Direct Assistance)

I. Financial Assistance from the Federal Awarding Agency Only
II. Total project costs including grant funds and all other financial participation

a. Salaries and Wages	$88,682.00
b. Fringe Benefits	$48,510.00
c. Total Personnel Costs	$137,192.00
d. Equipment	$0.00
e. Supplies	$1,592.00
f. Travel	$0.00
g. Construction	$0.00
h. Other	$10,840.00
i. Contractual	$0.00
j. TOTAL DIRECT COSTS	$149,624.00
k. INDIRECT COSTS	$25,376.00
l. TOTAL APPROVED BUDGET	$175,000.00
m. Federal Share	$175,000.00
n. Non-Federal Share	$0.00

34. Accounting Classification Codes

FY-ACCOUNT NO.	DOCUMENT NO.	ADMINISTRATIVE CODE	OBJECT CLASS	ASSISTANCE LISTING	AMT ACTION FINANCIAL ASSISTANCE	APPROPRIATION
1-939ZRDR	21U01DP006605	DP	41.41	93.946	$0.00	75-21-0948
2-939ZRDR	21U01DP006605	DP	41.41	93.946	$0.00	75-22-0948
3-939ZRDR	21U01DP006605	DP	41.41	93.946	$0.00	75-23-0948
4-939ZRDR	21U01DP006605	DP	41.41	93.946	$0.00	75-24-0948
5-939ZRDH	21U01DP006605	DP	41.41	93.946	$175,000.00	75-25-0948

AWARD ATTACHMENTS

OREGON HEALTH AUTHORITY 5 U01DP006605-05-00

1. Terms and Conditions DP006605

AWARD INFORMATION

Incorporation: In addition to the federal laws, regulations, policies, and CDC General Terms and Conditions for Research awards at https://www.cdc.gov/grants/federal-regulations-policies/index.html, the Centers for Disease Control and Prevention (CDC) hereby incorporates Notice of Funding Opportunity (NOFO) number **DP-21-001, entitled Pregnancy Risk Assessment Monitoring System (PRAMS)**, **award DP006605 – Oregon Health Authority,** and application dated January 6, 2025, as may be amended, which are hereby made a part of this Research award hereinafter referred to as the Notice of Award (NOA).

Note: Due to grants management administration system parameters, the budget category names on Page 1 of this NOA may be altered from the budget categories submitted with the SF-424 Research and Related Budget application.

Applicability of 2 CFR 200 Provisions Beginning October 1, 2024
This award is subject to the requirements in 45 CFR Part 75, except as amendated by the following provisions of 2 CFR Part 200, which apply to new, continuation, and supplemental awards made on or after October 1, 2024.

- 2 CFR § 200.1. Definitions, "Modified Total Direct Cost", "Equipment", and "Supplies"
- 2 CFR § 200.313(e). Equipment, Disposition
- 2 CFR § 200.314(a). Supplies
- 2 CFR § 200.320. Procurement methods
- 2 CFR § 200.333. Fixed amount sub awards
- 2 CFR § 200.344. Closeout
- 2 CFR § 200.414(f). Indirect costs, De Minimis Rate
- 2 CFR § 200.501. Audit requirements

2 CFR 200 citation	**Replaces 45 CFR 75 citation**
2 CFR § 200.1. Definitions, *"Modified Total Direct Cost"*	45 CFR § 75.2. Definitions, *"Modified Total Direct Cost"*
2 CFR § 200.1. Definitions, *"Equipment"*	45 CFR § 75.2. Definitions, *"Equipment"*
2 CFR § 200.1. Definitions, *"Supplies"*	45 CFR § 75.2. Definitions, *"Supplies"*
2 CFR § 200.313(e). Equipment, *"Disposition"*	45 CFR § 75.320(e). Equipment, *Disposition"*
2 CFR § 200.314(a). Supplies	45 CFR § 75.321(a). Supplies
2 CFR § 200.320. Procurement methods	45 CFR § 75.329. Procurement procedures
2 CFR § 200.333. Fixed amount subawards	45 CFR § 75.353 Fixed amount subawards
2 CFR § 200.344. Closeout	45 CFR § 75.381 Closeout
2 CFR § 200.414(f). Indirect costs, De Minimis Rate	45 CFR § 75.414(f). Indirect (F&A) costs, De Minimis Rate
2 CFR § 200.501. Audit requirements	45 CFR § 75.501. Audit requirements

Total Approved Funding is included in Summary Federal Award Financial Information on page 1 of the NOA. All future year funding will be based on satisfactory programmatic progress and the availability of funds.

The federal award amount is subject to adjustment based on total allowable costs incurred and/or the value of any third-party in-kind contribution when applicable.

Note: Refer to the Payment Information section for draw down and Payment Management System (PMS) subaccount information.

Approved Component/Project Funding: The NOFO provides for the funding of multiple components under this award. The approved component funding levels for this notice of award are:

NOFO Component	Amount
Component A	$175,000
Total Approved Budget	$175,000

Recipients are to review the **Payment Management System (PMS) Subaccount** section in this document to determine the appropriate subaccount document number for the referenced Component. Program specific authorizing legislation, budgetary appropriations, or similar authority may require the creation of more than one subaccount document number per award.

Financial Assistance Mechanism: Cooperative Agreement

Substantial Involvement by CDC: It is anticipated that CDC will have substantial programmatic involvement after the award is made. Substantial involvement is in addition to all post-award monitoring, technical assistance, and performance reviews undertaken in the normal course of stewardship of federal funds.

CDC program staff will assist, coordinate, or participate in carrying out effort under the award, and recipients agree to the responsibilities as detailed in the NOFO and included below.

Component A:

1. Maintain CDC Institutional Review Board approvals as required when engaged in research involving human subjects.
2. Obtain Office of Management and Budget (0MB) approval in accordance with the PaperworkReduction Act (PRA), as required.
3. Provide model procedures and assist with development of jurisdiction-specific written procedures. Conduct periodic review of written procedures and provide recommendations for improvement if needed.
4. Provide CDC-provided software system for use in data collection procedures and monitoring of PRAMS operational data.
5. Provide training, operations management and ongoing technical support for CDC supported software.
6. Assist with the specification of variable descriptions and format layouts of all data files.
7. Assist with the development of computer programs for sampling and analysis.
8. Provide statistical guidance on development, implementation, and modification of sampling plan.

9. Provide technical assistance to resolve problems in data collection procedures.
10. Conduct regular operational evaluations and provide recommendations for improvements if needed.
11. Provide technical assistance for data editing.
12. Provide technical assistance on implementation of survey supplements to address emerging issues that may arise during the project.
13. Assist with implementation of a new version of the questionnaire (Phase 9) with potential adaptions to the existing PRAMS methodology (e.g. online data collection) in conjunction with awardees and stakeholders in maternal and infant health.
14. Provide awardees with epidemiologic technical assistance including identifying relevant data sources, developing descriptive analyses and preparing reports on a range of topics.
15. Conduct the statistical weighting and create annual data sets for awardees. Processing of data for weighted data sets by CDC is subject to awardees' adherence to protocol and meeting a minimum response rate target.
16. Assist awardee staff in obtaining training in software to analyze PRAMS data.
17. Facilitate the dissemination of weighted analytic datasets to researchers per data sharing agreement.
18. Facilitate dissemination and translation of findings for use in development and evaluation of MCH programs.
19. Organize on-going opportunities for exchange of information on challenges and best practices in establishing surveillance or other enhanced activities.
20. Participate with awardees in workshops, trainings, meetings, and coordinating committees to exchange information among awardees.
21. Coordinate and participate in PRAMS National Awardee Meetings.
22. Participate in the voluntary PRAMS Coordinating Committee comprised of CDC Project Scientists and awardees to promote exchange of information and best practices for program development and evaluation.
23. Assist awardee with complying with the CDC PRAMS Standard Data Management Plan for AR25 https://www.cdc.gov/grants/additionalrequirements/ar-25.html.

Additionally, an HHS/CDC Project Officer or other HHS/CDC staff will provide day-to-day programmatic, administrative, and fiscal management in support of the project as defined above.

Additionally, an HHS/CDC agency Program Official will be responsible for the normal scientific and programmatic stewardship of the award. The SPO will be:

- Named in the Notice of Grant Award (NGA) as the Program Official to provide oversight and assure overall scientific and programmatic stewardship of the award.
- Monitor performance against approved project objectives; and
- Assure assessment of the public health impact of the research conducted under this funding opportunity announcement and promote translation of promising practices, programs, interventions, and other results from the research.

Areas of Joint Responsibility include: Participation in the PRAMS Coordinating Committee:

- The PRAMS Coordinating Committee (CC) is comprised of CDC Project Scientists and the Awardee Working Group (AWG). This work group been established to help with project planning and to promote exchange of information and best practices for program development and evaluation. CDC Project Scientists and awardees meet to discuss a variety of programmatic,

operational, and methodologic subjects. Topics include questionnaire revision, national meeting, training activities, software issues, alternative data collections methods, and others. The AWG consists of a primary and secondary representative from 7 defined regions.

• Primary representatives actively participate in calls and serve as the liaison between the AWG and the awardee in their assigned region as needed (i.e., take the lead in conveying or gathering information). Secondary representatives participate in calls and back up the primary representatives as needed. Representation rotates each year so that secondary representatives become primary representatives and each jurisdiction in the region has an opportunity to participate during the grant cycle. The AWG meets quarterly by phone. The frequency of the meetings is subject to change depending on the operational and methodologic issues underway.

Awardees and CDC Project Scientists are expected to participate in the following:

1 Routine conference calls to discuss operational and analytic activities at the jurisdiction-level.
2. All awardee calls to discuss emerging issues that affect all awardees; and
3. In-person awardee meetings.

Technical Review Response: Any strengths and weaknesses of the proposal performance progress will be communicated via email directly from the CDC Scientific Program Officer/Program Official (SPO/PO) noted in the Staff Contacts section of this NOA. A response must be submitted via email to the SPO/PO by the due date of, June 1, 2025. Failure to respond will cause delay in programmatic progress and may adversely affect the future funding of this project.

Data Management Plan: As identified in the NOFO, a data management plan is required. The recipient is required to submit a Data Management Plan to the Scientific Program Official noted in the Staff Contacts section of this NOA, no later than 30 days from the budget period start date.

Expanded Authority: The recipient is permitted expanded authorities in the administration of the award.

The expanded authorities selected below apply to this NoA.

☒ Carryover of unobligated balances from one budget period to a subsequent budget period. Unobligated funds may be used for purposes within the scope of the project as originally approved. Recipients will report use, or intended use, of unobligated funds in Section 12 “Remarks” of the annual Federal Financial Report submitted in eRA Commons. If the GMO determines that some or all the unobligated funds are not necessary to complete the project, the GMO may restrict the recipient’s authority to automatically carry over unobligated balances in the future, use the balance to reduce or offset CDC funding for a subsequent budget period, or use a combination of these actions.

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Indirect Costs:

Indirect costs are approved based on the recipient's approved Cost Allocation Plan dated July 1, 2024.

REPORTING REQUIREMENTS

The CDC General Award Terms and Conditions include annual and final FFR, RPPR, FFATA, FISMA, and FAPIIS reporting requirements.

PAYMENT INFORMATION

Payment Management System Subaccount: Funds awarded in support of approved activities have been obligated in a newly established subaccount in the PMS, herein identified as the "P Account". Funds must be used in support of approved activities in the NOFO and the approved application. All award funds must be tracked and reported separately.

The grant document number identified on the bottom of page 2 of the NOA must be known to draw down funds.

Subaccount Title: 21U01DP006605

CLOSEOUT REQUIREMENTS

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CDC STAFF CONTACTS

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Grants Management Specialist
Tracy Rice
Centers for Disease Control and Prevention
Office of Financial Resources (OFR)
Office of the Chief Operating Officer (OCOO)
Research Branch 2, Team 1
Tel: 678-475-4964
Email: tjn4@cdc.gov

Scientific Program Official/Project Officer: The SPO is the federal official responsible for monitoring the programmatic, scientific, and/or technical aspects of grants and cooperative agreements, as well as contributing to the effort of the award under cooperative agreements.

Programmatic Contact:
Natalie Brown
Extramural Research Program Operations and Services
Centers for Disease Control and Prevention
4770 Buford Highway
Atlanta, GA 30341
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Email: fmc7@cdc.gov

Grants Management Officer: The GMO is the federal official responsible for the business and other non-programmatic aspects of grant awards. The GMO is the only official authorized to obligate federal funds and is responsible for signing the NOA, including revisions to the NOA that change the terms and conditions. The GMO serves as the counterpart to the business officer of the recipient organization.

Grants Management Officer
Ahmad Chabkoun
Centers for Disease Control and Prevention
Office of Financial Resources (OFR)
Office of the Chief Operating Officer (OCOO)
Research Branch 2, Team 1
Tel: 404-498-4164
Email:jwg6@cdc.gov

EXHIBIT 9

Thursday, May 1, 2025 at 10:42:02 Central Daylight Time

Subject: RE: 2025 Certificate of Compliance
Date: Tuesday, April 29, 2025 at 8:13:14 AM Central Daylight Time
From: NCCD/OSH/Federal Cigarette Labeling and Advertising Act (CDC)
To: Meghan Joiner
CC: Lauren Donald, NCCD/OSH/Federal Cigarette Labeling and Advertising Act (CDC), Eric Estes
Attachments: image001.jpg

EXTERNAL: This email originated from outside of the organization.

Due to the impact of the HHS Reduction in Force and reorganization, CDC is pausing any ingredient submissions and will not issue Certificates of Compliance at this time. Ingredient submissions received by CDC are being treated as confidential in accordance with law and applicable protocols. More information will be forthcoming. CDC intends to share this information with relevant State and Territorial authorities.

Centers for Disease Control and Prevention

From: Meghan Joiner <m.joiner@xcaliberinternational.com>
Sent: Wednesday, April 2, 2025 5:02 PM
To: NCCD/OSH/Federal Cigarette Labeling and Advertising Act (CDC) <nccdoshfclaa@cdc.gov>
Cc: Lauren Donald <l.donald@xcaliberinternational.com>; NCCD/OSH/Federal Cigarette Labeling and Advertising Act (CDC) <nccdoshfclaa@cdc.gov>; Eric Estes <e.estes@xcaliberinternational.com>
Subject: Re: 2025 Certificate of Compliance

CAUTION: This email originated from outside of the organization. Do not click links or open attachments unless you recognize the sender and know the content is safe.

Thank you so much for confirming receipt. Do you have an anticipated date by which we can expect an approval letter?

Get Outlook for iOS

From: NCCD/OSH/Federal Cigarette Labeling and Advertising Act (CDC) <nccdoshfclaa@cdc.gov>
Sent: Wednesday, April 2, 2025 3:46:26 PM
To: Meghan Joiner <m.joiner@xcaliberinternational.com>
Cc: Lauren Donald <l.donald@xcaliberinternational.com>; NCCD/OSH/Federal Cigarette Labeling and Advertising Act (CDC) <nccdoshfclaa@cdc.gov>
Subject: RE: 2025 Certificate of Compliance

EXTERNAL: This email originated from outside of the organization.

Meghan,

Thank you for your email. XCaliber's submission has been received.

Office on Smoking and Health

Centers for Disease Control and Prevention

From: Meghan Joiner <m.joiner@xcaliberinternational.com>
Sent: Tuesday, April 1, 2025 4:06 PM
To: Hayes, Ruth L. (CDC/NCCDPHP/OSH) (CTR) <aro5@cdc.gov>; NCCD/OSH/Federal Cigarette Labeling and Advertising Act (CDC) <nccdoshfclaa@cdc.gov>
Cc: Lauren Donald <l.donald@xcaliberinternational.com>
Subject: 2025 Certificate of Compliance

CAUTION: This email originated from outside of the organization. Do not click links or open attachments unless you recognize the sender and know the content is safe.

Ms. Hayes:

Lauren Donald submitted Xcaliber's 2025 Ingredient List submission via fax and Federal Express on March 13, 2025. Today she sent a follow up email to confirm receipt, but the email came back undeliverable. Is there a different email address with which we may correspond?

Thank you for any assistance you can provide.

XCALIBER INTERNATIONAL

Meghan Joiner

Senior Associate General Counsel

(918) 824-0300 (main)
(918) 824-6648 (desk)
(918) 824-0025 (mobile)
m.joiner@xcaliberinternational.com
http://xcaliberinternational.com
One Tobacco Road, Pryor, OK 74361

EXHIBIT 10

HeadStart.gov

Head Start Approach

headstart.gov/programs/article/head-start-approach

Head Start programs support children's growth from birth to age 5 through services that support early learning and development, health, and family well-being. Head Start staff actively engage parents, recognizing family participation throughout the program as key to strong child outcomes.

Head Start services are available at no cost to children ages birth to 5 in eligible families. Head Start Preschool services work with families with children ages 3 to 5. Early Head Start services work with families with children ages birth to 3, and many also serve expectant families. Many programs operate both Head Start Preschool and Early Head Start services. Programs deliver child development services in center-based, home-based, or family child care settings. All Head Start programs continually work toward our mission for eligible children and families to receive high-quality services in safe and healthy settings that prepare children for school and life.

Does my family qualify?

Services for Children and Families

Head Start programs are helping children get ready to succeed in school and in life through learning experiences tailored to their changing needs and abilities.

Early Learning and Development

Our programs are:

- Building strong relationships as the foundational driver for early learning
- Engaging families in their child's learning and recognizing parents as a child's first and most influential teacher
- Implementing effective practices to promote children's growth in five key domains: approaches to learning, social and emotional development, language and literacy, cognition, and physical development
- Encouraging learning through play, creative expression, and guided activities with schedules and lesson plans that include the cultural and language heritage of each child and family in relevant ways

- Creating welcoming learning environments in indoor and outdoor settings that are well-organized and safe
- Conducting ongoing screenings and assessments to ensure each child is making progress, and collaborating with parents and community agencies when further assessment is needed
- Supporting services for children with disabilities and building on their strengths

Health and Wellness

Our programs are:

- Engaging all children in both indoor and outdoor physical activity
- Serving breakfast, lunch, and snacks that are healthy and nutritious
- Ensuring children receive medical, dental, hearing, vision, and behavioral screening
- Making sure children brush their teeth after meals and promoting oral health and hygiene
- Helping families understand and support their child's health and behavioral health needs
- Assisting with mental health services for children and families, as needed
- Building resilience to help children and families heal from traumatic experiences or events and overwhelming situations

Family Well-being

Our programs are:

- Providing parenting support and strategies
- Supporting parental health and links to community services during pregnancy
- Connecting families to community and federal assistance
- Assisting families in identifying and reaching their goals and dreams, including those related to finances and economic mobility, housing, employment, and education
- Providing a career pathway in early care and education — *about 25% of program staff are former Head Start parents!*

Family Engagement

Our programs are:

- Inviting parents to share information and insights about their child
- Celebrating the role of fathers and male caregivers through father engagement
- Engaging parents as their child's lifelong advocate
- Welcoming parents to offer ways to improve children and families' experiences in the program, including through leadership roles on the Policy Council
- Supporting child and family transitions when the child is ready for the next step, to Head Start, kindergarten, or another early childhood program

Meeting Community Needs

To reach the children and families who need Head Start services the most, programs are designed according to community need. Directly funded at the local level, Head Start programs tailor their programs as appropriate for families in the designated service area. These programs may be provided in different settings and hours according to the needs indicated by their community assessment.

Federal-to-Local Funding Model

The federal government funds Head Start programs through the U.S. Department of Health and Human Services, Administration for Children and Families. Across the country, school districts, nonprofit and for-profit groups, faith-based institutions, tribal councils, and other organizations qualify to become a Head Start recipient and receive federal funding. The federal-to-local model allows local leaders to create a Head Start experience that is responsive to the unique and specific needs of their community. Many programs are combining funding from federal, state, and local sources to maximize service delivery and continuity. Head Start Collaboration Offices facilitate partnerships between Head Start agencies and other state entities that provide services to benefit low-income children and their families.

Migrant and Seasonal Head Start (MSHS) programs serve children ages birth to 5 from families engaged in agricultural work, either seasonally or across geographic regions. American Indian and Alaska Native (AIAN) Head Start programs serve children from federally recognized tribes and others in their communities.

Head Start programs either provide transportation services or assist families to arrange transportation of children to program activities.

Eligibility and Enrollment

Head Start services are for children from birth to compulsory school age, as well as pregnant women and expectant families. Eligible participants include children whose families meet the federal low-income guidelines — that is, whose incomes are at or below the federal poverty guidelines or who participate in Temporary Assistance for Needy Families, Supplemental Security Income, or Supplemental Nutrition Assistance Program public assistance services. Other eligible participants include children who are in the foster care system or experiencing homelessness. Programs may also accept a limited number of children who do not meet any of those eligibility criteria.

MSHS programs have specific eligibility requirements for the children of farmworkers. AIAN Head Start programs enroll tribal children from reservations or nearby areas. All programs enroll children with disabilities and welcome children who speak a language other than English at home.

As there are generally more eligible children than is supported by program funding, each program maintains a waiting list according to their selection criteria for when a spot becomes available.

Program Settings

Head Start services are delivered in a variety of settings, sometimes referred to as “options.” This consistent, supportive setting is designed to foster strong relationships between program staff, families, and children. The selection of settings offered by any Head Start program is determined by its assessment of community needs.

- Center-based services are located in child development centers. More than half of Head Start children are enrolled in center-based services, five days per week, for at least six hours per day.
- Home-based services are mostly delivered in a family’s own home, along with planned group socialization activities. More than a third of children enrolled in Early Head Start programs receive home-based services.
- Family child care services are located in a family-based child care setting.
- Locally-designed services are often delivered through some combination of the above settings, depending on the needs of the community.

Outcomes

Since 1965, Head Start programs have reached 40 million children and their families. Children who enrolled in Head Start programs are more likely to graduate from high school and attend college, have improved social, emotional, and behavioral development, and are better prepared to be parents themselves than similar children who did not attend the program. Children enrolled in Early Head Start programs have significantly fewer child welfare encounters related to sexual or physical abuse between the ages of 5 and 9 than those who don't attend.

Research consistently shows a broad pattern of impacts for children at the end of their Head Start enrollment. While these benefits may appear to diminish in the early grades, economic benefits emerge as children become adults. The Head Start program's two-generation design — coupled with research-based, high-quality comprehensive services — has the power to change the trajectory for children's outcomes.

Read more:

Programs

Last Updated: February 5, 2025

EXHIBIT 11

Due to current HHS restructuring, the information provided on aspe.hhs.gov is not being updated currently. Please refer to hhs.gov for more information.

An official website of the United States government Here's how you know

U.S. Department of Health and Human Services

ASPE
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FOR PLANNING AND EVALUATION

MENU

Frequently Asked Questions Related to the Poverty Guidelines and Poverty

What are the differences between the poverty guidelines and the poverty thresholds?

Poverty thresholds are used for calculating all official poverty population statistics — for instance, figures on the number of Americans in poverty each year. They are updated each year by the Census Bureau. Poverty thresholds since 1973 (and for selected earlier years) and weighted average poverty thresholds since 1959 are available on the Census Bureau's web site. For poverty thresholds before 1980, contact the Census Bureau at 1-800-923-8282. For an example of how the Census Bureau applies the thresholds to a family's income to determine its poverty status, see " How the Census Bureau Measures Poverty " on the Census Bureau's web site.

The poverty guidelines are a simplified version of the federal poverty thresholds used for administrative purposes — for instance, determining financial eligibility for certain federal programs. They are issued each year in the Federal Register by the Department of Health and Human Services (HHS).

Key differences between the poverty thresholds and the poverty guidelines are summarized in the table below. For more information, see the discussion of poverty thresholds and poverty guidelines on the Institute for Research on Poverty's web site.

Key Differences Between Thresholds and Guidelines

	Poverty Thresholds	**Poverty Guidelines**
Issuing Agency	Census Bureau	Department of Health and Human Services
Purpose/Use	Statistical — calculating the number of people in poverty	Administrative — determining financial eligibility for certain programs
Characteristics by Which They Vary	Detailed (48-cell) matrix of thresholds varies by family size, number of children, and, for 1- & 2-person units, whether or not elderly. Weighted average thresholds vary by family size and, for 1- & 2-person units, whether or not elderly. There is no geographic variation; the same figures are used for all 50 states and D.C.	Guidelines vary by family size. In addition, there is one set of figures for the 48 contiguous states and D.C.; one set for Alaska; and one set for Hawaii.
Timing of Annual Update	The Census Bureau issues preliminary poverty thresholds in January, and final poverty thresholds in September of the year after the year for which poverty is measured. The poverty thresholds are adjusted to the price level of the year for which poverty is measured. For example, the poverty thresholds for calendar year 2020 were issued in 2021 (preliminary in January, final in September), were used to measure poverty for calendar year 2020, and reflect the price level of calendar year 2020.	HHS issues poverty guidelines in late January of each year. Some programs make them effective on date of publication, others at a later date. For example, the 2021 poverty guidelines were issued in January 2021, calculated from the calendar year 2019 thresholds issued in September 2020, updated to reflect the price level of calendar year 2020. Therefore, the 2021 poverty guidelines are approximately equal to the poverty thresholds for 2020 (for most family sizes).

	Poverty Thresholds	Poverty Guidelines
How Updated or Calculated	The 48-cell matrix is updated each year from the 1978 threshold matrix using the CPI-U. The preliminary weighted average thresholds are updated from the previous year's final weighted average thresholds using the CPI-U. The final weighted average thresholds are calculated from the current year's 48-cell matrix using family weighting figures from the Current Population Survey's Annual Social and Economic Supplement.	Guidelines are updated from the latest published (final) weighted average poverty thresholds using the CPI-U. (Figures are rounded, and differences between adjacent-family-size figures are equalized.)
Rounding	Rounded to the nearest dollar	Rounded to various multiples of $10 — may end only in zero

What is "the official poverty line defined by the Office of Management and Budget"?

This phrase refers to the Census Bureau poverty thresholds, although it is included in the legislative section of the 1981 Omnibus Budget Reconciliation Act (OBRA) that requires the Secretary of Health and Human Services to update the poverty guidelines annually. The thresholds are mentioned in this legislative section because they are the starting point from which the poverty guidelines are calculated. (The legislative section is section 673(2) of OBRA-1981 or of the Community Services Block Grant Act; the U.S. Code citation is 42 U.S.C. 9902(2) .)

The Census Bureau poverty thresholds are described using this phrase because in August 1969, the Bureau of the Budget (the predecessor of the Office of Management and Budget) issued a document designating the Census Bureau poverty thresholds as the federal government's official statistical definition of poverty. (The 1978 version of this document is available on the Census Bureau website.) However, the role of the Office of Management and Budget (OMB) vis-a-vis the poverty line was limited to this one-time designation of the poverty thresholds as the official federal statistical definition of poverty. OMB has never issued either the poverty thresholds or the poverty guidelines.

To make a statutory reference to the poverty guidelines, one can use the phrase "the poverty guidelines updated periodically in the Federal Register by the U.S. Department of Health and Human

Services under the authority of 42 U.S.C. 9902(2)."

Where can I find historical tables of the poverty guidelines and the poverty thresholds?

For the poverty guidelines since 1982, summary figures are available on this HHS web site. For a historical table of the poverty guidelines since 1965, visit Historical Poverty Guidelines.

For historical tables of weighted average poverty thresholds since 1959, see the historical poverty threshold table on the Census Bureau's Historical Poverty web site. The Census Bureau also has tables showing the detailed matrix of poverty thresholds for individual years back to 1973 (and for selected earlier years).

What is the poverty line for [my state OR my metropolitan area OR my city]?

The Census Bureau's poverty thresholds are the same nationwide, with no separate figures for different states, metropolitan areas, or cities.

The Department of Health and Human Services' poverty guidelines, which are a simplified version of the Census Bureau's poverty thresholds used for program eligibility purposes, are the same for the 48 contiguous states and the District of Columbia. Due to Office of Economic Opportunity administrative practices beginning in the 1966-1970 period, there are separate poverty guidelines for Alaska and for Hawaii.

Poverty Guidelines (for Program Eligibility)

Since 2006, the poverty guidelines have been published in late January (except for 2010). The Federal Registration notices published since 1982 may be viewed by visiting the Prior HHS Poverty Guidelines and Federal Register References page.

When are the poverty guidelines effective?

The poverty guidelines may be used as soon as they are published in the Federal Register each year — usually in late January — unless a program has chosen to make them effective at a later date. To determine when the poverty guidelines are effective for a particular program, one must contact the office or organization that administers that program.

I have a chart showing percentage multiples [e.g., 125 percent, 150 percent, etc.] of last

year's poverty guidelines. How can I get an updated version of that chart based on this year's guidelines?

The only way to get an official update of a chart showing percentage multiples of the poverty guidelines is to contact the organization or office that prepared it. While ASPE calculates the poverty guidelines each year, ASPE does not calculate or prepare any official charts showing percentage multiples of the poverty guidelines even though such charts may indicate the HHS poverty guidelines as the source. However, ASPE provides a spreadsheet tool to assist organizations in creating these charts. Be aware, however, that the rounding rules for these calculations, as well as procedures for calculating monthly income, are determined by the federal, state, and local program offices that use the poverty guidelines for eligibility purposes. Therefore, the numbers in these spreadsheets could differ somewhat from what is used by other federal, state, or other organizations.

Chart showing different multiples of the poverty guidelines for 2024 (XLSX)
Chart showing different multiples of the poverty guidelines for 2024 (PDF)
Chart showing different multiples of the poverty guidelines for prior years (XLSX)

**This content is in the process of Section 508 review. If you need immediate assistance accessing this content, please submit a request to Kendall Swenson, Kendall.Swenson@hhs.gov. Content will be updated pending the outcome of the Section 508 review.*

I have a sliding fee scale [indicating that families between certain percentage multiples of the poverty guidelines should pay a certain percentage of the full fee] based on last year's poverty guidelines. How can I get an updated version of that sliding fee scale based on this year's guidelines?

The only way to get an update of a sliding fee scale is to contact the organization or office that prepared it. While ASPE calculates the poverty guidelines each year, ASPE does not calculate or prepare any sliding fee scales even though such scales may indicate the HHS poverty guidelines as the source.

What programs use the poverty guidelines?

The HHS poverty guidelines, or percentage multiples of them (such as 125 percent, 150 percent, or 185 percent), are used as an eligibility criterion by a number of federal programs, including those listed below. For examples of major means-tested programs that do not use the poverty guidelines, see the end of this response.

- Department of Health and Human Services:

- Community Services Block Grant
- Head Start
- Low-Income Home Energy Assistance Program (LIHEAP)
- PARTS of Medicaid
- Hill-Burton Uncompensated Services Program
- AIDS Drug Assistance Program
- Children's Health Insurance Program
- Medicare – Prescription Drug Coverage (subsidized portion only)
- Community Health Centers
- Migrant Health Centers
- Family Planning Services
- Health Professions Student Loans — Loans for Disadvantaged Students
- Health Careers Opportunity Program
- Scholarships for Health Professions Students from Disadvantaged Backgrounds
- Job Opportunities for Low-Income Individuals
- Low-Income Household Water Assistance Program

- Department of Agriculture:
  - Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamp Program)
  - Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
  - National School Lunch Program (for free and reduced-price meals only)
  - School Breakfast Program (for free and reduced-price meals only)
  - Child and Adult Care Food Program (for free and reduced-price meals only)
  - Expanded Food and Nutrition Education Program
- Department of Energy:
  - Weatherization Assistance for Low-Income Persons
- Department of Labor:
  - Job Corps
  - National Farmworker Jobs Program
  - Senior Community Service Employment Program
  - Workforce Investment Act Youth Activities
- Department of the Treasury:
  - Low-Income Taxpayer Clinics
- Corporation for National and Community Service:

- Foster Grandparent Program
- Senior Companion Program

- Legal Services Corporation:
  - Legal Services for the Poor

Most of these programs are non-open-ended programs — that is, programs for which a fixed amount of money is appropriated each year. A few open-ended or "entitlement" programs that use the poverty guidelines for eligibility are the Supplemental Nutrition Assistance Program (formerly Food Stamps), the National School Lunch Program, certain parts of Medicaid, and the subsidized portion of Medicare – Prescription Drug Coverage.

Some state and local governments have chosen to use the federal poverty guidelines in some of their own programs and activities. Examples include financial guidelines for child support enforcement and determination of legal indigence for court purposes. Some private companies (such as utilities, telephone companies, and pharmaceutical companies) and some charitable agencies also use the guidelines in setting eligibility for their services to low-income persons.

Major means-tested programs that do not use the poverty guidelines in determining eligibility include the following:

- Supplemental Security Income (SSI)
- Earned Income Tax Credit (EITC)
- State/local-funded General Assistance (in most cases)
- Some parts of Medicaid
- Section 8 low-income housing assistance
- Low-rent public housing

Are the poverty guidelines before-tax or after-tax? Are they gross income or net income? What definition of income is used with the poverty guidelines?

There is no simple answer to these questions. When determining program eligibility, some agencies compare before-tax income to the poverty guidelines, while other agencies compare after-tax income. Likewise, eligibility can be dependent on gross income, net income, or some other measure of income. Federal, state, and local program offices that use the poverty guidelines for eligibility purposes may define income in different ways. To find out the specific definition of income (before-tax, after-tax, etc.) used by a particular program or activity, one must consult the office or organization that administers that program.

While there is no standard definition of income for program eligibility purposes, the Census Bureau uses a standard definition of income for computing poverty statistics based on the official poverty thresholds. More information is available on the Census Bureau's web site.

To calculate the 2024 poverty guidelines, do you use a projection of what the Consumer Price Index (CPI-U) will be for 2024

No. ASPE does not project price changes for the current year; instead, we issue guidelines based on price changes through the most recent completed year. Accordingly, the 2024 poverty guidelines, issued in January 2024, reflect actual price changes through calendar year 2022

Poverty Thresholds (for Statistical Purposes) and Their Origin

How was the poverty line developed?

The poverty thresholds were originally developed in 1963-1964 by Mollie Orshansky of the Social Security Administration. Orshansky took the dollar costs of the U.S. Department of Agriculture's economy food She followed somewhat different procedures to calculate thresholds for one- and two-person units in order to allow for the relatively larger fixed costs that small family units face. (The economy food plan used by Orshansky is included in a 1962 Agriculture Department report .)

Orshansky used a factor of three because the Agriculture Department's 1955 Household Food Consumption Survey found that for families of three or more persons, the average dollar value of all food used during a week (both at home and away from home) accounted for about one third of their total money income after taxes.

In May 1965, the U.S. Office of Economic Opportunity adopted Orshansky's poverty thresholds as a working or quasi-official definition of poverty. In August 1969, the U.S. Bureau of the Budget (predecessor of the Office of Management and Budget) designated the poverty thresholds with certain revisions as the federal government's official statistical definition of poverty.

More information is available on how Orshansky developed the thresholds and their subsequent history as the official U.S. poverty measure .

Was the thrifty food plan used to develop or update the poverty thresholds?

No. The Agriculture Department's economy food plan — the predecessor of the current thrifty food plan — was used in developing the poverty thresholds in 1963-1964. (The economy food plan used to develop the thresholds is included in a 1962 Agriculture Department report.) The thrifty food plan was not established until 1975, when it replaced the economy food plan at the same general level of

cost. The thrifty food plan has never been used to update or revise the poverty thresholds. Poverty thresholds are updated for price changes only using the Consumer Price Index.

Are the poverty thresholds calculated every year by multiplying the cost of an Agriculture Department food plan by three?

No. The "three-times-the-cost-of-the-food-plan" calculation was done only once, for the 1963 base year poverty thresholds, using the Agriculture Department's economy food plan. Poverty thresholds for years since 1963 have been updated for price changes only using the Consumer Price Index.

What share of the poverty line goes for housing? for transportation? for home heating?

The poverty thresholds were not developed as an item-by-item budget with specific dollar amounts for each consumption category. If one tries to consider the thresholds as a budget, all that one can say is that they were developed in 1963-1964 by multiplying the cost of the economy food plan by three. Other than that, it is not possible to say what share of the poverty line goes for any specific consumption category. (Note that the food share used to develop the thresholds does not represent today's consumption pattern for either the general population or the poverty population.)

Other Poverty-Related Questions

How many people are in poverty in the United States? How many people are in poverty in [my state OR my county OR my city]?

The Census Bureau is the federal agency that prepares statistics on the number of people in poverty in the United States. To obtain figures on the number of people in poverty since 1959, visit the Poverty section of the Census Bureau's web site, or contact the Census Bureau's Customer Service Center at 1-800-923-8282 (toll-free), or visit ask.census.gov.

The Census Bureau's poverty statistics represent the number of people below the Census Bureau poverty thresholds. Neither the Census Bureau nor the U.S. Departmen`t of Health and Human Services publish tabulations of the number of people below the HHS poverty guidelines, which are a simplified version of the poverty thresholds used for program eligibility purposes, although they are used when estimating the number of persons eligible for particular programs. The best approximation for the number of people below the HHS poverty guidelines inx a particular area would be the number of persons below the Census Bureau poverty thresholds in that area.

Since there is an official federal definition of "poverty," does the federal government also have official definitions for such terms as

"middle class," "middle income," "rich," and "upper income"?

No. The federal government does not have official definitions for such terms as "middle class," "middle income," "rich," and "upper income.

FILES

Chart showing different multiples of the poverty guidelines for prior years (xlsx, 48.64 KB)

Chart showing different multiples of the poverty guidelines for 2025 (pdf, 199.84 KB)

Chart Showing different multiples of the poverty guidelines for 2025 (xlsx, 57.76 KB)

Historical Poverty Guidelines through 2024 (xlsx, 44.95 KB)

Poverty Guidelines

Prior HHS Poverty Guidelines and Federal Register References

Frequently Asked Questions

Further Resources

Mollie Orshansky

Poverty Guidelines API

Poverty Estimates, Trends, and Analysis

Marginal Tax Rates/Benefit Cliffs

Paid Family Leave

Program Participation

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Better Research for Better Policy

The Assistant Secretary for Planning and Evaluation (ASPE) is the principal advisor to the Secretary of the U.S. Department of Health and Human Services on policy development, and is responsible for major activities in policy coordination, legislation development, strategic planning, policy research, evaluation, and economic analysis.

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EXHIBIT 12

KFF Health News

Trump HHS Eliminates Office That Sets Poverty Levels Tied to Benefits for at Least 80 Million People

By Arthur Allen

UPDATED APRIL 11, 2025
ORIGINALLY PUBLISHED APRIL 11, 2025

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(PAVLO GONCHAR/SOPA IMAGES/LIGHTROCKET VIA GETTY IMAGES)

President Donald Trump's firings at the Department of Health and Human Services included the entire office that sets federal poverty guidelines, which determine whether tens of millions of Americans are eligible for health programs such as Medicaid, food assistance, child care, and other services, former staff said.

CBS NEWS

This story also ran on CBS News. It can be republished for free.

The small team, with technical data expertise, worked out of HHS' Office of the Assistant Secretary for Planning and Evaluation, or ASPE. Their dismissal mirrored others across HHS, which came without warning and left officials puzzled as to why they were "RIF'ed" — as in "reduction in force," the bureaucratic language used to describe the firings.

“I suspect they RIF’ed offices that had the word ‘data’ or ‘statistics’ in them,” said one of the laid-off employees, a social scientist whom KFF Health News agreed not to name because the person feared further recrimination. “It was random, as far as we can tell.”

Among those fired was Kendall Swenson, who had led development of the poverty guidelines for many years and was considered the repository of knowledge on the issue, according to the social scientist and two academics who have worked with the HHS team.

The sacking of the office could lead to cuts in assistance to low-income families next year unless the Trump administration restores the positions or moves its duties elsewhere, said Robin Ghertner, the fired director of the Division of Data and Technical Analysis, which had overseen the guidelines.

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The poverty guidelines are “needed by many people and programs,” said Timothy Smeeding, a professor emeritus of economics at the La Follette School of Public Affairs at the University of Wisconsin. “If you’re thinking of someone you fired who should be rehired, Swenson would be a no-brainer,” he added.

Under a 1981 appropriations bill, HHS is required annually to take Census Bureau poverty-line figures, adjust them for inflation, and create guidelines that agencies and states use to determine who is eligible for various types of help.

There’s a special sauce for creating the guidelines that includes adjustments and calculations, Ghertner said. Swenson and three other staff members would independently prepare the numbers and quality-check them together before they were issued each January.

Everyone in Ghertner's office was told last week, without warning, that they were being put on administrative leave until June 1, when their employment would officially end, he said.

"There's literally no one in the government who knows how to calculate the guidelines," he said. "And because we're all locked out of our computers, we can't teach anyone how to calculate them."

ASPE had about 140 staff members and now has about 40, according to a former staffer. The HHS shake-up merged the office with the Agency for Healthcare Research and Quality, or AHRQ, whose staff has shrunk from 275 to about 80, according to a former AHRQ official who spoke on the condition of anonymity.

HHS has said it laid off about 10,000 employees and that, combined with other moves, including a program to encourage early retirements, its workforce has been reduced by about 20,000. But the agency has not detailed where it made the cuts or identified specific employees it fired.

"These workers were told they couldn't come into their offices so there's no transfer of knowledge," said Wendell Primus, who worked at ASPE during the Bill Clinton administration. "They had no time to train anyone, transfer data, etc."

HHS defended the firings. The department merged AHRQ and ASPE "as part of Secretary Kennedy's vision to streamline HHS to better serve Americans," spokesperson Emily Hilliard said. "Critical programs within ASPE will continue in this new office" and "HHS will continue to comply with statutory requirements," she said in a written response to KFF Health News.

After this article published, HHS spokesperson Andrew Nixon called KFF Health News to say others at HHS could do the work of the RIF'ed data analysis team, which had nine members. "The idea that this will come to a halt is totally incorrect," he said. "Eighty million people will not be affected."

Secretary Robert F. Kennedy Jr. has so far declined to testify about the staff reductions before congressional committees that oversee much of his agency. On April 9, a delegation of 10 Democratic members of Congress waited fruitlessly for a meeting in the agency's lobby.

The group was led by House Energy and Commerce health subcommittee ranking member Diana DeGette (D-Colo.), who told reporters afterward that Kennedy must appear before the committee "and tell us what his plan is for keeping America healthy and for stopping these devastating cuts."

Matt VanHyfte, a spokesperson for the Republican committee leadership, said HHS officials would meet with bipartisan committee staff on April 11 to discuss the firings and other policy issues.

ASPE serves as a think tank for the HHS secretary, said Primus, who later was Rep. Nancy Pelosi's senior health policy adviser for 18 years. In addition to the poverty guidelines, the office maps out how much Medicaid money goes to each state and reviews all regulations developed by HHS agencies.

"These HHS staffing cuts — 20,000 — obviously they are completely nuts," Primus said. "These were not decisions made by Kennedy or staff at HHS. They are being made at the White House. There's no rhyme or reasons to what they're doing."

HHS leaders may be unaware of their legal duty to issue the poverty guidelines, Ghertner said. If each state and federal government agency instead sets guidelines on its own, it could create inequities and lead to lawsuits, he said.

And sticking with the 2025 standard next year could put benefits for hundreds of thousands of Americans at risk, Ghertner said. The current poverty level is $15,650 for a single person and $32,150 for a family of four.

“If you make $30,000 and have three kids, say, and next year you make $31,000 but prices have gone up 7%, suddenly your $31,000 doesn’t buy you the same,” he said, “but if the guidelines haven’t increased, you might be no longer eligible for Medicaid.”

The 2025 poverty level for a family of five is $37,650.

As of October, about 79 million people were enrolled in Medicaid or the related Children’s Health Insurance Program, both of which are means-tested and thus depend on the poverty guidelines to determine eligibility.

Eligibility for premium subsidies for insurance plans sold in Affordable Care Act marketplaces is also tied to the official poverty level.

One in eight Americans rely on the Supplemental Nutrition Assistance Program, or food stamps, and 40% of newborns and their mothers receive food through the Women, Infants, and Children program, both of which also use the federal poverty level to determine eligibility.

Former employees in the office said they were not disloyal to the president. They knew their jobs required them to follow the administration’s objectives. “We were trying to support the MAHA agenda,” the social scientist said, referring to Kennedy’s “Make America Healthy Again” rubric. “Even if it didn’t align with our personal worldviews, we wanted to be useful.”

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*[**Update:** This article was revised at 11:30 a.m. ET on April 11, 2025, to include statements from Department of Health and Human Services officials submitted after publication.]*

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HEALTH

With Trump coming into power, the NIH is in the crosshairs

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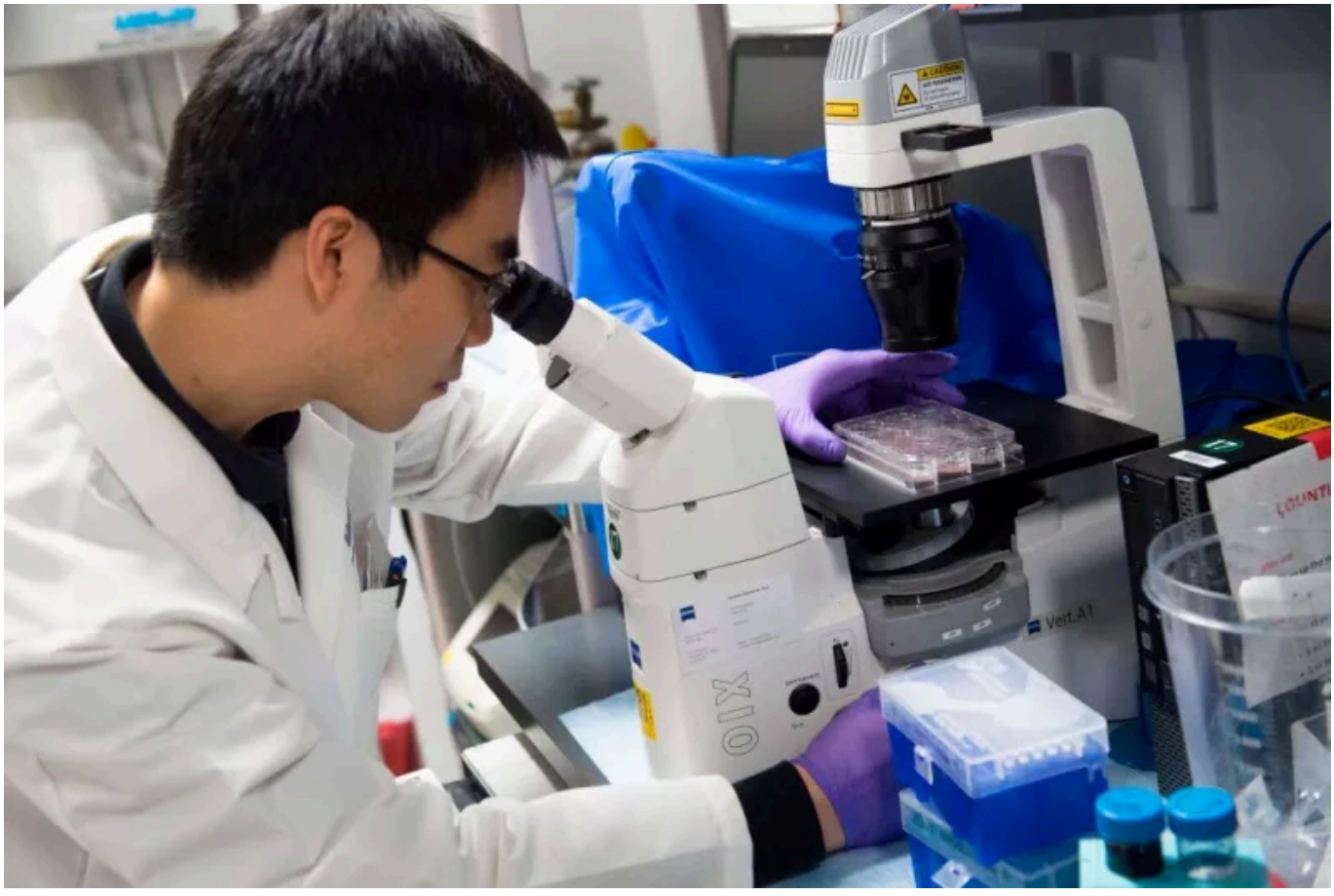


Dr. Benjamin Jin, a biologist, works on immunotherapy for HPV+ cancers, in a lab at the National Cancer Institute at the National Institutes of Health (NIH) in Bethesda, Md., in 2018. The NIH has a $48 billion budget to fund biomedical research.

Saul Loeb/AFP/Getty Images

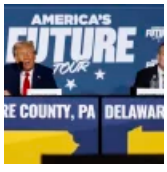
As the next Trump administration overhauls the federal government, the National Institutes of Health could be among the top targets for restructuring.

"I do think you probably will see changes in NIH, as well as other public health agencies like CDC and maybe even FDA," says Dr. Joel Zinberg, a senior fellow at the Competitive Enterprise Institute and director of the Public Health and American Wellbeing Initiative at the Paragon Health Institute, both conservative think tanks. "And that's primarily I think because there was a real erosion in trust in those agencies during the pandemic," he says.

Sponsor Message

While the NIH — which gets $48 billion annually for biomedical research — has historically enjoyed bipartisan support, Trump proposed cutting its budget during his first term. And the pandemic didn't leave positive feelings towards the agency in some quarters.

"I think changes are warranted. It's important to restore trust in public health agencies, of which NIH is one," Zinberg says.



POLITICS

Trump picks former Rep. Lee Zeldin to be his EPA administrator

Some major changes at the NIH would require congressional approval. Trump has the authority to pick the NIH director right away, though the new director would

have to be confirmed by the Senate. The current director, Monica M. Bertagnolli, was appointed by President Biden in November.

And shaking up the NIH has fans. Robert F. Kennedy Jr., a vocal critic of mainstream medicine, has President-elect Donald Trump's ear. Over the weekend, Kennedy said he'd like to immediately replace 600 NIH employees.

"We need to act fast, and we want to have those people in place on Jan. 20 so that on Jan. 21, 600 people are going to walk into offices at NIH, and 600 people are going to leave," Kennedy said while speaking at the Genius Network Annual Event in Scottsdale, Ariz.

And Republican members of Congress as well as conservative think tanks like the Heritage Foundation have been floating long to-do lists for changing the NIH.

One proposal would winnow the NIH from 27 separate institutes and centers to 15.

"The agency now works in discreet silos that are largely organized on the basis of either diseases or organs rather than taking a more holistic approach to disease," Zinberg says. "So I think there's an appetite to break down those silos, to streamline the agency [and] make the various institutes more cross-cutting."

Dr. Brett Giroir, who held several health positions and played a significant role in the COVID response during Trump's first term, agrees.

"I do think a potential reorganization could be important. The institutes have become very stove-piped," he says.

"Cross-institutional kinds of scientific needs were not very well addressed. And I wound up introducing people at the NIH who had never met each other before or had never worked seriously with each other before."

Another proposal would impose term limits on NIH leaders to prevent the establishment of future figures like Dr. Anthony Fauci, the long-time head of the National Institutes of Allergy and Infectious Diseases. Fauci became a lightning rod for Republican criticism because of his changing advice about masks during the pandemic, his advocacy for the vaccines and his criticizing the use of ineffective treatments, as well as the debate about the origins of the SARS-CoV2 virus, which caused the pandemic.

"No one could think after that these agencies were competent or capable of providing good information," Zinberg says.

Dr. Anthony Fauci, former director of the National Institute of Allergy and Infectious Diseases, arrives to testify before the House Oversight and Accountability Committee Select Subcommittee on the Coronavirus Pandemic at the Rayburn House Office Building on June 03, 2024, in Washington, D.C.

Chip Somodevilla/Getty Images

There's a lot of talk about revamping how the agency spends its budget.

"There's a lot of concern that the grant-making process at NIH is inefficient, burdensome — it requires a awful lot of paperwork and preliminary data," Zinberg says. "And that it's kind of inbred and ossified in the sense that most of the grants go to people who've had previous grants. Most of the grants go to a small group of universities — most of the grants go to older researchers."

One proposal causing special concern among some NIH supporters is to give at least some of the NIH budget directly to states through block grants, bypassing the agency's intensive peer-review system. States would then dispense the money.

Many proponents of biomedical research agree that some changes may be warranted and helpful.

But some fear they could result in big budget cuts to the NIH, which could undermine the scientific and economic benefits from the biomedical research generated by the agency.

"Why would you want to dismantle an institute that is the leading research institute in the world?" says Ellie Dehoney, a senior vice president at Research!America, a nonprofit group that advocates for scientific research. It would be like saying, 'Let's undo our national defense and block grant it.' There's no reason to take a successful institution and dismantle it."

Many in the medical community are "deeply, deeply concerned," says Dr. George Daley, dean of the Harvard Medical School. "Any restructuring that would lead to an overall decrease in the support for medical research could really have a devastating effect."

The states don't have the expertise to pick the best scientific projects through block grants, according to Dr. Elias Zerhouni, who ran the NIH from 2002 to 2008 under President George W. Bush.

"I don't think it will work because it wouldn't really guarantee what I think is the crown-jewel process that we have and that is independent peer review," Zerhouni says. "It's going to be more political than it needs to be and that it should be. You want it to be above politics. It's one of those things that we need to protect from political influence."

The next Trump administration may also crack down funding certain kinds of biomedical research, such as "gain-of-function" research that studies how pathogens become dangerous, as well as human embryonic stem cell research, which raises ethical issues for some.

Restricting certain types of research has some supporters.

"There are potential positives that a Trump administration might bring to NIH and its agenda," says Daniel Correa, chief executive officer at the Federation of American Scientists. "Tightening lab security and revisiting and strengthening

oversight over risky research, like gain-of-function research, may be central to the next NIH agenda. And I think that would be welcome."

But Correa and others say that the new administration also appears likely to impose restrictions on other types of medical research as well. For example, the Trump administration is likely to restore restrictions on using tissue from aborted fetuses for biomedical research, which were lifted by Biden.

"It would be a mistake to restore a ban on fetal tissue research since it was based on false and misleading claims of a lack of important progress and use of fetal tissue," says Dr. Lawrence Goldstein, who studies fetal tissue at the University of California, San Diego. "If Americans want to see rapid research on repairing organ damage and brain damage and all the other diseases we're trying to fight, fetal tissue is a really important part of that tool box."

Goldstein is far from alone in his opinion.

"The impact of fetal tissue research and embryonic stem cell research is undisputed and has led to some extraordinary advances in treating disease," agrees Heather Pierce, senior director for science policy and regulatory counsel for the Association of American Medical Colleges.

2024 election trump nih robert f. kennedy, jr.

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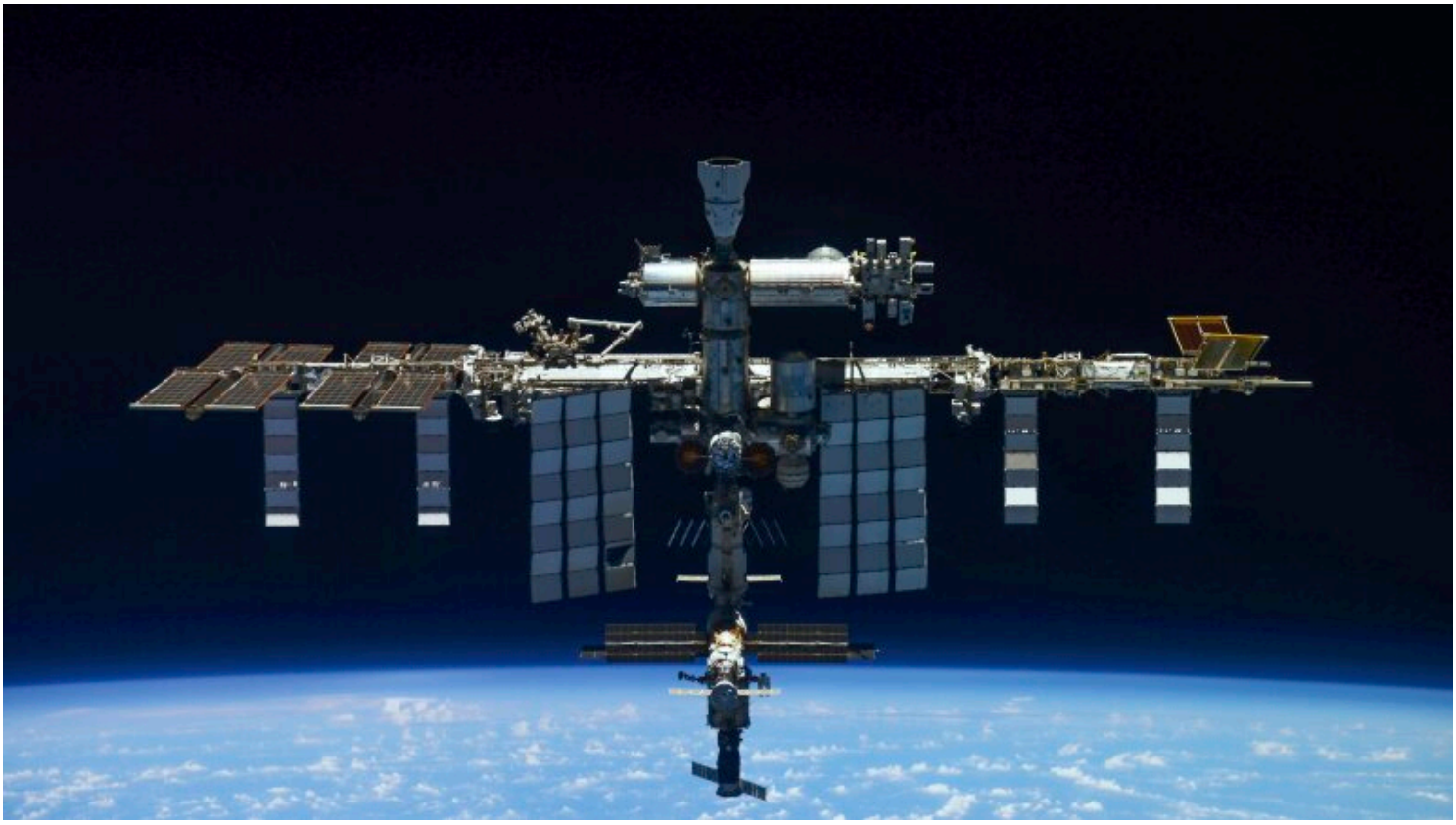

SCIENCE

Economists warn Trump's research cuts could have dire consequences for GDP

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On Teacher Appreciation Week, union leaders say teachers are underpaid and under attack

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EXHIBIT 14

Everything RFK Jr. Has Said About What He'll Do If Named Trump Health Czar

Robert F. Kennedy Jr. vowed to take Anthony Fauci down three years ago. Soon enough, he may replace him as the nation's top health official.

If former President Donald Trump is elected president, the nation's loudest anti-vaccine proponent could conceivably be in a position to drastically transform U.S. health policy.

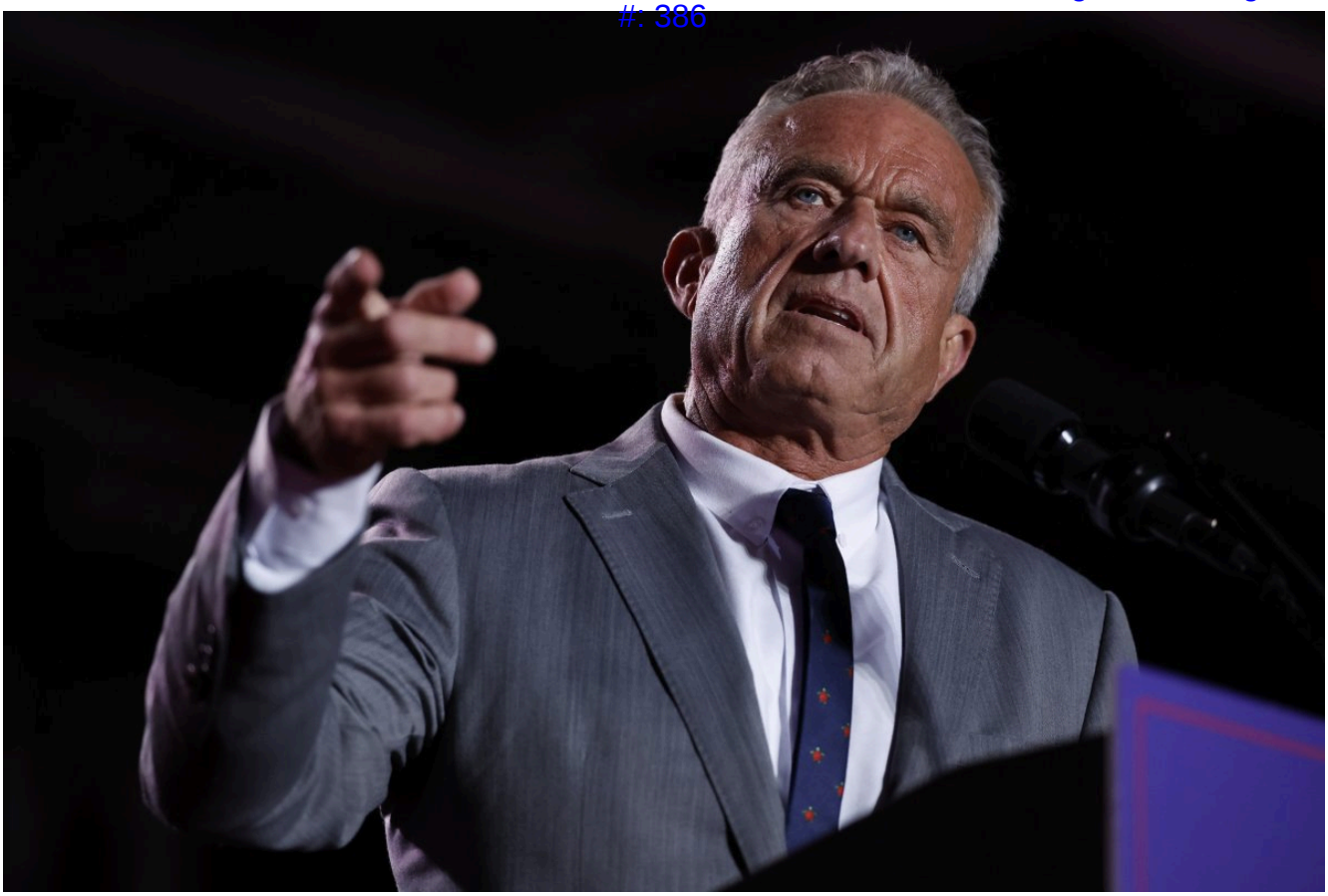
Last week during a Zoom organizing call, Kennedy, who sits on Trump's transition team, said in leaked remarks that the Republican nominee has promised him "control of the public health agencies," including but not limited to the Department of Health and Human Services (HHS), the Centers for Disease Control and Prevention (CDC), the Food and Drug Administration (FDA), the National Institutes of Health (NIH) and the Department of Agriculture (USDA).

Trump transition co-chair Howard Lutnick quickly denied to CNN's Kaitlan Collins that there were any plans to put Kennedy up for secretary of Health and Human Services (HHS) if Trump were re-elected. "He's not getting a job for HHS," Lutnick said, though that doesn't rule out an appointment as a senior White House adviser in second Trump term.

Newsweek reached out to Kennedy via email for comment.

After a failed bid for the presidency, first as a Democratic candidate and then an independent candidate, Kennedy suspended his campaign in August and endorsed Trump. Despite publicly feuding earlier this year, their unlikely alliance has blossomed.

Trump, who once called Kennedy the "dumbest member" of the dynastic Kennedy clan, promised his antagonist-turned-ally "a big role" in the federal public health bureaucracy during a Friday stop in Dearborn, Michigan.



"He's going to have a big role in health care, a very big role. He knows it better than anybody," Trump said, adding that Kennedy "has some views I happen to agree with strongly and I have for a long time."

Over the weekend, Trump also said that Kennedy could work on anything with the exception of oil policy, saying the Democratic scion wants "women's health, he wants men's health, he wants kids, he wants everything."

"I've known him a long time and all he wants to do is very simply he wants to make people healthy and I think it's important," Trump said.

Kennedy is the nephew of President John F. Kennedy and son of former attorney general and Senator Robert F. Kennedy. Both his uncle and father were assassinated.

Paul Offit, a nationally-recognized pediatrician who serves as the director of the vaccine education center at Children Hospital of Philadelphia, told *Newsweek* that he was unsure how Kennedy would work with public health agencies, given the fundamental ethos of those organizations.

"Those are all science-based agencies," he said. "They make decisions based on science. Robert F. Kennedy Jr. is a science denialist. He doesn't believe in science if it contradicts his other beliefs."

"What could be more dangerous than having someone having sway over these agencies?" Offit added.

Daniel Havlichek, the former chief of Michigan State University's division of infectious diseases, told *Newsweek*, "I am concerned that [Kennedy] lacks even marginal scientific and public health training. This would lead to public health decisions based on his hunch about what to do. This is not good policy."

Should Trump win, he could use Kennedy to usher in an extreme shake-up of federal public health policy. Here's what may come:

Drinking Water

Kennedy has vowed to immediately remove fluoride from drinking water, a major reversal in a decades-long practices that has been praised for drastically reducing cavities and strengthening teeth.

Adding low levels of fluoride—a naturally occurring mineral found in many foods—to drinking water has long been considered one of the greatest public health achievements of the last century and has been recommended by the U.S. Public Health Service since 1962.

"On January 20, the Trump White House will advise all U.S. water systems to remove fluoride from public water," Kennedy said in a post on X, formerly Twitter, Sunday.

"Fluoride is an industrial waste associated with arthritis, bone fractures, bone cancer, IQ loss, neurodevelopmental disorders, and thyroid disease."

Kennedy, who is also an environmental lawyer, has built a reputation for fighting for clean water with Waterkeeper Alliance, which he founded in 1999.

Officials lowered their recommendation for fluoride levels in drinking water in 2015 to address a tooth condition called fluorosis, while a federal agency determined in August "with moderate confidence" that there is a link between very high levels of fluoride exposure and lower IQ in kids. According to the CDC, more than 200 million Americans drink from fluoridated water systems.

What has Trump said?

Asked about the fluoride proposal on Sunday, Trump told NBC News that he had not spoken to Kennedy yet, "but it sounds OK to me. You know it's possible."

What does the expert say?

"Fluoride has clearly been shown to decrease cavities," Offit said. "Dentists do far less drilling than they did when I was a kid."

Vaccines

Kennedy, who is on leave as the chair of the anti-vaccine group Children's Health Defense, has long repeated the debunked claim that childhood vaccines cause autism. Despite insisting that he is not anti-vax and claiming that he's never told the public to avoid getting vaccinated, he is a vocal opponent to immunizations.

Asked on the Lex Fridman podcast if there are any good vaccines, Kennedy said in July, "There's no vaccine that is, you know, safe and effective."

When Fridman pushed Kennedy on his stance, asking specifically about the polio vaccine, Kennedy suggested that it may have killed more people than it saved. The CDC estimates that the polio vaccine, which is widely considered one of the other greatest medical advances of the 20th century, has saved more than 1.5 million lives and prevented paralysis in more than 20 million children.

Kennedy also came under criticism for advocating against COVID-19 vaccines during the pandemic as well as statements he made comparing lockdowns to Nazi Germany and claiming that the virus "ethnically targeted" to spare Ashkenazi Jews and Chinese people.

Asked in February if he would have allowed the FDA's emergency approval of certain COVID vaccines to move forward, Kennedy responded, "I would have said that they need to do science to show that the vaccine is actually going to avert more problems than it's causing."

What has Trump said?

The Trump campaign has gone all-in on Kennedy's views in recent weeks, embracing his anti-vax rhetoric and suggesting that a vaccine ban could happen during a second Trump presidency.

Asked about the possibility of banning a vaccine Sunday, Trump told NBC that he would talk to Kennedy and "other people, and I'll make a decision."

"But he's a very talented guy and has strong views," Trump added.

Trump's running mate Senator JD Vance also told Joe Rogan last week that he had been "red-pilled" about the COVID vaccine, saying that he had a worse reaction to the initial dose than to the virus itself.

"I was in bed for two days, my heart was racing, I was like, the fact that we're not even allowed to talk about that. Even, you know — no like, serious injury, but even the fact that we're not even allowed to talk about the fact that I was as sick as I've ever been for two days and the worst Covid experience I had was like a sinus infection," Vance said.

The CDC has repeatedly disputed such claims, stating that the worse side effect from COVID vaccines are not worse than the potential effects of the virus itself and that vaccines do not increase the risk of death, while the virus does.

Lutnick also told CNN that Kennedy wants access to health data to prove that vaccines are unsafe.

"He says, if you give me the data, all I want is the data and I'll take on the data and show that it's not safe. And then if you pull the product liability, the companies will yank these vaccines right off of the market," Lutnick said. "So that's his point."

It's unclear what data Lutnick is referring to. Extensive research on vaccine safety is publicly available.

What does the expert say?

Offit said that at the time the COVID vaccine was introduced, it was a "lifesaver" because the only other option was avoiding human-to-human contact. But as vaccine mandates became common, vaccinations "rubbed a significant percent of the population the wrong way."

"There was never really a politics to the anti-vaccine movement," Offit said.

For a long time, anti-vaccine voices came from both the far-left and the far-right. On the far-left was the all-things-natural, crunchy granola types. On the right were the get-the-government-off-our-back libertarians.

"When Trump says, 'We'll let Bobby do what he wants," Offit said the former president is trying to appeal to those voices on the right.

He also warned that as more parents exempt their children from getting vaccinated, "we'll get to a point where that's not acceptable." Pointing to the 2014 measles epidemic in southern California, Offit said the outbreak was what ultimately pushed parents to change their minds.

"It's a shame that it would have to come to this," he said.

Havlichek added: "Worldwide, vaccines have improved health and survival for hundreds of years. Despite best efforts, measles, mumps, polio, rubella, and Covid continue to exist worldwide and reintroduction to the US is only a plane ride away. We need to remain vigilant against these pathogens and vaccination is a highly effective way to protect ourselves and our children."

"Eliminating this protection without a well vetted plan is naive," Havlichek said.

Reforming Public Health Agencies

Kennedy has vowed to "clean up" public health agencies that "have become sock puppets for the industries they're supposed to regulate."

"FDA's war on public health is about to end," Kennedy said on X last month. "This includes its aggressive suppression of psychedelics, peptides, stem cells, raw milk, hyperbaric therapies, chelating

compounds, ivermectin, hydroxychloroquine, vitamins, clean foods, sunshine, exercise, nutraceuticals and anything else that advances human health and can't be patented by Pharma."

"If you work for the FDA and are part of this corrupt system, I have two messages for you: 1. Preserve your records, and 2. Pack your bags," he warned.

Kennedy also proposed in a *Wall Street Journal* op-ed that half of NIH's research budget should be spent on "preventative, alternative and holistic" medicines.

What has Trump said?

Trump said on the Rogan podcast last month that he told Kennedy he could "focus on health, you can do whatever you want."

"I'm going to let him go wild on health. I'm going to let him go wild on the food. I'm going to let him go wild on medicines," Trump added at his Madison Square Garden rally in new York.

When he was president, Trump's administration repeatedly undercut the FDA.

In the early days of his first term, he proposed to slash the agencies regulations by 75 to 80 percent, which critics said could "fundamentally destroy the ability of the agency to protect patients and consumers from unsafe or ineffective medications and medical devices, hazardous foods and dietary supplements, and dangerous tobacco products, among other things."

"The end result would be countless preventable deaths, injuries and illnesses across the U.S.," Dr. Michael Carome, the director of Public Citizen's health research group, said in a January 2017 statement.

What does the expert say?

"Regulation is a good thing," Offit said. "You want drugs and airplanes to be regulated. You want that safety net."

He said that "if these agencies stand tall and do the regulation they're in charge of," then there won't be major reversals in public health policy even with Kennedy as a leading official.

Offit also added that it would be difficult for any president to come into office and overturn major health care regulations without the help of Congress.

EXHIBIT 15

Smoking and Tobacco Use

MAY 15, 2024

Tobacco Ingredient and Nicotine Reporting

UPDATE

Due to the impact of the HHS Reduction in Force and reorganization, CDC is pausing any ingredient submissions and will not issue Certificates of Compliance at this time. Ingredient submissions received by CDC are being treated as confidential in accordance with law and applicable protocols.

WHAT TO KNOW

Understand current laws about reporting tobacco ingredients and nicotine in tobacco products.

Deadline extension on data submissions

CDC has re-evaluated the previously announced deadline extension on data submissions and has determined that data submissions can recommence. Required ingredient reports and nicotine analysis reports must be submitted to CDC on or before March 31, 2024. Beginning March 31, 2024, ingredient reports for cigarette and/or smokeless tobacco products and specifications of the quantity of nicotine contained in smokeless tobacco products that are imported to the United States for the first time must also be submitted at the time of importation.

For more information, please visit the notice published in the Federal Register on September 29, 2023: Recommencement in Reporting Requirements for the Federal Cigarette Labeling and Advertising Act (FCLAA) and Comprehensive Smokeless Tobacco Health Education Act (CSTHEA).

To the extent there are questions or concerns that CDC can address, please contact OSH through nccdoshfclaa@cdc.gov.

Federal Cigarette Labeling and Advertising Act and Comprehensive Smokeless Tobacco Health Education Act

The Federal Cigarette Labeling and Advertising Act (FCLAA), Public Law 89–92, and Comprehensive Smokeless Tobacco Health Education Act (CSTHEA), Public Law 99–252, require CDC's Office on Smoking and Health to collect, store, and analyze the list of ingredients added to cigarettes and smokeless tobacco products.

The following pages provide relevant background information and guidance to manufacturers, packagers, and importers responsible for reporting ingredient and nicotine data.[A] They are not exhaustive and are subject to change.

Description of the laws

Cigarettes

The Federal Cigarette Labeling and Advertising Act (FCLAA), 15 U.S.C. §1335a(a), Public Law 89–92, in part requires that each person who manufactures, packages, or imports cigarettes annually submit to the Department of Health and Human Services (HHS) a list of ingredients added to tobacco in the manufacture of cigarettes (Ingredient Report). The Centers for Disease Control and Prevention (CDC), Office on Smoking and Health (OSH), has been delegated the responsibility of implementing these provisions. The Ingredient Report must include all additives and flavors. Submissions are due to CDC, OSH by March 31; and for importers, the Ingredient Report is also due upon initial importation into the United States. The report submitted by March 31 each year must represent the ingredients added to tobacco in the manufacture of cigarettes during the previous calendar year.

Under FCLAA, one may submit information which does not identify the company that uses the ingredients or the brand of cigarettes that contain the ingredients. A person or group of persons required to provide the ingredient list may designate an individual or entity to provide the list. In the event that another individual or entity, such as an attorney or counsel, is designated to submit this information on your behalf, this individual or entity should clearly state the name(s) of the importer(s) or company(ies) for whom they are submitting the information.

Smokeless tobacco

The Comprehensive Smokeless Tobacco Health Education Act (CSTHEA), 15 U.S.C. §4403(a)(A), Public Law 99–252, in part requires each manufacturer, packager, or importer of smokeless tobacco products to annually submit to HHS the list of ingredients added to tobacco in the manufacture of smokeless tobacco products (Ingredient Report). CSTHEA, 15 U.S.C. §4403(a)(1)(B), further requires the submission of the quantity of nicotine contained in each smokeless tobacco product (Nicotine Report). CDC, OSH has been delegated the responsibility of implementing these provisions. Submissions are due to CDC, OSH by March 31; and for importers, the Ingredient Report is also due upon initial importation into the United States. The reports submitted by March 31 each year must represent the ingredients added to tobacco in the manufacture of smokeless tobacco during the previous calendar year; and the specification of the quantity of nicotine contained in smokeless tobacco products manufactured or imported during the previous calendar year.

Under CSTHEA, one may submit information which does not identify the company that uses the ingredients or the brand of smokeless tobacco that contains the ingredients. A person or group of persons required to provide the nicotine data and ingredient list may designate an individual or entity to provide the list. In the event that you designate another individual or entity, such as an attorney or counsel, to submit this information on your behalf, this individual or entity should clearly state the name(s) of the company(ies) for whom they are submitting the information.

Tobacco-related legal requirements and obligations

United States Code

United States Code Main Page

- Federal Cigarette Labeling and Advertising Act, 15 USC §1331–1341
- Comprehensive Smokeless Tobacco Health Education Act, 15 USC § 4401–440
- Collection of State Cigarette Taxes, 15 USC § 375–378
- Trafficking in Contraband Cigarettes Act, 18 USC § 2341–2346
- Requirements Applicable to Imports of Certain Cigarettes, 19 USC § 1681–1681b
- Alcohol, Tobacco, and Certain Other Excise Taxes, 26 USC § 5701–5708
- Qualification Requirements for Manufacturers and Importers of Tobacco Products and Cigarette Papers and Tubes, and Export Warehouse Proprietors, 26 USC § 5711–5713
- Restriction on Importation of Previously Exported Tobacco Products, 26 USC § 5754, 5761

Code of Federal Regulations

Code of Federal Regulations Main Page

- Regulations Under the Comprehensive Smokeless Tobacco Health Education Act of 1986, 16 CFR 307–307.12
- Manufacture of Tobacco Products and Cigarette Papers and Tubes, 27 CFR 40.1–40.478
- Importation of Tobacco Products and Cigarette Papers and Tubes, 27 CFR 41.1–41.228
- Removal of Tobacco Products, and Cigarette Papers and Tubes, without Payment of Tax, for Use by the United States, 27 CFR 45.1–45.51

Master Settlement Agreement

- In 1998, the Attorneys General of 46 states signed the Master Settlement Agreement (MSA) with the four largest tobacco companies (Phillip Morris, RJ Reynolds, Brown and Williamson, and Lorillard) in the United States to settle state suits to recover costs associated with treating smoking-related illnesses.
- The Attorney General of each state are responsible for enforcing the provisions of this agreement.
- The National Association of Attorneys General Tobacco page includes a summary of the agreement and amendments, an application to join, and more.
- Four states—Florida, Minnesota, Texas, and Mississippi settled their tobacco cases separately, prior to the MSA.

Reporting instructions

Certification

Deadline

As detailed in 64 FR 14086, March 23, 1999; and 66 FR 17559, April 2, 2001, all submissions required under the Federal Cigarette Labeling and Advertising Act (FCLAA) and Comprehensive Smokeless Tobacco Health Education Act (CSTHEA) for cigarettes and smokeless tobacco are

due upon initial importation and annually thereafter by March 31. Submissions to CDC's Office on Smoking and Health are reflective of ingredient information required by FCLAA and CSTHEA during the previous calendar year.

Once an accurate submission of an Ingredient Report and Nicotine Report (where applicable) have been received, CDC will issue a Certificate of Compliance valid until March 31 of the following year.

Note: All faxed submissions should be immediately followed with a mailed original.

Report format

CDC requests all submissions be on letterhead of the manufacturer, packager, importer, respective counsel, or designated individual or entity.

Electronic mail submissions are not accepted at this time given the inability to ensure the confidentiality of information submitted. CDC no longer accepts submissions transmitted on CD, 3-inch floppy disk, and/or thumb drive.

Reports may also be submitted via facsimile, but all faxed lists should be followed-up with a mailed original.

To the best of our knowledge, laboratory analysis is not available that will provide a complete representation of the ingredients added to tobacco in the manufacture of cigarettes or smokeless tobacco. Laboratory analysis in lieu of the Ingredient Report is not acceptable.

Note: If no ingredients are added to tobacco in the manufacture of cigarettes or smokeless tobacco, a statement to that effect must be submitted in writing.

- Recommended Formats for Reporting
- Contact information for submissions to OSH

Reporting categories

The reporting status of manufacturers, packagers, and importers will be coded by CDC as either “compliant,” “noncompliant,” or “inactive.”

Compliant

The reporting status of manufacturers, packagers, and importers will be coded by CDC as either "compliant," "noncompliant," or "inactive."

A Certificate of Compliance will be issued for submissions that meet all of the following requirements:

- The submission clearly states on whose behalf the submission is made.
- The list of ingredients, including chemical names and corresponding Chemical Abstract Service (CAS) registry numbers, added to tobacco in the manufacture of cigarettes and/or smokeless tobacco products is complete and without error.

Example:

Chemical Name: Menthol

CAS Number: 89–78–1

- The submission clearly states on whose behalf the submission is made.
- The submission for smokeless tobacco products contains a specification of the quantity of nicotine through the reporting of the amount of total nicotine, amount of unionized nicotine and percentage of unionized nicotine, total moisture, and pH for each smokeless product.

Noncompliant

Failure to provide the annual Ingredient Report and Nicotine Report (for smokeless tobacco) by the **March 31 deadline** and failure to correct inadequacies or errors in a submission **within 60 days of notification** will result in CDC deeming the manufacturer, packager, or importer noncompliant.

In addition, if a report is submitted by a designated individual, the manufacturer, packager, or importer on whose behalf the report is submitted must be identified with the submission. Otherwise, the company will be deemed noncompliant.

Noncompliant status will be changed upon receipt of required information.

Inactive

Companies are encouraged to inform CDC if they are no longer manufacturing, packaging, or importing tobacco products. CDC communicates with other federal agencies involved in the regulation of tobacco products and will share the information of a company’s status as appropriate.

Other requirements

In addition to the requirements detailed here, manufacturers, packagers, and importers of tobacco products may have additional legal obligations to consider. Although not an exhaustive list, other federal agencies that may have applicable laws include the Alcohol and Tobacco Tax and Trade Bureau (TTB), U.S. Customs (Customs), and the Federal Trade Commission (FTC).

Contact information for submissions to OSH

Federal Register Notices

- Notice Regarding Requirement for Submission of List of Ingredients Added to Tobacco in Cigarettes (1985) [PDF–591 KB] PDF
- Notice Regarding Requirement for Submission of List of Ingredients Added to Tobacco in the Manufacture of Smokeless Tobacco Products (1994) [PDF–592 KB] PDF
- Notice Regarding Requirement for Annual Submission of the Quantity of Nicotine Contained in Smokeless Tobacco Products Manufactured, Imported, or Packaged in the United States (1999)
- Notice Regarding Revised Protocol for Analysis of Nicotine, Total Moisture, and pH in Smokeless Tobacco Products (2009) [PDF–668 KB] PDF

Recommended formats for reporting

- Recommended Format for Smokeless Tobacco Nicotine Data Reporting—CSTHEA [PDF–69 KB] PDF
- Recommended Smokeless Tobacco Ingredient Reporting Format—CSTHEA [PDF–62 KB] PDF
- Recommended Cigarette Ingredient Reporting Format—FCLAA [PDF–66 KB] PDF

Frequently asked questions

What is the Federal Cigarette Labeling and Advertising Act (FCLAA)?

The FCLAA, Public Law 89–92, is a statute that was designed to “establish a comprehensive federal program to deal with cigarette labeling and advertising with respect to any relationship between smoking and health.” In 1984, this Act was amended by PL 98–474, the Comprehensive Smoking Education Act, 15 U.S.C. § 1335a(a) to in part provide the Department of Health and Human Services with a list of the ingredients added to tobacco in the manufacture of cigarettes.

What is the Comprehensive Smokeless Tobacco Health Education Act (CSTHEA)?

The CSTHEA, Public Law 98–252, was passed in 1986 to inform the public of any dangers to human health resulting from the use of smokeless tobacco products. CSTHEA requires, in part, that each person who manufactures, packages, or imports smokeless tobacco products to annually submit to the Department of Health and Human Services the list of ingredients added to tobacco in the manufacture of smokeless tobacco products as well as a specification of the quantity of nicotine contained in each smokeless tobacco product.

What products are covered by FCLAA and CSTHEA?

FCLAA defines a cigarette as "any roll of tobacco wrapped in paper or in any substance not containing tobacco, and any roll of tobacco wrapped in any substance containing tobacco which, because of its appearance, the type of tobacco used in the filler, or its packaging and labeling, is likely to be offered to, or purchased by, consumers as a cigarette. . ."

CSTHEA defines smokeless tobacco as "any finely cut, ground, powdered, or leaf tobacco that is intended to be placed in the oral cavity."

What products are not covered by FCLAA and CSTHEA?

FCLAA and CSTHEA do not apply to cigars or cut rag tobacco unless the cut rag tobacco is packaged as a final product for consumption (i.e., no further manipulation is required in order to be consumed). Other items not covered by FCLAA or CSTHEA include little cigars; or roll-your-own, hookah, or pipe tobacco.

To whom does FCLAA and CSTHEA apply?

Manufacturers, packagers, and importers of cigarettes and smokeless tobacco products.

Who receives the Ingredient Report and the Nicotine Report?

Both FCLAA and CSTHEA require manufacturers, packagers, and importers to annually report ingredients added to tobacco in the manufacture of cigarettes and smokeless tobacco to the Secretary of Health and Human Services. In turn, the Secretary has delegated this responsibility to the Centers for Disease Control and Prevention, Office on Smoking and Health (OSH), as stated in 50 FR 49617, December 3, 1985 [PDF–51.4 KB] PDF; 59 FR 4717, February 1, 1994 [PDF–59.7 KB] PDF, respectively.

Contact information for submissions to OSH

Are the submission requirements the same for cigarettes and smokeless tobacco products?

Both FCLAA and CSTHEA require manufacturers, packagers, and importers to annually report ingredients added to tobacco in the manufacture of cigarettes and smokeless tobacco.

However, CSTHEA additionally requires manufacturers, packagers, and importers of smokeless tobacco products to annually report on the specific quantity of nicotine in these products by submitting data on total nicotine, unionized nicotine, total moisture, and pH.

Recommended Formats for Reporting

What does a Nicotine Report consist of?

The Nicotine Report is a specification of the quantity of nicotine (total nicotine, un–ionized nicotine, total moisture, and pH) contained in smokeless tobacco products from the previous calendar year. A uniform analytical protocol was developed that consists of standard laboratory methods to measure nicotine, moisture, and pH in smokeless tobacco products, and an equation to calculate un–ionized nicotine. It includes standardized parameters for pH, moisture, and nicotine determination (sample size, sample preparation, quantity and purity of standards and reagents, instrumentation, measurement time and conditions, etc.). It is the responsibility of the manufacturer, packager, or importer to submit the Nicotine Report according to the specifications set forth in the protocol.

For detailed information on the protocol for testing smokeless tobacco products and the recommended format for reporting total nicotine, amount of unionized nicotine, and percentage of unionized nicotine, total moisture, and pH for each smokeless product, please review the following:

- Notice Regarding Requirement for Annual Submission of the Quantity of Nicotine Contained in Smokeless Tobacco Products Manufactured, Imported, or Packaged in the United States (1999)
- Recommended Formats for Reporting

When are submissions due?

All submissions are due annually by March 31 and upon initial import. These submissions reflect ingredients added to cigarettes and smokeless tobacco products which are manufactured, packaged, or imported in the previous calendar year; as well as a specification of the quantity of nicotine contained in smokeless tobacco products manufactured or imported during the previous calendar year.

Can I submit my Ingredient Report and Nicotine Report electronically?

Electronic mail submissions are not accepted at this time given the inability to ensure the confidentiality of information submitted. In addition, CDC no longer accepts submissions transmitted on CD, 3-inch floppy disk, and/or thumb drive. Reports may also be submitted via facsimile, but all faxed lists should be followed-up with a mailed original.

What are Chemical Abstract Service (CAS) numbers?

Each chemical compound has a unique CAS number for purposes of identification, assigned by the American Chemical Society. A CAS registry is available from the National Institutes of Health National Library of Medicineexternal icon.

Initially natural additives and flavors were not given CAS registry numbers; however, because these ingredients are now regularly used in manufacturing, many have been assigned CAS registry numbers.

Flavors made of multiple chemicals will have a separate CAS registry number for each chemical in that compound.

Why must CAS numbers be included with the Ingredient Report?

CAS numbers are required to properly identify and reduce ambiguity among ingredients used in tobacco products. This is particularly important, as an ingredient with a common name may have different chemical names and thus, different CAS assignments. An example of this is sugar, whose chemical names can be fructose, glucose, or sucrose.

Do I have to report information that is trade secret or confidential?

Yes, the U.S. Congress gave full weight and consideration to the sensitive nature of tobacco ingredients in drafting FCLAA and CSTHEA. The list of ingredients added to tobacco in the manufacture of cigarettes and smokeless tobacco products and the specification of the quantity of nicotine contained in each smokeless tobacco product received by CDC, OSH under 15 U.S.C. Section 1335a(a) of FCLAA and 15 U.S.C. Section 4403(a)(1)(A) and (B) of CSTHEA are generally trade secret or confidential information subject to section 552(b)(4) of Title 5external icon. However, 15 U.S.C. Section 1335a(2)(B) of FCLAA and 15 U.S.C. Section 4403(b)(2)(B) of CSTHEA do not authorize the withholding of the list of ingredients from any duly authorized subcommittee or committee of the Congress. If a subcommittee or committee of the Congress requests the Secretary of HHS to provide it such a list, the Secretary of HHS or a representative of CDC will make the list available to the subcommittee or committee and shall, at the same time, notify in writing the person who provided the list of such request.

What steps does CDC take to secure confidential information?

A limited number of staff has access to confidential information [PDF–117 KB]. Each of these persons has signed a pledge of confidentiality and these statements along with a list of their names are located in a locked safe. Additionally, the list of ingredients and the specification of the quantity of nicotine are secured in a locked safe located in a locked office. Electronic information is stored on a removable hard drive also kept in the safe. Further, OSH redacts privileged, proprietary, and confidential information from public files.

How does a manufacturer, packager, or importer submit an Ingredient Report or Nicotine Report?

CDC requests all submissions be provided on letterhead of the manufacturer, packager, importer, or designated individual or entity. They may be mailed or faxed; however, a faxed copy should be accompanied by a mailed original. Because CDC cannot ensure the confidentiality of information submitted via E-mail, this is not an acceptable format. In addition, CDC no longer accepts submissions transmitted on CD, 3-inch floppy disk, and/or thumb drive.

- Contact information for submissions to
- Recommended Formats for Reporting

Must the designated individual disclose the identity of its clients when submitting an Ingredient Report and/or Nicotine Report?

Yes. Under 15 U.S.C. Section 1335a(a) of FCLAA and 15 U.S.C. Section 4403(a)(2) of CSTHEA a person or group of persons required to provide a list of ingredients and a specification of the quantity of nicotine may designate an individual or entity to provide the above-referenced lists required by these federal laws. In the event that another individual or entity is designated to submit the required information, such as an attorney acting on behalf of a manufacturer or importer; or a manufacturer acting on behalf of an importer, that individual or entity should clearly state the name of the company for whom the information is being submitted.

Must an Ingredient Report be submitted if there have been no changes in the list of ingredients added to the tobacco products?

If there have been no changes to the ingredient list in the previous calendar year, the manufacturer, packager, importer, or designated individual or entity as addressed above may submit a letter stating that there have been no changes in the list of ingredients added to the tobacco products along with a copy of the original submission.

Must an Ingredient Report be submitted if no ingredients have been added?

In order to confirm whether or not a manufacturer, packager, or importer is compliant with FCLAA or CSTHEA, a statement should be submitted in writing if no ingredients are added to tobacco in the manufacture of cigarettes or smokeless tobacco.

What if I am an importer and the manufacturer will not provide me with the list of ingredients?

The manufacturer of the tobacco product or of the flavoring added to the tobacco products may submit a list of ingredients and/or a specification of the quantity of nicotine contained in the smokeless tobacco product directly to CDC on behalf of the importer. As with any submission, the list of ingredients and the specification of the quantity of nicotine shall be treated as trade secret or confidential information [PDF–117 KB] subject to section 552(b)(4) of Title 5, United States Code and "shall not be revealed... to any person other than those authorized by the Secretary in carrying out their official duties under this section."

- Contact information for submissions to OSH
- Recommended Formats for Reporting

What happens after I submit the Ingredient Report?

Once the accuracy of the submitted information is verified, CDC will issue a certificate of compliance for that calendar year. If missing data or errors are noted (e.g., an invalid or missing CAS registry number), a letter will be sent requesting clarification of the submission within 60 days.

The process of verifying an Ingredient Report and providing a response may take several weeks. Frequently, however, this process only takes a few days, although this can vary depending on the complexity and completeness of submissions. If the Ingredient Report contains many errors, the process may become more lengthy.

Are there other federal agencies responsible for collecting information under FCLAA?

Yes. While this is not an exhaustive list of federal agencies that are responsible for tobacco-related matters, the Federal Trade Commission's (FTC) Division of Advertising Practices is responsible for reviewing and approving health warning label plans for all cigarette and smokeless tobacco products, whether manufactured domestically or abroad, that enter the U.S. stream of commerce.

Are there any other federal agencies with whom I may need to interact?

Yes. While this is not an exhaustive list, other agencies with whom you may need to interact include the Federal Trade Commission (FTC); the Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF); Alcohol and Tobacco Tax and Trade Bureau (TTB); and U.S. Customs.

Are there penalties for failing to comply with FCLAA or CSTHEA?

Yes. According to 15 U.S.C. §1338 [–121 KB] PDF "Any person who violates the provisions of this chapter shall be guilty of a misdemeanor and shall on conviction thereof be subject to a fine of not more than $10,000." 15 U.S.C. Section 4404 has a similar penalty provision.

Does FCLAA or CSTHEA preempt state and local initiatives?

Yes, both laws contain some preemptive provisions, however they do not preempt stricter state-level requirements regarding the submission of ingredient information. 15 U.S.C. 1334(a)-(b), of FCLAA reads:

(a) Additional statements

No statement relating to smoking and health, other than the statement required by section 1333 of this title, shall be required on any cigarette package.

(b) State regulations

No requirement or prohibition based on smoking and health shall be imposed under State law with respect to the advertising or promotion of any cigarettes the packages of which are labeled in conformity with the provisions of this chapter.

And the CSTHEA, 15 U.S.C. §4406(a)-(c), states:

(a) Federal action

No statement relating to the use of smokeless tobacco products and health, other than the statements required by section 4402 of this title, shall be required by any Federal agency to appear on any package or in any advertisement (unless the advertisement is an outdoor billboard advertisement) of a smokeless tobacco product.

(b) State and local action

No statement relating to the use of smokeless tobacco products and health, other than the statements required by section 4402 of this title, shall be required by any State or local statute or regulation to be included on any package or in any advertisement (unless the advertisement is an outdoor billboard advertisement) of a smokeless tobacco product.

(c) Effect on liability law

Nothing in this chapter shall relieve any person from liability at common law or under State statutory law to any other.

Key terms and definitions

Chemical Abstract Service (CAS) Number

CAS is the acronym for the Chemical Abstract Service registry number. Each chemical compound has a unique CAS number for purposes of identification, assigned by the American Chemical Society. A CAS registry is available from the National Institutes of Health National Library of Medicine.

Cigarette

According to U.S. Code 15 USC § 1332(1), the term “cigarette” means— (A) any roll of tobacco wrapped in paper or in any substance not containing tobacco, and (B) any roll of tobacco wrapped in any substance containing tobacco which, because of its appearance, the type of tobacco used in the filler, or its packaging and labeling, is likely to be offered to, or purchased by, consumers as a cigarette described in subparagraph (A).

Compliant

A manufacturer, packager, or importer has successfully submitted an Ingredient Report that lists each ingredient with their proper chemical name and CAS registry number, and, as applicable, a specification of the quantity of nicotine in smokeless tobacco products.

Comprehensive Smokeless Tobacco Health Education Act (CSTHEA)

The Comprehensive Smokeless Tobacco Health Education Act (CSTHEA), Public Law 98–252, was passed in 1986 to inform the public of any dangers to human health resulting from the use of smokeless tobacco products. CSTHEA requires, in part, that each person who manufactures, packages, or imports smokeless tobacco products to annually submit to the Department of Health and Human Services the list of ingredients added to tobacco in the manufacture of smokeless tobacco products as well as a specification of the quantity of nicotine contained in each smokeless tobacco product.

Federal Cigarette Labeling and Advertising Act (FCLAA)

The Federal Cigarette Labeling and Advertising Act (FCLAA), Public Law 89–92, is a statute that was designed to “establish a comprehensive federal program to deal with cigarette labeling and advertising with respect to any relationship between smoking and health.” In 1984, this Act was amended by PL 98–474, the Comprehensive Smoking Education Act, 15 U.S.C. § 1335a(a) to in part provide the Department of Health and Human Services with a list of the ingredients added to tobacco in the manufacture of cigarettes.

Inactive

A company that, to our knowledge, is no longer manufacturing, packaging, or importing tobacco products.

Ingredient Report

A list of ingredients and their corresponding CAS numbers that are added to tobacco in the manufacture of cigarettes and smokeless tobacco products during the previous calendar year.

Nicotine Report

A specification of the quantity of nicotine (total nicotine, un-ionized nicotine, total moisture, and pH) contained in smokeless tobacco products from the previous calendar year.

Noncompliant

A manufacturer, packager, or importer has failed to provide the annual Ingredient Report (and as applicable, Nicotine Report for smokeless tobacco) by the March 31 deadline or upon initial import, and/or failed to correct inadequacies or errors in a submission within 60 days of notification of these errors.

Smokeless Tobacco

The Comprehensive Smokeless Tobacco Health Education Act (CSTHEA), 15 U.S.C. §4408, defines smokeless tobacco as “any finely cut, ground, powdered, or leaf tobacco that is intended to be placed in the oral cavity.”

SOURCES

CONTENT SOURCE:
National Center for Chronic Disease Prevention and Health Promotion; Office on Smoking and Health

FOOTNOTES

A. Reporting of nicotine applies to smokeless tobacco only.

EXHIBIT 16

Due to current HHS restructuring, the information provided on aspe.hhs.gov is not being updated currently. Please refer to hhs.gov for more information.

An official website of the United States government Here's how you know

U.S. Department of Health and Human Services

ASPE
OFFICE OF THE ASSISTANT SECRETARY
FOR PLANNING AND EVALUATION

MENU

Poverty Guidelines

The 2025 poverty guidelines will be on public display at the Federal Register tomorrow and will be published in the next few days.

The Poverty Guidelines API is now available with the 2025 data.

U.S. Federal Poverty Guidelines Used to Determine Financial Eligibility for Certain Programs

HHS Poverty Guidelines for 2025

Join our listserv to stay up-to-date on the latest news regarding the poverty guidelines.

2025 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA	
Persons in family/household	**Poverty guideline**
1	$15,650
2	$21,150
3	$26,650

2025 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA	
Persons in family/household	**Poverty guideline**
4	$32,150
5	$37,650
6	$43,150
7	$48,650
8	$54,150
For families/households with more than 8 persons, add $5,500 for each additional person.	

2025 POVERTY GUIDELINES FOR ALASKA	
Persons in family/household	**Poverty guideline**
1	$19,550
2	$26,430
3	$33,310
4	$40,190
5	$47,070
6	$53,950
7	$60,830

2025 POVERTY GUIDELINES FOR ALASKA	
Persons in family/household	**Poverty guideline**
8	$67,710
For families/households with more than 8 persons, add $6,880 for each additional person.	

2025 POVERTY GUIDELINES FOR HAWAII	
Persons in family/household	**Poverty guideline**
1	$17,990
2	$24,320
3	$30,650
4	$36,980
5	$43,310
6	$49,640
7	$55,970
8	$62,300
For families/households with more than 8 persons, add $6,330 for each additional person.	

Resources

- Prior Poverty Guidelines and Federal Register References
- A chart with percentages (e.g., 125 percent) of the guidelines (PDF)
- Frequently Asked Questions (FAQs) on the Poverty Guidelines and Poverty

- Poverty guidelines — gross or net income
- The poverty line for a state or city
- The number of poor people in a state or city
- How the poverty line was developed

- Further Resources on Poverty Measurement, Poverty Lines, and Their History
- ASPE research on poverty
- The Census Bureau's Poverty Home Page

The separate poverty guidelines for Alaska and Hawaii reflect Office of Economic Opportunity administrative practice beginning in the 1966-1970 period. Note that the poverty thresholds — the original version of the poverty measure — have never had separate figures for Alaska and Hawaii. The poverty guidelines are not defined for Puerto Rico, the U.S. Virgin Islands, American Samoa, Guam, the Republic of the Marshall Islands, the Federated States of Micronesia, the Commonwealth of the Northern Mariana Islands, and Palau. In cases in which a Federal program using the poverty guidelines serves any of those jurisdictions, the Federal office which administers the program is responsible for deciding whether to use the contiguous-states-and-D.C. guidelines for those jurisdictions or to follow some other procedure.

The poverty guidelines apply to both aged and non-aged units. The guidelines have never had an aged/non-aged distinction; only the Census Bureau (statistical) poverty thresholds have separate figures for aged and non-aged one-person and two-person units.

Programs using the guidelines (or percentage multiples of the guidelines — for instance, 125 percent or 185 percent of the guidelines) in determining eligibility include Head Start, the Supplemental Nutrition Assistance Program (SNAP), the National School Lunch Program, the Low-Income Home Energy Assistance Program, and the Children's Health Insurance Program. Note that in general, cash public assistance programs (Temporary Assistance for Needy Families and Supplemental Security Income) do NOT use the poverty guidelines in determining eligibility. The Earned Income Tax Credit program also does NOT use the poverty guidelines to determine eligibility. For a more detailed list of programs that do and don't use the guidelines, see the Frequently Asked Questions (FAQs).

The poverty guidelines (unlike the poverty thresholds) are designated by the year in which they are issued. For instance, the guidelines issued in January 2025 are designated the 2025 poverty guidelines. However, the 2025 HHS poverty guidelines only reflect price changes through calendar year 2024; accordingly, they are approximately equal to the Census Bureau poverty thresholds for calendar year 2024. (The 2024 thresholds are expected to be issued in final form in September 2025; the Census Bureau normally makes available a preliminary version of the thresholds early each calendar year.)

The poverty guidelines may be formally referenced as "the poverty guidelines updated periodically in the Federal Register by the U.S. Department of Health and Human Services under the authority of 42 U.S.C. 9902(2)."

There are two slightly different versions of the federal poverty measure: poverty thresholds and poverty guidelines.

The **poverty thresholds** are the original version of the federal poverty measure. They are updated each year by the **Census Bureau**. The thresholds are used mainly for statistical purposes — for instance, preparing estimates of the number of Americans in poverty each year. (In other words, all official poverty population figures are calculated using the poverty thresholds, not the guidelines). Poverty thresholds since 1973 (and for selected earlier years) and weighted average poverty thresholds since 1959 are available on the Census Bureau's Web site. For an example of how the Census Bureau applies the thresholds to a family's income to determine its poverty status, see "How the Census Bureau Measures Poverty" on the Census Bureau's web site.

The **poverty guidelines** are the other version of the federal poverty measure. They are issued each year in the Federal Register by the **Department of Health and Human Services** (HHS). The guidelines are a simplification of the poverty thresholds for use for **administrative** purposes — for instance, determining financial eligibility for certain federal programs.

The poverty guidelines are sometimes loosely referred to as the "federal poverty level" (FPL), but that phrase is ambiguous and should be avoided, especially in situations (e.g., legislative or administrative) where precision is important.

Key differences between poverty thresholds and poverty guidelines are outlined in a table under Frequently Asked Questions (FAQs). See also the discussion of this topic on the Institute for Research on Poverty's web site.

The January 2025 poverty guidelines are calculated by taking the 2023 Census Bureau's poverty thresholds and adjusting them for price changes between 2023 and 2024 using the Consumer Price Index (CPI-U). The poverty thresholds used by the Census Bureau for statistical purposes are complex and are not composed of standardized increments between family sizes. Since many program officials prefer to use guidelines with uniform increments across family sizes, the poverty guidelines include rounding and standardizing adjustments.

FILES

Chart Showing different multiples of the poverty guidelines for 2025 (xlsx, 57.76 KB)

Chart showing different multiples of the poverty guidelines for 2025 (pdf, 199.84 KB)

Chart showing different multiples of the poverty guidelines for prior years (xlsx, 48.64 KB)

Historical Poverty Guidelines through 2024 (xlsx, 44.95 KB)

Poverty Guidelines

Prior HHS Poverty Guidelines and Federal Register References

Frequently Asked Questions

Further Resources

Mollie Orshansky

Poverty Guidelines API

Poverty Estimates, Trends, and Analysis

Marginal Tax Rates/Benefit Cliffs

Paid Family Leave

Program Participation

Return to top

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EXHIBIT 17

AGENCY PROFILE

Department of Health and Human Services (HHS)

Filter by: FY 2024

Overview | Status of Funds | Award Spending

Department of Health and Human Services (HHS)

Overview

Data through 9/29/2024

Agency Mission

It is the mission of the U.S. Department of Health & Human Services (HHS) to enhance and protect the health and well-being of all Americans. We fulfill that mission by providing for effective health and human services and fostering advances in medicine, public health, and social services.

Website

https://www.hhs.gov/

Congressional Justification of Budget (CJ)

https://www.hhs.gov/cj

FY 2024 Summary

Data through 9/29/2024

How much funding is available to this agency?

$2.86 Trillion in budgetary resources

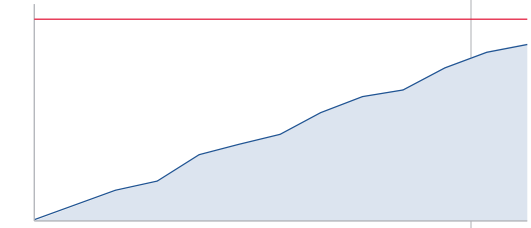
23.4% of the FY 2024 U.S. federal budget

Total Budgetary Resources Over Time

How much has this agency planned to spend?

$2.52 Trillion in total obligations

87.9% of total budgetary resources

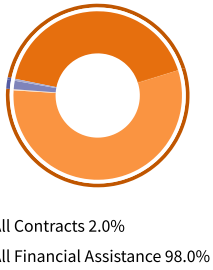


Total Obligations Over Time

How much has this agency planned to spend on awards?

$1.85 Trillion in award obligations

73.6% of total obligations



Award Obligations by Type

Status of Funds

Data through 9/29/2024

How was funding distributed in FY 2024 for Department of Health and Human Services (HHS)?

Each year federal agencies receive funding from Congress, known as **budgetary resources**. In FY 2024, the Department of Health and Human Services (HHS) had $2.86 Trillion distributed among its 14 sub-components. Agencies spend available budgetary resources by making financial promises called **obligations**. In this section, we show the total budgetary resources broken out by agency sub-component and how much of that funding has been obligated for the fiscal year selected.

We also show **outlays** for each agency sub-component, or the amount of money that has actually been paid out and not just promised ("obligated"). Note that outlays for any given year are not a subset of the agency's obligations for that year since agencies can pay out funds related to obligations from previous years.

Select a segment in the chart below to dive deeper into the data.

PARENT AGENCY

Department of Health and Human Services (HHS)

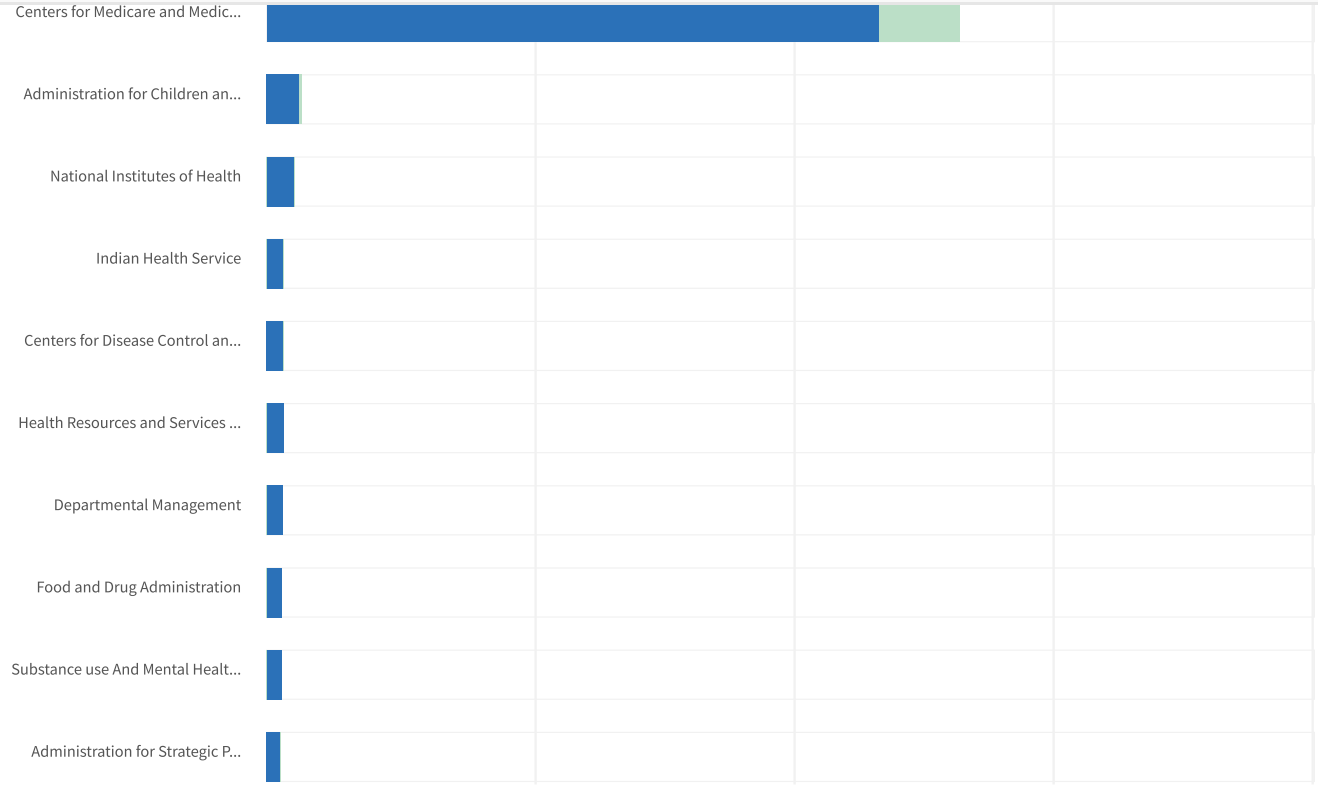
$2.52T committed of **$2.86T** Total Budgetary Resources

AGENCY PROFILE

Department of Health and Human Services (HHS)

Filter by:

Overview | Status of Funds | Award Spending



1 2

1-10 of 14 results

NOTE: The agency sub-components displayed in this section were added to provide greater transparency into the organization of agencies' account data. These sub-components are based on the Bureau associated with a federal account in OMB's Master Accounts Title file. Sub-components are identified using Agency Identifier (AID) and MAIN Account codes. Where possible, Department of Defense (DoD) sub-components correspond to the branches of the Armed Forces and accounts for the agency are attributed to the appropriate branch/sub-component based on the Agency Codes found at the bottom of OMB Circular A-11 Appendix C.

Award Spending

Data through 9/30/2024

How much is Department of Health and Human Services (HHS) spending on contracts and financial assistance?

Federal agencies use some portion of their **budgetary resources** for awards to recipients in the form of contracts and financial assistance. Each award consists of a roll-up of individual **transactions**, including transactions that obligate money. In this section, we show which sub-agencies of Department of Health and Human Services (HHS) have issued awards through different types of contracts or financial assistance and how much each sub-agency has obligated (promised to spend).

All Awards | Contracts | Contract IDVs | Grants | Loans | Direct Payments | Other Financial Assistance

Award Obligations	Number of Transactions	Number of New Awards
$1.85 Trillion	378,022	62,118

AGENCY PROFILE

Department of Health and Human Services (HHS)

Filter by:

Overview Status of Funds Award Spending

	Administration for Children and Families	[illegible]	[illegible]	[illegible]
>	National Institutes of Health	$42,677,168,551	167,969	27,844
>	Centers for Disease Control and Prevention	$13,280,261,057	49,750	2,867
>	Health Resources and Services Administration	$12,830,329,509	52,152	8,819
>	Substance Abuse and Mental Health Services Administration	$6,859,238,292	15,752	1,285
>	Office of Assistant Secretary for Preparedness and Response	$6,353,328,714	2,089	387
>	Indian Health Service	$5,975,775,791	20,814	5,348
>	Administration for Community Living	$2,436,601,302	15,072	1,770
>	Food and Drug Administration	$1,960,364,292	6,302	1,594

< 1 2 >

1-10 of 15 results

NOTE: The sub-agencies presented in this section represent awarding organizations and were sourced from the General Services Administration (GSA) Federal Hierarchy (available at https://sam.gov/content/hierarchy). This award hierarchy establishes the relationship between a department or independent agency's sub-tiers and its offices and is used by federal agencies as the authoritative source for managing federal funding and awarding organizations.

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AGENCY PROFILE

Department of Health and Human Services (HHS)

Filter by:

Overview Status of Funds Award Spending

Mission

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EXHIBIT 18

motherjones.com

Mass HHS firings gutted "vital" office for reproductive health

Kiera Butler and Anna Merlan

11–14 minutes

Trump, holding babies on the campaign trail in 2016, has promised to support pregnant women and expand access to IVF—but the Department of Health and Human Services fired many of the people who do both. Stacie Scott/The Gazette/AP

Get your news from a source that’s not owned and controlled by oligarchs. Sign up for the free *Mother Jones Daily*.

One of the casualties of Tuesday’s massive purge of workers from the Department of Health and Human Services (HHS) is an office

dedicated to promoting healthy pregnancies. Most of the more than 100 employees at the Division of Reproductive Health lost their jobs this week, including some who conduct work mandated by federal law, according to seven former staffers who provided *Mother Jones* with the most complete public overview of its inner workings to date.

> "How does cutting this program support the administration's position? I don't understand at all."

The move runs afoul of President Donald Trump's and members of his administration's pledge to prioritize healthy pregnancies and family planning. The mass purge came less than a week after Trump, at a Women's History Month event at the White House, promised to be "the fertilization president." And in January, at the anti-abortion March for Life, Trump said he would "work to offer a loving hand to new mothers and young families" and "protect women and vulnerable children."

Experts and former staff say the latest firings will halt the IVF and family planning work Trump campaigned on.

The CDC's reproductive health division functioned as "a key source of support for maternal and child health programs nationwide," Elizabeth Kielb, director of maternal and infant health at March of Dimes, a nonprofit organization focused on maternal and infant health, said in a post on LinkedIn. "Cuts to this division risk disrupting prenatal care, contraception access, and efforts to reduce maternal and infant mortality."

Kielb added: "Additionally, state and local health departments will now face added burdens without the federal backing they've relied on for decades. The ability to monitor, research, and improve

reproductive health outcomes is at risk.”

Some of the former officials told *Mother Jones* they hope their firings will be reversed after Robert F. Kennedy Jr. admitted Thursday to ABC News that some HHS firings were mistakes. An HHS official told *Mother Jones*, “Critical CDC programs will continue as a part of Secretary Kennedy’s vision to streamline HHS to better serve the American people,” but did not respond to specific questions about the Division of Reproductive Health. Spokespeople for the White House did not respond to questions from *Mother Jones* by Friday morning for this story. The division had an estimated $99 million budget as of fiscal year 2023, according to an internal document.

Employees of the division who received reduction in force (RIF) notices included the approximately 40-person women’s health and fertility branch, which included a team working on assisted reproductive technology (ART). Trump campaigned on expanding access to in vitro fertilization (IVF), the most common type of ART. In February, he signed an executive order demanding “a list of policy recommendations on protecting IVF access and aggressively reducing out-of-pocket and health plan costs for IVF treatment.” But, by eliminating the six-person ART team at the reproductive health division, Trump is stopping the very work he promised to promote.

The ART team collected data from assisted reproductive technology clinics on their pregnancy success rates, as mandated by Congress in 1992, and maintained a nationwide database of clinics. The team also produced an online tool people could use to estimate their success of IVF and was in the middle of researching how to make treatments cheaper through state-mandated

insurance, according to a former team member. “I don’t know if anyone else [in the federal government] that has the expertise that our team does,” the former staffer said. “How does cutting this program support the administration’s position? I don’t understand at all.”

Barbara Collura, president and CEO of RESOLVE: The National Infertility Association, said in a statement that as a result of the firings, “there will be no experts on infertility who will be able to inform public policy, brief members of Congress, publish articles and reports, and advance public awareness on the causes and treatments for infertility.” Micah Hill, president of the Society for Assisted Reproductive Technology, which worked with the CDC team, called their work “vital to the field of reproductive medicine.”

“Dismantling PRAMS will make America less healthy, not more.”

The women’s health and fertility branch also included a team that collected national data about maternal and infant health outcomes through the Pregnancy Risk Assessment Monitoring Program (PRAMS). The massive, nearly 40-year-old annual survey collects anonymized information about peoples’ health and access to doctors before, during, and after their pregnancies, which state officials and health care providers then use to improve health outcomes. Researchers also use it to investigate promising interventions. As of 2020, the survey data represented more than 80 percent of births, with all but three states participating, HHS said.

Two members of the PRAMS team, which former staffers said consisted of about 15 people, told *Mother Jones* getting RIF notices and being fired came as a shock. “Our team is basically

considered the gold standard for survey data collection,” Isaac Michael, a mathematical statistician on the team, said.

Michael says that while support for PRAMS should be bipartisan, it should also be a particular priority for the Trump administration, given that Vice President JD Vance and Trump’s sidekick, Elon Musk, have said they want to encourage more Americans to have more kids.

“This data will directly help their agenda,” Michael said. “If Republicans are interested in decreasing the infant and maternal mortality rates and increasing fertility rates, we have those variables. You can’t make any solid decisions without the data, and we’re the ones with the data.” Without the state-level data, another former PRAMS team member added, federal officials “won’t know where the funding for necessary resources have to go, and that will put women and infants at risk.”

Last month, a group of congresspeople wrote to CDC Acting Director Susan Monarez—now the new nominee tapped to replace Dave Weldon, whose nomination was withdrawn—raising their concerns of the potential loss of PRAMS under the reorganization of HHS, noting its “increasing importance as the US is experiencing a maternal health crisis.” But it’s unclear if Monarez ever responded to that letter, and spokespeople for the senator’s offices did not respond to questions from *Mother Jones* on Thursday night.

Laura Lindberg, a professor at the Rutgers School of Public Health, has used the PRAMS data in her own research on unintended pregnancy and in her classes as a teaching tool. “Abruptly shutting down PRAMS jeopardizes women and infants

health at a time when maternal mortality rates in the US have been rising and access to maternity care is increasingly difficult,” Lindberg told me. “Dismantling PRAMS will make America less healthy, not more.”

The approximately ten-person fertility epidemiology studies team was also eliminated from the women’s health and fertility branch, according to an official. That team wrote the CDC’s contraception guidance for healthcare providers and conducted the annual abortion surveillance report, which collects voluntary data about legal abortions (and which, despite the cuts Trump is imposing, Project 2025 advocates for expanding).

A former official familiar with the team’s work said it was especially critical in light of mounting threats to contraception and increasing abortion restrictions nationwide. “We need guidance like this so that clinicians across the country can help women to make the best decisions for themselves—especially at a time when the ability to make those decisions is being threatened,” the official said.

Everyone in the reproductive health division’s field support branch was also fired, which included an approximately eight-person team that worked on providing guidance on the needs of pregnant and postpartum people and infants in emergencies, such as COVID-19, Zika, and Ebola, all of which posed particular risks for pregnant women.

That team’s work was mandated by Congress, which has repeatedly reauthorized a law first passed in 2006 requiring that HHS take pregnant women and other vulnerable populations into account when planning emergency responses.

“Pregnant, postpartum, lactating women have very special needs in emergencies,” the former official told me. “If they’re pregnant, they need to have continued access to prenatal care; if they’re postpartum or lactating, they potentially need assistance with feeding their infants or postpartum care.” The former official believes the firings of the emergency response team were “an unintended casualty,” adding, “I don’t think they realized it when they cut the entire branch.”

The field support branch also had a team of about a dozen senior CDC epidemiologists who deployed to state health departments to improve reproductive health, youth mental health, and healthcare access for parents and infants, in part by training more junior staffers in those fields. Prior participants helped establish state Maternal Mortality Review Committees, collected state-level data about COVID-19 in pregnant people, and worked to increase the enrollment of families on food stamps, according to an internal document describing the program.

“Many state and local health departments are understaffed and overworked, so they do not have the capacity to take on more focused research on topics like reproductive health, maternal health, and infant and child health,” a former scientist in the division said. “Cutting the entire branch will cause maternal and child health in those states and territories to worsen.”

The CDC only pays for 20 percent of the program, and states are responsible for paying for the rest—so it’s unclear why the program was targeted for termination.

The only team of the reproductive health division that remains is maternal and infant health branch, which works on tracking and

preventing maternal and infant mortality. According to HHS, a new, so-called “Administration for a Healthy America” agency will take over maternal and child health issues. The fired staffers said they were glad that team will remain, given the maternal mortality crisis in the US, which ranks the highest among all wealthy nations and is worsening in light of expanding abortion bans. But, even so, the fate of that team remains unclear. “There’s a lot of unknowns, even for the programs that have survived,” one of the former officials said.

Michael, the statistician who was on the PRAMS team, knows one thing for sure: This was not what he signed up for when he voted for Trump. “I agree with a lot of the Trump administration,” he said. “But I think our team fell through the cracks, and I’ve got to advocate for it, because it’s important.”

Update, April 4: This story has been updated with a comment from an HHS official.

EXHIBIT 19

NewsRoom

4/2/25 AP Alerts 12:57:04

AP Alerts
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April 2, 2025

Mass layoffs rattle Head Start leaders already on edge over funding problems

The Associated Press

WASHINGTON

WASHINGTON (AP) — The problems for Head Start began days after President Donald Trump took office.

Trump's administration announced it would freeze federal grants — the primary funding for the early education program that serves more than half a million low-income children. Then came glitches with the funding website that forced nearly two dozen Head Start centers to close temporarily .

Even after the funding freeze was aborted — and the website was restored — those who run the programs remained on edge. On Tuesday, the administration gave them another reason to worry: mass layoffs .

Scores of government employees who help administer Head Start, which is federally funded but run by schools and nonprofits, have been put on leave. Preschool operators say they have received no communication from the Office of Head Start and don't know who to turn to if they have questions about grants or need the office to sign off on equipment expenditures.

They fear the program, which serves some of the nation's neediest kids and families , could fall victim to the Trump administration's sweeping cuts.

Head Start was started six decades ago as part of President Lyndon B. Johnson's War on Poverty. While the early childhood program has enjoyed bipartisan support since then, some Republicans have emphasized its shortcomings and criticized efforts to increase funding. And Project 2025, the policy blueprint created by the conservative Heritage Foundation, called for eliminating Head Start altogether.

Joel Ryan, head of the Washington State Association of Head Start, said he is worried the administration is slowly dismantling the program without outright eliminating it. "It doesn't have to be from an act of Congress," Ryan said. "You can kneecap programs simply by cutting significant numbers of their workforce."

Preschools say they need federal staff

Head Start operates in all 50 states, helping families who are homeless or are in poverty. Parents who otherwise would not be able to afford child care rely on it when they work or go to school. Supporters say that underscores the importance of Head Start to the economy and at-risk children alike.

At least five of the 12 regional offices for Head Start were closed Tuesday as part of layoffs at the Department of Health and Human Services, according to the National Head Start Association. While individual preschools' funding remains unchanged, the association's statement said the cuts happened without a "clear plan for how the administration intends on supporting Head Start."

Some worry Head Start will become partisan.

"What I don't want Head Start to be is a political football," said Rhett Cecil, executive director of the Indiana Head Start Association. "Because a Republican household, a Democratic household, a libertarian household could be a Head Start household."

In mid-March, Health Secretary Robert F. Kennedy Jr., whose department oversees Head Start, visited a Head Start in Alexandria, Virginia, praising the program and its staff.

"I had a very inspiring tour," Kennedy said in a video on his department's Instagram account. "They're getting the kind of education and socialization that they need."

Still, advocates worry the GOP's efforts to slash the federal budget will ensnare programs like Head Start.

Already, the staff layoffs have caused concerns. Head Start preschools in Washington state had been awaiting approval to replace downed fencing around a playground and to purchase a refrigerator for a center. Ryan said he fears some operators will lose funding because grant applications won't get processed.

Panic, then closures

The preschools are deeply reliant on federal money. During the brief hold on federal grants, no program was impacted more immediately. Unable to make payroll the day of the freeze, several Head Start centers temporarily closed — cutting off child care for low-income families, for whom a day without work is often a day without pay .

The news about the funding freeze emerged in January as Head Start leaders from across the country were together at the Capital Hilton, a few blocks away from the White House, preparing to meet with Congress members. Gathered in a conference room, many leaders simultaneously realized they were locked out of their funds.

"You could almost feel ... the wave of panic all over the room when I think we all realized at the same time that everyone was locked out of that payment management system," said Chanda Hillman, executive director of Early Flowers Learning. The group operates 17 Head Start campuses in rural parts of southwestern Michigan.

A few hours later, Hillman had to make the call: She would shut down the Early Flowers Learning campuses.

Kahli Lorenz, whose daughter attends Early Flowers, had traveled with Hillman to D.C. as part of a parent advisory council. She had been reeling at the possibility her daughter would have no place to go the following day — or that her beloved preschool would close. So when Lorenz heard Hillman make the announcement, she fell apart.

Both she and her husband work — and she was out of town. Without Head Start the next day, he would miss half of his shift — and half of his pay — at the factory where he works. But she thought of all of her daughter's classmates, and all the parents like her who might not be able to work without Head Start.

"That meant all of the families were not going to have anywhere to have their kids," she said.

'They cannot go to work'

Halfway across the country, Cecil of the Indiana Head Start Association learned about the reported freeze from a Head Start director, and immediately began to fret. The closure of Head Start centers across the state would leave

families in a pinch. But he also worried about those who would be furloughed — Head Start is Indiana's 78th largest employer with nearly 4,000 staff.

Not long after came another confusing piece of news: Head Start was never supposed to be a part of the funding freeze. So why, Head Start directors wondered, had they been shut out of the funding portal? Asked about the pause, the Department of Health and Human Services responded with an automatic message that said it was freezing all communication.

Even after the freeze was aborted and the Head Start portal was supposed to be fixed, many centers discovered they still could not access their funds. A week later, at least 45 grant recipients across the country were still locked out, and many were on the verge of closure. In Waukesha, Wisconsin, Head Start programs shut their doors and furloughed most of their staff. The programs would not reopen until the following week when their leaders could access the funds.

Unable to make payroll, two Head Start centers that served rural communities in western New York shut their doors, laying off 84 employees and leaving the families of more than 200 children without care. They would not reopen until Feb. 10, when they were finally able to draw down funds.

Head Start leaders said members of Congress from both parties were in touch during the crisis, working to get them answers.

For Hillman, it raised hope that Head Start will continue to enjoy bipartisan support — even if some conservatives oppose it.

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Cheyanne Mumphrey contributed reporting from Phoenix, Arizona.

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---- Index References ----

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Region: (Americas (1AM92); Indiana (1IN12); North America (1NO39); U.S. Midwest Region (1MI19); U.S. West Region (1WE46); USA (1US73); Washington (1WA44); Wisconsin (1WI54))

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Word Count: 1238

End of Document

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NewsRoom

EXHIBIT 20

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF RHODE ISLAND

STATE OF NEW YORK, et al., Plaintiffs, v. ROBERT F. KENNEDY, JR., in his official capacity as SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., Defendants.	Case No. 1:25-cv-00196-MRD-PAS

DECLARATION OF LEONARD F. PERUSKI

I, Leonard F. Peruski, PhD, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the foregoing is true and correct:

1. I am the Director of the Wadsworth Center of the New York State Department of Health ("Wadsworth Center" or "Wadsworth"). I am familiar with the information in the statements set forth below either through personal knowledge, in consultation with the New York State Department of Health staff, or from documents that have been provided to and reviewed by me.

2. I submit this Declaration in support of the States' Motion for a Preliminary Injunction.

Professional Background

3. I am the Director of the Wadsworth Center. My career in public health has spanned the past thirty years. Before joining Wadsworth in May 2023, I led international laboratory operations for the Centers for Disease Control and Prevention (CDC), an operating division of the U.S. Department of Health and Human Services (HHS).

4. During my time at the CDC, I served as the agency lead in Nigeria during the Ebola outbreak in West Africa and was deployed extensively during outbreaks in southeast Asia for anthrax, botulism and influenza, and across Latin American for Zika and Chikungunya viruses. I previously spent seventeen years stationed overseas developing sustainable laboratory capacity and guiding laboratory-centric public health research in more than seventy countries. I also worked to support several significant domestic public health responses, including as commander of the U.S. military team deployed to New York City in the aftermath of the 2001 anthrax attack, and leading the military team that provided biodefense testing at the 2002 Winter Olympics in Salt Lake City.

5. I have authored or co-authored over 70 publications in peer-reviewed scientific journals on the pathology of specific infectious diseases, as well as laboratory management.

6. The Wadsworth Center is a science-based community committed to protecting and improving the health of New Yorkers through laboratory analyses, investigations and research, as well as laboratory certification and educational programs. Wadsworth Center scientists:

a. Study ongoing public health issues, from drug resistance to emerging infections and environmental exposures;

b. Investigate basic biological processes that contribute to human health and disease; and

c. Employ modern methods, such as next generation sequencing technologies, and other state-of-the-art technologies, for clinical testing and public health research.

7. The Wadsworth Center is also New York State's public health reference laboratory. As such, Wadsworth Center:

a. Responds to urgent public health threats as they arise, from bioterrorism and chemical threats to SARS to synthetic cannabinoids to Legionella outbreaks;

b. Develops advanced methods to detect microbial agents and genetic disorders; and

c. Develops new methods and uses advanced accredited methods to monitor toxic environmental contaminants in drinking water, food, and human samples.

8. In addition, the Wadsworth Center:

a. Operates the most comprehensive laboratory licensure and oversight programs for clinical and environmental laboratories, and blood and tissue banks;

b. Trains the next generation of scientists through programs for doctoral, master's, and undergraduate students, as well as specialized training for postdoctoral fellows and others;

c. Maintains Clinical Laboratory Permits for three clinical laboratories: the David Axelrod Institute; the Biggs Laboratory; and the Griffin Laboratory; and

d. Maintains accreditation as an environmental testing laboratory at the Biggs Laboratory and David Axelrod Institute.

9. Moreover, the Wadsworth Center maintains and operates a Biosafety Level (BSL) 3 Laboratory.

10. The Wadsworth Center conducts its work out of five facilities, including the main laboratory at the Empire State Plaza, Albany, New York 12237.

11. The Wadsworth Center employs approximately 800 staff, fellows, interns, students and volunteers. In addition, on average, Wadsworth Center trains 50 students and visiting scientists per year.

12. I am providing this declaration to explain the impacts on New York State resulting from the CDC's reduction in capacity to test for infectious diseases, and conduct other important functions, since April 1, 2025.

Reliance on CDC Laboratory Testing Prior to April 1, 2025

13. Prior to April 1, 2025, New York State directed specimens for reference and confirmatory testing to the Hepatitis and Sexually Transmitted Infection (STI) laboratories at the CDC. The CDC has developed highly sophisticated tools including bioinformatic genetic analysis programs used for hepatitis outbreak investigations that are not available in any other laboratory.

14. For example, the Wadsworth Center would routinely utilize genetic analysis programs only available at the CDC electronically to identify suspect hepatitis C cases.

15. The Wadsworth Center would routinely send bacterial isolates to the CDC in order to perform surveillance for antibacterial resistance to understand the prevalence and spread of antibacterial resistance as well as to monitor for emergence of novel resistance markers in bacteria.

16. The Wadsworth Center would send specimens for enterovirus and Parechovirus to the CDC Respiratory Virus laboratory for diagnostic testing. These viruses cause severe respiratory disease as well as acute flaccid paralysis, especially in children.

17. The Wadsworth Center would send suspect Marburg specimens to the CDC Viral Special Pathogens Laboratory for diagnostic testing in order to identify this deadly disease, which is not present in the U.S.

18. This testing by the CDC was important to the Wadsworth Center because some of this testing is not performed routinely at the Wadsworth Center. Having surveillance testing

performed at the CDC allowed Wadsworth Center scientists to develop tests for other pathogens that may be circulating in New York and infecting a larger number of residents. The CDC also has BSL4 laboratories, which are not available in New York State, that allow the CDC to perform additional characterization of pathogens such as Marburg virus and other hemorrhagic fever viruses.

19. In addition, the Wadsworth Center would routinely send reference blood and urine samples to the CDC's National Center for Environmental Health's Division of Laboratory Services to be analyzed for toxic metals; these samples were then shared with almost all state public health laboratories to help for calibration and training purposes. This testing by the CDC was important to the Wadsworth Center because it provided access to reference methods not always readily available to state public health laboratories, and it provided a critical quality assurance tool that helped states harmonize their testing for toxic metals in human blood and urine.

20. This testing by the CDC was important to New York State residents because it ensured Wadsworth produced high quality data on New York State residents' exposure to environmental contaminants that could be compared to national exposure data produced by the CDC.

Changes in CDC Infectious Diseases Laboratory Testing Since April 1, 2025

21. Since April 1, 2025, the Wadsworth Center has been forced to respond to significant changes to the CDC's laboratory capacity resulting in a significant reduction in the availability of infectious disease and environmental testing.

22. The CDC has historically served as the leading national resource for testing rare or complex cases of infections, in particular Hepatitis and STIs. But, on April 1, 2025, Wadsworth Center became aware that HHS's reductions in force had impacted the CDC's infectious diseases laboratory testing programs.

23. Wadsworth Center first learned that the CDC would be eliminating much, if not all, of its reference and confirmatory testing for STIs. And, on April 2, 2025, Wadsworth began receiving outreach from other jurisdictions outside of New York State asking if the Wadsworth Center could perform testing for Hepatitis viruses, because the Hepatitis testing capacity within the CDC had been compromised. Wadsworth Center later learned that the entirety of the CDC's Hepatitis laboratory capacity had been eliminated due to the layoffs within the CDC's Division of Viral Hepatitis (DVH).

24. The elimination of the CDC's Hepatitis laboratories is especially concerning because DVH has developed and maintained a proprietary Global Hepatitis Outbreak and Surveillance Technology (GHOST) system to characterize viral genotypes and transmission links among cases with hepatitis C virus (HCV) infection in outbreak settings. The Wadsworth Center does not have access to the GHOST system and cannot replace the CDC's unique capability to track HCV infections in real time without committing significant, additional resources.

25. It is difficult to create a comprehensive list of the tests no longer performed by the CDC that Wadsworth Center has previously relied upon. Continuous changes have and continue to be made, and they have not been announced publicly or directly to Wadsworth in advance; rather, changes have been published on the CDC website with little or no advanced notice.

26. Wadsworth Center has had no direct, formal communication with the CDC regarding changes. At times, Wadsworth has been contacted by a specific laboratory at the CDC indicating that a test is being discontinued and asking if Wadsworth can do this testing. Other times, Wadsworth receives communication from the Association of Public Health Laboratories (APHL) asking if Wadsworth can do testing that the CDC has discontinued.

27. In addition to changes related to testing, Wadsworth has learned that the CDC has suspended support and investigation services to jurisdictions responding to lead contamination crises.

28. Wadsworth Center has also become aware that the Moffett Laboratory, an ISO-accredited facility within the FDA that is responsible for developing and certifying high quality food reference materials used to assess the proficiency of state laboratories, has been closed.

Effect on Institutional Operations

29. The Wadsworth Center has been significantly affected by the changes to the CDC infectious disease and environmental testing described above.

30. The changes to the CDC infectious diseases testing described above have forced the Wadsworth Center to divert resources to testing for pathogens including arboviruses, Mpox virus, mycobacteria, Neisseria gonorrhoeae, as well as Enteroviruses and Parechoviruses (including enterovirus-D68 (EV-D68)); testing for these pathogens was formerly performed by the CDC's infectious diseases laboratories. This has required Wadsworth to hire or train

additional staff for its core infectious disease programs in bacteriology, parasitology, virology, and mycology in order to maintain continuity of operations for the state.

31. In addition, the changes to the CDC infectious diseases laboratory testing have strained the Wadsworth Center's resources because it has received, and continues to receive, samples from other jurisdictions that cannot be tested anywhere in the U.S. other than the Wadsworth Center after CDC laboratory closures. The Wadsworth Center is the only laboratory other than the CDC capable of testing for certain pathogens. For example, only two laboratories in the U.S. can conduct reference testing for Chagas Disease: a CDC laboratory that is now closed, and the Wadsworth Center. The CDC has also ceased testing for critical exotic viral pathogens, including Mayaro virus, Heartland virus, bourbon virus, and dengue virus. The same is true for Leishmaniasis, a disease that can be fatal without early detection. Even for more common diseases, like gonorrhea, Mpox, or hepatitis, Wadsworth Center has had no choice but to fill in for gaps created by the closures of various CDC laboratories, including the Viral Hepatitis laboratory. In the last month alone, the Wadsworth Center performed tests for dengue, Mayaro, heartland, bourbon, and chikungunya viruses from patient samples from six different states due to the loss of testing from the CDC.

32. This increased demand for testing is harmful because the Wadsworth Center is intended to be a resource for New York State, not for the country as a whole. Our pricing models, liability insurance, and staffing were built to serve the needs of our State alone. Indeed, Wadsworth is not equipped to conduct many of the functions formerly undertaken by the CDC, including national surveillance of infectious diseases. The CDC's former status as the most elite and capable infectious disease laboratory system was built with federal funding and other federal resources that are simply unavailable to the Wadsworth Center, and cannot be replicated.

33. These changes risk significant harm to public health in New York State because, without adequate testing for infectious diseases throughout the country, our residents are at risk of being affected by dangerous outbreaks and chemical exposures that would otherwise be detected and controlled through our national public health systems, which have been developed and managed by the CDC.

34. Finally, the Wadsworth Center operates a program to regulate medical devices developed and used by clinical laboratories. These are referred to as laboratory developed tests (LDTs) and the Wadsworth Center routinely relies on the U.S. Food and Drug Administration to discuss oversight of LDTs when new and emerging technologies are being used. The April 1, 2025, reduction in force has significantly impacted the Wadsworth Center's interactions with the FDA.

Conclusion

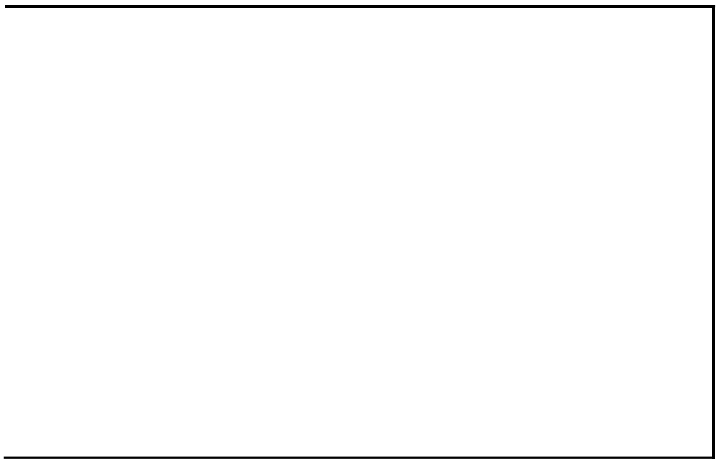
35. The changes to the CDC's infectious diseases laboratory testing described above harm the Wadsworth Center because it has been forced to take on testing responsibilities that were previously handled by the CDC and, in some cases, forgo the vital testing of samples taken from New Yorkers if Wadsworth Center does not have the capacity to do such testing on its own. In addition, as one of the only laboratories capable of testing certain samples other than the CDC before April 1, 2025, the Wadsworth Center has been forced to respond to urgent requests for testing from other jurisdictions, straining its already-limited resources allocated for the benefit of New Yorkers.

36. These new demands are already straining the institution's limited resources and contributing to an increased risk of public health harms in New York State, both from the loss of the CDC resources and services and the interruption of the Wadsworth Center's ability to conduct its day-to-day functions.

Leonard F. Peruski, PhD

Date: May 7, 2025

EXHIBIT 21



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Wendy Underwood

Digitally signed by Wendy Underwood
Date: 2025.05.07 16:55:56 -05'00'

EXHIBIT A

From: McCarthy, Susan (Susie) (CDC/NCCDPHP/OSH)
To: Thill, Christina (She/Her/Hers) (MDH)
Cc: Lauren, Diane (MDH); Hanson Perez, Julie (She/Her/Hers) (MDH); Cotton, Sylvia L. (CDC/NCCDPHP/OSH); Diamond, Catherine (MDH); Keller, Paula (She/Her/Hers) (MDH)
Subject: RE: Minnesota Revised Spend Plan
Date: Wednesday, March 12, 2025 5:01:22 PM
Attachments: image001.gif

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Do not select links or open attachments unless verified. Report all suspicious emails to Minnesota IT Services Security Operations Center.

Christina,

Thank you for the detail and comprehensiveness of the spend plan you submitted earlier today. It is very clear! I just wanted to confirm that you expect to obligate the funding for contactor Tunheim Partners by end of April for communications for events that will occur after April (e.g., No Menthol Sunday in May and American Indian Heritage Month looks like it's in November). You also have pow wows, which I understand might occur throughout the year.

We appreciate meeting with you and your colleagues on March 11 to discuss the spend plan and for your thorough follow-up.

Thanks very much,

Susie McCarthy, CHES®, NBC-HWC | Public Health Advisor
Program Services Branch, Office on Smoking and Health
Centers for Disease Control and Prevention
Mobile (470) 421-1415 | Email: smccarthy@cdc.gov

From: Thill, Christina (She/Her/Hers) (MDH) <christina.thill@state.mn.us>
Sent: Wednesday, March 12, 2025 11:36 AM
To: Cotton, Sylvia L. (CDC/NCCDPHP/OSH) <crk3@cdc.gov>; McCarthy, Susan (Susie) (CDC/NCCDPHP/OSH) <zcu0@cdc.gov>
Cc: Lauren, Diane (MDH) <diane.lauren@state.mn.us>; Hanson Perez, Julie (She/Her/Hers) (MDH) <julie.hanson.perez@state.mn.us>; Diamond, Catherine (CDC state.mn.us) <catherine.diamond@state.mn.us>; Keller, Paula (She/Her/Hers) (MDH) <Paula.Keller@state.mn.us>
Subject: Minnesota Revised Spend Plan

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EXHIBIT A

Hi Susie and Sylvia,
Thank you for the opportunity to submit a revised spend plan. We made changes to the original spend plan submitted. This version provides more details of the amount of the contract, what we have paid since July 2024 when the FFR was submitted, and the remaining balance. We will submit this as a note in GrantSolutions.

Please let us know if you need any additional information.

Thanks!

Christina

Christina Thill (she/her/hers)
Commerical Tobacco Control Manager | Office of Statewide Health Improvement Initiatives

Minnesota Department of Health
Office: 651-201-3668 |
iconmdhmnemail

EXHIBIT B

From: Thompson, Keisha (CDC/OCOO/OFR/OGS)
To: Thill, Christina (She/Her/Hers) (MDH)
Cc: Hanson Perez, Julie (She/Her/Hers) (MDH); Diamond, Catherine (MDH)
Subject: RE: Amendment Application# NU58DP2025027269 for Minnesota Department of Health (grant# NU58DP006818) has been returned to the grantee by the Grants Servicing Office
Date: Monday, May 5, 2025 9:01:40 AM
Attachments: image002.png
image003.gif

Hello Christina

Thank you for your patience. Due to organizational changes at HHS/CDC the Continuation Application for DP20-2001 YR 5 Supplemental Extension has been returned. CDC has granted a 6-month no-cost extension through October 29, 2025. We will provide further updates as they become available.

Thanks

Keisha Thompson, M.P.A.
Grants Management Officer (GMO)
Office of Grants Services (OGS)
Office of Financial Resources (OFR)
Centers for Disease Control and Prevention (CDC)
Department of Health and Human Services (HHS)
770-488-2681 (office) |

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From: Thill, Christina (She/Her/Hers) (MDH) <christina.thill@state.mn.us>
Sent: Wednesday, April 30, 2025 6:32 PM
To: Thompson, Keisha (CDC/OCOO/OFR/OGS) <dwt6@cdc.gov>
Cc: Hanson Perez, Julie (She/Her/Hers) (MDH) <julie.hanson.perez@state.mn.us>; Diamond, Catherine (CDC state.mn.us) <catherine.diamond@state.mn.us>
Subject: FW: Amendment Application# NU58DP2025027269 for Minnesota Department of Health (grant# NU58DP006818) has been returned to the grantee by the Grants Servicing Office

CAUTION: This email originated from outside of the organization. Do not click links or open attachments unless you recognize the sender and know the content is safe.

Hi Keisha,

I am reaching out to inquire about the Continuation Application for DP20-2001 YR 5 Supplemental Extension. We submitted our application in Grant Solutions and understood from the CDC Office on Smoking and Health staff that the funding package for DP20-2001 was sent to CDC Grant Management Services. It was our understanding that we would be funded for an additional year.

The amendment is for a NCE for time. However, will you please clarify when CDC is planning to share additional updates about the YR5 Supplemental Extension and funding.

Thank you for your assistance.

Christina

Christina Thill (she/her/hers)
Commercial Tobacco Prevention and Control Section Manager |Injury Prevention and Mental Health Division

Minnesota Department of Health
Office: 651-201-3668 | Cell: 651-503-6846

EXHIBIT B

iconmdhmnemail

From: Keisha Thompson (Grantsolutions) <noreply@grantsolutions.gov>
Sent: Monday, April 21, 2025 3:02 PM
To: Thill, Christina (She/Her/Hers) (MDH) <christina.thill@state.mn.us>
Subject: Amendment Application# NU58DP2025027269 for Minnesota Department of Health (grant# NU58DP006818) has been returned to the grantee by the Grants Servicing Office

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GrantSolutions.gov

The following electronic Amendment application for Minnesota Department of Health (grant# NU58DP006818) has been returned to the grantee by the Grants Servicing Office for the following reason

There have been organizational changes at HHS/CDC, and we are waiting on further decisions related to these awards. At this time, we are able to provide DP20-2001 - National and State Tobacco Control Program grant recipients a no-cost extension that will be effective April 29, 2025. We will provide additional updates when available.

For further information, contact the Grants Servicing Office.

Application#: NU58DP2025027269

Amendment Type: Supplement

This message has been sent by GrantSolutions (https://www.grantsolutions.gov)

GrantSolutions.gov

EXHIBIT C

From: Thill, Christina (She/Her/Hers) (MDH)
To: Thompson, Keisha (CDC/OCOO/OFR/OGS)
Cc: Hanson Perez, Julie (She/Her/Hers) (MDH); Diamond, Catherine (MDH)
Subject: FW: Amendment Application# NU58DP2025027269 for Minnesota Department of Health (grant# NU58DP006818) has been returned to the grantee by the Grants Servicing Office
Date: Wednesday, April 30, 2025 5:32:00 PM
Attachments: DP20-2001 Supplement Extension Guidance Has Posted.msg
DP20-2001 YR 5 Supplement Extension Guidance Revised 11.5.2024.pdf
image001.gif

Hi Keisha,

I am reaching out to inquire about the Continuation Application for DP20-2001 YR 5 Supplemental Extension. We submitted our application in Grant Solutions and understood from the CDC Office on Smoking and Health staff that the funding package for DP20-2001 was sent to CDC Grant Management Services. It was our understanding that we would be funded for an additional year.

The amendment is for a NCE for time. However, will you please clarify when CDC is planning to share additional updates about the YR5 Supplemental Extension and funding.

Thank you for your assistance.

Christina

Christina Thill (she/her/hers)
Commercial Tobacco Prevention and Control Section Manager |Injury Prevention and Mental Health Division

Minnesota Department of Health
Office: 651-201-3668 | Cell: 651-503-6846
iconmdhmnemail

From: Keisha Thompson (Grantsolutions) <noreply@grantsolutions.gov>
Sent: Monday, April 21, 2025 3:02 PM
To: Thill, Christina (She/Her/Hers) (MDH) <christina.thill@state.mn.us>
Subject: Amendment Application# NU58DP2025027269 for Minnesota Department of Health (grant# NU58DP006818) has been returned to the grantee by the Grants Servicing Office

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GrantSolutions.gov

The following electronic Amendment application for Minnesota Department of Health (grant# NU58DP006818) has been returned to the grantee by the Grants Servicing Office for the following reason

EXHIBIT C

There have been organizational changes at HHS/CDC, and we are waiting on further decisions related to these awards. At this time, we are able to provide DP20-2001 - National and State Tobacco Control Program grant recipients a no-cost extension that will be effective April 29, 2025. We will provide additional updates when available.

For further information, contact the Grants Servicing Office.

Application#: NU58DP2025027269

Amendment Type: Supplement

This message has been sent by GrantSolutions (https://www.grantsolutions.gov)

GrantSolutions.gov

EXHIBIT C

From: Miller, Angeline (CDC/NCCDPHP/OSH) on behalf of Sneegas, Karla S. (CDC/NCCDPHP/OSH)
Subject: DP20-2001 Supplement Extension Guidance Has Posted
Date: Monday, November 18, 2024 6:20:27 AM

This message may be from an external email source.
Do not select links or open attachments unless verified. Report all suspicious emails to Minnesota IT Services Security Operations Center.

Dear NTCP Awardees,

I am happy to announce that the DP20-2001 Year 5 supplement extension guidance has posted on GrantSolutions. Please review the guidance carefully and in its entirety for all requirements and deliverables. The deadline for your supplement application documents is **Thursday, January 30, 2025.** Below is important information as you begin the supplement application process.

- This guidance and funding extends Year 5 Strategies which is a **12-month** period between **4/29/2025 – 4/28/2026.**
- Remember to include a Spend Plan for any Year 4 unobligated funds with the supplement application. See the Supplement Extension Guidance for more information.
- When using AMP to prepare the Work Plan(s) and Annual Progress Reports, remember to do the following:
  - Click the Submit for Review Button
  - Click the Export button and Save as a PDF
  - Submit with the Supplement Application Packet in GrantSolutions
- If you have any questions regarding the supplement extension guidance document, please submit them using the following link:
  CDC-RFA-DP20-2001: National and State Tobacco Control Program | Smoking and Tobacco Use | CDC
- Your Year 5 supplement application is due in Grantsolutions on **Thursday, January 30, 2025.** If you need further information regarding the supplement extension guidance process or if you have any problems meeting that deadline, please contact Nadirah Watson, Caloria Osborne, or Darryl Mitchell, Grants Management Specialist, at kog8@cdc.gov, ube7@cdc.gov or dvm1@cdc.gov.

Sincerely,

Karla

EXHIBIT C

Supplemented Extension
Centers for Disease Control and Prevention (CDC)
Office of Financial Resources
Catalog of Federal Domestic Assistance (CFDA): *93.387*
Notice of Funding Opportunity Number (NOFO): *CDC-RFA-DP20-2001*

National and State Tobacco Control Program
National Center for Chronic Disease Prevention and Health Promotion
Office on Smoking and Health

Purpose:
The purpose of this supplement is to announce that additional funding is available to the current CDC-RFA-DP20-2001 recipients to support the implementation of the *National and State Tobacco Control Program*.

The supplement will fund this cooperative agreement for an additional 12 months (April 29, 2025 – April 28, 2026) to allow for completion of program activities and extended evaluation of the program.

Eligibility:
These one-time funds will be awarded to the recipients currently funded under **CDC-RFA-DP20-2001: National and State Tobacco Control Program.**

Anticipated Funding Level:
For this award, recipients are required to prepare their fiscal year 25 budget based on the current year's award amount. Please refer to the most recent Notice of Award for the award amount.

Application Submission:
Applications must be submitted through www.grantsolutions.gov as an amendment following the steps below:

1. **Go to:** www.grantsolutions.gov
2. **Access**: My Grants List Screen
3. **Click the Link:** "Manage Amendments"
4. **Click Button:** "New"
5. **Select Amendment Type**: Supplement
6. **Click Button**: "Create Amendment"

Applications must be submitted to GrantSolutions by **Thursday, January 30, 2025, 11:59 p.m. Eastern Standard Time**. If you encounter any difficulties submitting your application at www.grantsolutions.gov, please contact the GrantSolutions helpdesk at 866-577-0771 or email help@grantsolutions.gov prior to the submission deadline. If you need further information regarding the supplemented extension, please contact Nadirah Watson, Caloria Osborne, or Darryl Mitchell, Grants Management Specialist, at kog8@cdc.gov, ube7@cdc.gov or dvm1@cdc.gov. For programmatic information, please contact Tiffany Turner, Project Officer, at hyu1@cdc.gov.

Annual Reporting Requirements:

- **Progress Performance Report:** Due to the extension of the final budget period, CDC must receive Annual Progress Reports (APR) every 12 months. Recipients are required to submit an APR for reporting period **January 1, 2024 – December 31, 2024.** The APR must be submitted with this supplement application.

EXHIBIT C

- **Annual Federal Financial Report (FFR):** Annual financial reporting is required every twelve-month period. Due to the extension period, the final budget period has been extended and an additional annual financial report will be required. A completed FFR SF- 425 covering the original final budget period of April 29, 2024 – April 28, 2025 is due to the GMS/GMO by **July 28, 2025**. The report must be submitted in the Payment Management System (PMS).

Checklist of required contents of application packet:

1. Performance Progress and Monitoring Report (PPMR)
2. SF-424 Application for Federal Domestic Assistance Version 3 (online form)
3. SF-424A Budget Information-Non-Construction (online form) and Budget Justification (attachment)
4. Indirect Cost Rate Agreement (attachment)
5. Performance Narrative
6. SF-LLL Disclosure of Lobbying Activities (online form and instructions), if applicable[1], are located at www.grants.gov/forms/forms-repository/post-award-reporting-forms
7. Interim Federal Financial Report (FFR) SF-425 (if applicable) instructions are located at www.grants.gov/forms/forms-repository/post-award-reporting-forms
8. Additional Program Requirements, if applicable

1. Performance Progress and Monitoring Report:

- PPMR instructions are attached to the form located at PPMR https://www.cdc.gov/grants/documents/Performance-Progress-and-Monitoring-Report-PPMR.pdf.

2. SF-424 Application for Federal Domestic Assistance-Version 2:

- Instructions for completing SF-424 Application for Federal Domestic Assistance Version 3 https://www.grantsolutions.gov/gs/pdf/SF424V3_Instructions.pdf

3. SF-424A Budget Information and Justification:

- Instructions for completing SF-424A Budget Information-Non-Construction online form are located at https://www.grantsolutions.gov/gs/pdf/ophs-1_SF424A_Instruction.pdf
- The proposed supplement budget should be based on the federal funding level, which is stated on page one of this document.
- In a separate narrative, provide a detailed, line-item budget justification of the funding amount requested to support the activities to be carried out with those funds. Travel for program implementation should be justified and related to implementation activities.
- The budget justification must be prepared in the general form, format, and to the level of detail described in the CDC Budget Preparation Guidelines. The budget guidance is provided on CDC's internet at http://www.cdc.gov/grants/applying/application-resources.html.
- For any new, proposed subcontracts, provide the information specified in the Budget Guidance.
- When non-federal matching is required, provide a line-item list of non-federal contributions including source, amount, and/or value of third-party contributions proposed to meet a matching requirement.

4. Indirect Cost Rate Agreement (This is not applicable to institutions of higher education. The rates stay the same as the first-year award.):

A. If indirect costs are requested, include a copy of the current negotiated federal indirect cost rate agreement or a cost allocation plan approval letter for those recipients under such a plan.

[1] The form has instructions that indicate when the form is required.

B. Clearly describe the method used to calculate indirect costs. Make sure the method is consistent with the Indirect Cost Rate Agreement.
C. To be entitled to use indirect cost rates, a rate agreement must be in effect at the start of the budget period.
D. If there is no Indirect Cost Rate Agreement or the agreement has expired, indirect costs may be charged as direct if (1) this practice is consistent with the recipient's/applicant's approved accounting practices; and (2) if the costs are adequately supported and justified.
E. If applicable, attach and name the document, "Indirect Cost Rate."
F. If applicable, the recipient's indirect costs are based on a rate of ten percent of modified total direct costs (MTDC) as defined in 45 CFR Part 75.2.
G. For institutions of higher education, indirect costs are based on the negotiated indirect cost rate agreement used for the first-year award, and rates in that agreement are to be used for the remainder of the competitive segment in accordance with 45 CFR Part 75. Indirect cost/facilities and administration rates for subcontracts will be treated in the same manner as those for the recipient if the subcontractor is covered by 45 CFR Part 75.
H. For grants awarded to foreign organizations and foreign public entities and performed fully outside of the territorial limits of the U.S., indirect costs are based on a fixed rate of eight percent of MTDC exclusive of tuition and related fees, direct expenditures for equipment, and subawards in excess of $25,000.

4. Performance Narrative:

Section I. Current Budget Period Progress (January 1, 2024 – December 31, 2024):

Provide a brief report addressing the following elements of each objective or activity.

Annual Progress Report (Component 1 and Component 2): Recipients must provide a brief summary for Component 1 and/or Component 2 of key deliverables conducted thus far, successes, challenges, and technical assistance needs for each Strategy. The Annual Progress Reports should be labeled as follows: "Component 1 APR", and "Component 2 APR" for submission to GrantSolutions.

- **Successes**
  - Report progress on completing deliverables, activities, and logic model outcomes outlined in the Component 1 and Component 2 work plans. Progress should be measurable and demonstrate impact.
  - Highlight successes with implementing evidence-based policy, systems, and environmental strategies during the budget period.
  - Describe any additional successes (e.g., identified through evaluation results or lessons learned) achieved during the budget period.

- **Challenges**
  - Describe challenges that might affect their ability to achieve selected strategies, conduct performance measures, or complete the activities in the work plan.
  - Discuss additional challenges (e.g., identified through evaluations or lessons learned) encountered in the past year.
  - Describe how CDC could help overcome challenges to achieving strategies, performance measures, and completing activities outlined in the work plan.

- **Lessons Learned**
  - Provide lessons learned under each Strategy for the Population-Specific Disparities Requirements (Statewide, Community-Based, and Preventing Initiation of Emerging Tobacco Products). Do not repeat what was provided under Successes and Challenges.

EXHIBIT C

- **Spend Plan for Activities brought forward from previous budget periods (Carryover)** - In order to assess programmatic plans to address unobligated funds, please include the following information in a separate document. The information should detail the activities/funding brought forward from previous budget periods (Year 4) into the current budget period (Year 5). Name the document "Spend Plan for use/intended use of unobligated".
- A breakdown of the amount of unobligated funds by component brought forward from previous budget periods into the current budget period.
- Detailed plans for the use of or intended use of the unobligated funds carried forward into the current budget period.
- Categorize the information by Component/strategy/activity, with the associated dollar amounts.
- Include overhead, administration, and/or staffing costs as appropriate.

Section II. Supplemental Budget Period Proposed Objectives and Activities (April 29, 2025 – April 28, 2026): CDC recommends that recipients develop the work plan and budget concurrently, making sure the activities identified in the work plan are reflected in the budget and vice versa. Recipients are expected to clearly explain how their organization plans to use the funding to implement the NOFO strategies and achieve performance measure targets. Each activity listed in the work plan should be attached to an expenditure in the budget, and recipients are required to justify and itemize all expenditures.

Work Plan: Recipients should update their Year 5 Work Plan(s) for Component 1 and/or Component 2 to describe the work that will be accomplished during the supplemental performance period. The work plans should be labeled as follows for submission to GrantSolutions: "Component 1 Work Plan" and "Component 2 Work Plan".

- Select proposed strategies for the upcoming budget period. The strategies must support the intent of the original Notice of Funding Opportunity (NOFO).
- Each strategy should contain a performance or outcome measure that assesses the effectiveness of the project.
- For each Strategy:
  - Identify the priority population, geographic area, and key deliverables/outputs proposed.
  - Use the exact names provided in the table for the priority populations.
  - Do not select both "general population" and other population groups.
  - Only use "Other" if the selected priority population is not listed in the table.
- List activities that will be implemented, include the setting the activity is being implemented, the contributing partner(s), and the key contractors and consultants responsible for completing each activity; and
- Provide a timeline for accomplishment of activities.

Priority Populations	
• General Population	• Mental Health
• African American or Black	• Substance Use
• American Indian or Alaska Native	• Rural
• Asian American, Native Hawaiian, or Pacific Islander	• Veteran/Active Military

• Disability/Limitation	• Geographical Region or Area with High Commercial Tobacco Use
• Hispanic/Latino	• Young Adults (18-24)
• LGBTQ+	• Youth (below 18)
• Low SES	• Other (include in description)

Budget Narrative: Recipients must submit a separate 12-month budget for Component 1 and/or Component 2. The budgets should be labeled as follows: "Component 1 Budget" and "Component 2 Budget".

- **Direct Assistance:** Direct Assistance is available through this NOFO for Statistical Analysis Software (SAS) licenses and SUDAAN licenses.
  Trainings and Conferences: Attending required trainings and conferences is critical for building and maintaining the skills of the staff with responsibility for carrying out the program requirements of this NOFO. CDC's Office on Smoking and Health (OSH) requires attendance at specific trainings and conferences as a term and condition of this award. Specific conference dates, location, and guidance related to travel will be provided at a later date.
    - Recipients should budget for a minimum of three staff members to attend the National Tobacco Control Program Technical Assistance Meeting, August 25, 2025, and the National Conference on Tobacco or Health (NCTOH), August 26-28, 2025, in Chicago, Illinois. Staff members should include, at minimum, the tobacco control program manager and evaluator.
- **Local Lead Agency**: For the Community-Based Disparities Requirement, recipients must allocate funds from their Component 1 award or state dollars to fund one local lead agency to implement tobacco control strategies and activities in a community. The Local Lead Agency should be funded at an amount that will allow them to accomplish the strategies and activities outlined in their work plan. A line item should be included in the budget and labeled "Local Lead Agency" with the Name of Organization in parenthesis (i.e., Local Lead Agency (ABC Organization).

5. Additional Program Requirements

Impact Statements: Recipients must develop and submit at least 1 impact statement with the application. Impact Statements should be 1 page or less and include the following information:

- Burden/problem statement/priority population
- What your state/jurisdiction is doing (including timeframe - start and end date of highlighted activities)?
- How your state/jurisdiction used CDC resources to do the work?
- What happened?
- What was the impact/health outcomes (include numerical data if available, including number and percent impacted)?

The Impact Statement should be submitted as a separate attachment with the Application and labeled "Impact Statement State Abbreviation".

Community-Based Disparities Requirement: Recipients should continue to collaborate with the local lead agency, coalition, and community stakeholders to advance the work of this requirement. Activities may include one or more of the following:

- Implement a workplan with culturally appropriate tobacco control policy, systems, and environmental strategies and activities which seek to improve health equity and is led by the local lead agency and community.

EXHIBIT C

- Evaluate the requirement and share findings.
- Provide technical assistance, training, and guidance to the local lead agency.

A work plan should be submitted as a separate attachment with the Application and labeled "Local Lead Agency Work Plan".

Evaluation and Performance Measurements: Recipients are required to collect and report on evaluation results and performance measures.

- Performance Measurement Reports: Recipients are required to report relevant performance measure data annually. The performance measures for DP20-2001 standardize the assessment of strategies and outcomes across the funded tobacco control programs. Recipients will update their Performance Measurement Reports by submitting measurement data for Year 5 and performance measure targets for Year 6. The Performance Measurement Reports should adhere to the evaluation report guidance provided by OSH, titled "Guidance for Updating DP20-2001 Annual Performance Measures." The report must be submitted by July 28, 2025.
- Evaluation Report: Recipients are required to implement evaluation plans and collect evaluation data annually. Recipients will report evaluation findings from Year 4 and Year 5 together. The report must be submitted by July 28, 2025.
- Updated Evaluation Plan: If updates or revisions have been made by the recipient or requested by the OSH Evaluator, recipients are required to submit an updated Evaluation Plan by March 31, 2025. If there are no updates or revisions, the recipient is not required to submit an updated evaluation plan.

EXHIBIT D

From: STD Prevention Division Director (CDC)
To: STD Prevention Division Director (CDC)
Subject: DSTDP Reduction in Force – Laboratory Services
Date: Friday, April 11, 2025 10:30:32 AM

Some people who received this message don't often get email from dstdpd@cdc.gov. Learn why this is important

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Dear Colleagues,

On April 1st, 2025, the Centers for Disease Control and Prevention (CDC) experienced a large reduction in force (RIF), in accordance with President Donald Trump's Executive Order 14210 and the Department of Health and Human Services' (HHS) broader reorganization strategy to improve its efficiency and effectiveness.

We are writing to inform you that all staff within the Division of STD Prevention's STD Laboratory Reference and Research Branch (SLRRB), as well as the Disease Intervention and Response Branch (DIRB), received reduction in force (RIF) notices.

At this time, CDC is unable to provide STD-related laboratory services to state and local health departments and other partners.

Effective immediately, please refrain from submitting specimens for surveillance testing to CDC's Division of STD Prevention Laboratory Branch. Specimens should be frozen and held in storage until alternative testing pathways are identified. We are working with partners to develop contingency plans.

We will provide updates as more information becomes available.

We thank you for your understanding during this time of transition.

Kind regards,

Office of the Director
Division of STD Prevention (DSTDP)
National Center for HIV, Viral Hepatitis, STD and TB Prevention (NCHHSTP)
Centers for Disease Control and Prevention (CDC)
U.S. Department of Health and Human Services

EXHIBIT E

From: DVH_FOA (CDC) <dvh_foa@cdc.gov>
Sent: Thursday, April 3, 2025 1:05 PM
To: DVH_FOA (CDC) <dvh_foa@cdc.gov>
Subject: Status of CDC's Viral Hepatitis Laboratory

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On Thursday, March 27, the U.S. Department of Health and Human Services (HHS) issued a press release and fact sheet outlining the Department's plans for restructuring.

On April 1, 2025 the Division of Viral Hepatitis (DVH) Laboratory Branch staff received reduction in force (RIF) notices. At this time, CDC is unable to provide viral hepatitis - related laboratory services to state and local health departments and other partners.

Please reach out to DVH_FOA@cdc.gov with any questions.

Health Department Support, Division of Viral Hepatitis
Centers for Disease Control and Prevention

EXHIBIT 22

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF RHODE ISLAND

STATE OF NEW YORK, et al. Plaintiffs, v. ROBERT F. KENNEDY, JR., in his official capacity as SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., Defendants.	Case No. _____

DECLARATION OF GREGORY HOVAN

I, Gregory Hovan, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the foregoing is true and correct:

1. I am the Laboratory Director of Delaware State Public Health Laboratory. I have personal knowledge of the facts set forth in this declaration, and if required to testify, would and could competently do so.

2. I submit this Declaration in support of the States' Motion for a Preliminary Injunction.

Professional Background

3. I am a Laboratory Director at Delaware State Public Health Laboratory. I have over 15 years of public health laboratory experience, including academic research, with an undergrade in science and graduate degrees in business.

4. Delaware Public Health Laboratory's mission is to provide accurate and timely analytical data, information and consultation to protect and enhance the health of the people of Delaware.

5. Delaware Public Health Laboratory is centrally located in Delaware, providing a broad scope of laboratory services, both clinical and environmental, as well as logistical and regulatory, to support our state partners.

6. I am providing this declaration to explain the impacts on Delaware of the Center for Disease and Prevention's (CDC) reduction in capacity to test for infectious diseases since April 1, 2025. CDC's reduction in capacity to test for infectious diseases since April 1, 2025 has created a situation whereby Delaware Public Health Laboratory must drastically reduce our workforce, testing services, and partnerships with state, regional, and national partners, potentially impacting patient and public health, in response to these practices.

Reliance on CDC Infectious Diseases Laboratory Testing Prior to April 1, 2025

7. Prior to April 1, 2025, Delaware Public Health Laboratory utilized Center for Disease and Prevention (CDC) infectious disease testing when unable to provide services to support public health, which hinders our ability to identify, test for, and respond to emerging infectious diseases.

8. For example, Delaware Public Health Laboratory would routinely send clinical specimens (e.g., blood, cerebrospinal fluid, and other sterile sources) to CDC's infectious disease testing Laboratory to identify significant public health pathogens of concern.

9. This testing by the CDC was important to Delaware Public Health Laboratory because this testing is rarely performed at the regional or state level due to the low prevalence of disease.

10. This testing by the CDC was important to Delaware's residents because detecting these pathogens enabled public health to prevent further spread to the public.

Changes in CDC Infectious Diseases Laboratory Testing Since April 1, 2025

11. Since April 1, 2025, Delaware Public Health Laboratory has made changes to CDC's Infectious Diseases Laboratory testing resulting in a reduction in the availability of testing.

12. Specifically, we first became aware that the CDC laboratory for testing complex sexually transmitted infections closed after reading it in the news.

13. Specifically, as of April 4, 2025, CDC no longer tests for Herpes, Hepatitis, and Varicella Zoster Virus (VZV).

14. Additionally, we have observed a loss of communication with National Laboratory professionals, who would offer guidance and recommendations on laboratory operations, method development, and troubleshooting.

15. We received notification by a national public health laboratory advocacy group, Association for Public Health Laboratories (APHL), that services were discontinued.

Effect on Institutional Operations

16. Delaware Public Health Laboratory has been significantly affected by the changes to the CDC Infectious Diseases Laboratory Testing described above.

17. The changes to CDC Infectious Diseases Laboratory testing described above have forced Delaware Public Health Laboratory to rely on alternative labs for testing, which may contribute to an increase in costs, delayed testing, and/or reporting of public health disease for investigation.

18. These changes risk significant harm to public health in Delaware because the testing performed at the CDC infectious disease laboratory are rarely performed elsewhere, and if undetected, could spread throughout the community.

Conclusion

19. The changes to CDC Infectious Diseases Laboratory testing described above have significant impacts, not only in Delaware, but across the nation. Delaware is home to a number of transient populations, and without a national program to detect emerging pathogens, further spread of communicable diseases, specifically those with severe public health significance, may increase.

/s/ *Gregory Hovan*
Gregory Hovan

Date: May 7, 2025

EXHIBIT 23

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF RHODE ISLAND

STATE OF NEW YORK, et al. Plaintiffs, v. ROBERT F. KENNEDY, JR., in his official capacity as SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., Defendants.	Case No. 1:25-cv-00196

DECLARATION OF GLEN R. GALLAGHER, PHD

I, Glen R. Gallagher, PhD, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the foregoing is true and correct:

1. I am the Director of the Division of Rhode Island State Health Laboratories (RISHL), and I collaborate closely with the Division Director for the division of Emergency Preparedness Infectious Disease (EPID). Both are Divisions of the Rhode Island Department of Health (RIDOH).

2. I have personal knowledge of the facts set forth in this declaration, and if required to testify, would and could competently do so.

3. I submit this Declaration in support of the States' Motion for a Preliminary Injunction.

Professional Background

4. I am Glen R. Gallagher, PhD and I am an Associate Director at RIDOH, and I have served as the Director of the Division of State Health Laboratories since August of 2022. I completed B.S. degrees in Microbiology and Medical Technology at Ohio State University

before completing an APHL Emerging Infectious Disease fellowship at the CDC Dengue Branch. I then completed a PhD in Virology at the University of Massachusetts Medical School. Prior to joining the Rhode Island Department of Health, I was Division Director of Molecular Diagnostics and Virology at the Massachusetts State Public Health Laboratory.

5. RISHL's mission is to provide laboratory testing services to protect the health and safety of Rhode Islanders. RISHL is situated in a purpose-built laboratory facility and provides testing services for a broad range of biological (including infectious disease diagnostic and surveillance capacities), environmental, forensic, and clinical toxicology analytical testing services. RISHL serves as a conduit between the primary healthcare system and reference and public health testing available at CDC or through CDC funded networks.

6. EPID's mission is to control the spread of infectious disease in Rhode Island, and consists of three centers, two of which are focused on the spread of infectious disease: The Center for Acute Infectious Disease (CAIDE) and the Center for HIV, Hepatitis, STD, and Tuberculosis (CHHSTE). Staff in EPID monitor all reportable infectious diseases as required by state law and regulation. EPID identifies newly diagnosed cases reportable under Rhode Island law and analyzes trends in newly diagnosed cases through the utilization of laboratory results generated at RISHL and other diagnostic and public health laboratories. EPID uses this information to locate people exposed to infectious diseases and contacts them to guide them to action. Furthermore, EPID aims to control disease outbreaks, plans public health responses to outbreaks of infectious disease and react swiftly to contain outbreaks with healthcare providers in the community utilizing laboratory data reported to RIDOH.

7. I am providing this declaration to explain the impacts on Rhode Island of CDC's reduction in capacity to test for and track infectious diseases since April 1, 2025. CDC's

reduction in capacity to test for infectious diseases since April 1, 2025 has forced RISHL to quickly develop plans to submit and pay for testing services at commercial or other reference laboratories so that Rhode Island can maintain a ready posture for response to STI and viral hepatitis testing services to aid in clinical diagnosis and outbreak response.

Reliance on CDC Infectious Diseases Laboratory Testing Prior to April 1, 2025

8. RISHL relies on rapid antimicrobial susceptibility testing for *Neisseria gonorrhoeae* provided by regional testing centers coordinated by the CDC's Antimicrobial Resistance Laboratory Network (ARLN). While RISHL only referred four specimens for testing to this resource since 2023, this testing is an important component of ongoing monitoring for the early detection of extensively drug-resistant gonorrhea in Rhode Island.

9. Prior to April 1, 2025, RISHL relied on the CDC's Sexually Transmitted Disease (STD) Laboratory Reference and Research Branch to provide antimicrobial susceptibility testing for extensively drug-resistant *Neisseria gonorrhoeae* as an extended capacity of the regional reference laboratories in the ARLN. Specifically, the tests ordered for "*Neisseria gonorrhoeae* Surveillance Study" that include extended drug resistance testing is no longer available.

10. Antimicrobial resistance testing by the CDC is important to RISHL because these results are used by epidemiologists in EPID and hospital infection prevention specialists to track the spread and emergence of antimicrobial resistance in Rhode Island. This is critical to maintaining the appropriate use of antibiotics to limit the expansion of resistant bacteria, which allows us our clinicians to prescribe appropriately and keep our citizens safe.

11. Prior to April 1, 2025, RISHL utilized CDC's Viral Hepatitis Laboratory Branch for reference testing and genotyping in samples suspected for hepatitis infection. For example, in 2023 RISHL submitted samples for genotyping of hepatitis A to aid in cluster identification and

outbreak response. Results generated by CDC laboratories allowed EPID to link cases to other ongoing regional outbreaks and develop strategies to prevent onward spread of the disease.

Changes in CDC Infectious Diseases Laboratory Testing Since April 1, 2025

12. Effective April 1, 2025, the CDC indicated that it was no longer able to provide STD and viral hepatitis related laboratory services at the (STD) Laboratory Reference and Research Branch, and the Viral Hepatitis Laboratory Branch due to the abrupt closure of these laboratories through a reduction in force.

13. On April 11, 2025, RIDOH received a notice from the Office of Director of the Division of STD Prevention (CDC) indicating that they had experienced a large reduction in force in accordance with President Donald Trump's Executive Order 14210. The communication indicted that, effective April 1st (ten days earlier), due to "the Department of Health and Human Services' (HHS) broader reorganization strategy to improve its efficiency and effectiveness," the CDC "is unable to provide STD-related laboratory services." RIDOH received a similar notice regarding the closure of the Viral Hepatitis Laboratory around April 4th, 2025.

14. The closure of the CDC's Division of STD Prevention Laboratory Branch directly impacts the ability of RISHL and EPID to identify and track resistant gonorrhea cases in Rhode Island. This has been particularly important given the regional emergence of highly resistant gonorrhea, first identified in Massachusetts.

15. The closure of the CDC's Viral Hepatitis Laboratory Branch directly impacts the ability of RISHL and the two centers that fall within the Division of Emergency Preparedness Infectious Disease to identify and track the spread of viral hepatitis through laboratory testing. The testing services that are discontinued include several viral hepatitis diagnostic and

genotyping services. Specific tests include nucleic acid detection, virus serology, and genotyping services for Hepatitis A, Hepatitis B, Hepatitis C, Hepatitis D, and Hepatitis E.

16. Reference testing at the CDC is an important component to viral hepatitis surveillance efforts that are a core component of the Rhode Island Governor's Hepatitis C Elimination Plan (Strategic Plan for the Addressing Hepatitis C (HCV) in Rhode Island (2022)).

Effect on Institutional Operations

17. RISHL and EPID operations have been significantly affected by the changes to the CDC Infectious Diseases Laboratory Testing described above.

18. The changes to CDC Infectious Diseases Laboratory testing described above have forced RISHL to identify alternative labs for testing of extended drug resistance in *Neisseria gonorrhoeae* and viral hepatitis. Some of these services have very limited options for alternatives in commercial laboratories. For testing that is available through commercial labs, RIDOH will need to identify funding sources for these services that were previously provided at no cost to the State. Furthermore, this shift to analysis at commercial laboratories will significantly hamper the ability to compare results across States. This is an extremely important component of data analysis in the Northeast Region where there is often interstate mobility and clusters and outbreaks frequently involve multiple jurisdictions.

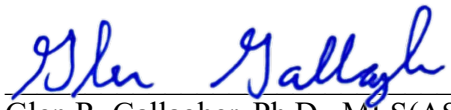
19. The changes to CDC Infectious Diseases Laboratory testing described above have reduced RISHL's ability to test for *Neisseria gonorrhoeae* drug susceptibility and detection and genotyping of viral hepatitis that was formerly performed by CDC's Infectious Diseases Laboratory, which means that until alternative testing laboratories are identified, RISHL and EPID will have limited ability to identify outbreaks of these diseases and may not be able to

effectively trace the sources of infections to implement appropriate public health measures and communication.

20. These changes create a significant risk of harm to public health in Rhode Island because there have been identified cases of extended drug-resistant *Neisseria gonorrhoeae* in neighboring Massachusetts and ongoing viral hepatitis outbreaks in the United States – specifically hepatitis A.

Conclusion

21. The changes to CDC Infectious Diseases Laboratory testing described above limit RIDOH's ability to respond to infectious disease clusters of sexually transmitted infections and viral hepatitis. In the absence of national reference testing services, RISHL must identify alternative commercial or other partner laboratories to maintain this capacity. Even if alternatives to the entirety of the testing that was discontinued at CDC laboratories could be identified, RIDOH would still bear the cost for testing, and would retain minimal ability to compare test results across jurisdictions, thereby further limiting EPID's ability to identify cases, determine common sources, and implement public health mitigation strategies.



Glen R. Gallagher, Ph.D., MLS(ASCP)^{CM}

Date: 5/7/2025

EXHIBIT 24

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF RHODE ISLAND

STATE OF NEW YORK, et al. Plaintiffs, v. ROBERT F. KENNEDY, JR., in his official capacity as SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., Defendants.	Case No. 1:25-cv-00196

DECLARATION OF DR. JEROME LARKIN

I, Jerome Larkin, M.D., declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the foregoing is true and correct:

1. I am the Director of the Rhode Island Department of Health (RIDOH). The information set forth in this Declaration is based on my personal knowledge, information gathered by and in consultation with RIDOH personnel, and a review of business records that have been provided to and reviewed by me.

2. I submit this Declaration in support of the States' Motion for a Preliminary Injunction.

Professional Background

3. I have held the position of Director of RIDOH since May 21, 2024. I am board-certified in Internal Medicine and Infectious Diseases by the American Board of Internal Medicine and in General Pediatrics by the American Board of Pediatrics. For the 16 years prior to my appointment as Director of RIDOH, I served as the Medical Director of Inpatient Infectious Diseases Consultation Services at Rhode Island Hospital, the Co-Director of Pediatric

HIV Clinic at Hasbro Children's Hospital, and the Medical Director of the Infectious Disease Clinic at Rhode Island Hospital.

4. The mission of RIDOH, founded in 1878, is to prevent disease and protect and promote the health and safety of the people of Rhode Island.

5. Unlike many other states, the Rhode Island Department of Health serves as the singular public health resource – an agency that serves over one million residents and over 28 million tourists, annually.

6. I am providing this Declaration to explain the impacts on Rhode Island of the cuts to HHS, including cuts to CDC, the FDA, and SAMHSA.

Reliance on HHS Data and Technical Expertise

7. Prior to April 1, 2025, the execution of RIDOH's mission relied heavily on the personnel, funding, information, expertise, technical assistance, communications, data and resources provided by the U.S. Department of Health and Human Services (HHS), its Centers for Disease Control and Prevention (CDC), the U.S. Food and Drug Administration (FDA), the Administration for Community Living (ACL) and the Substance Abuse and Mental Health Services Administration (SAMHSA).

8. Rhode Island relied on CDC for its assistance in maternal mortality review committees and other efforts to eliminate maternal mortality. In late March, the Region 1 (New England) Office of HHS was abruptly closed. Because staff were put on leave and eliminated, collaborative projects addressing regional maternal mortality, perinatal community capacity, and postpartum depression were cancelled.

9. Rhode Island has long relied on CDC for data relating to the health and well-being of pregnant people and babies, including the Pregnancy Risk Assessment Monitoring

System (PRAMS). PRAMS is a survey of those who recently gave birth, which seeks to learn about their behaviors and experiences before, during, and after pregnancy. Topics include preconception, prenatal and postpartum care, maternal tobacco/alcohol/substance use, IPV, contraception, economic status, maternal stressors, early infant development and health status, mental and physical health, breastfeeding, housing, occupational status and workplace leave, safe sleep practices, health insurance, vaccines, food/housing insecurities, SDOH, and education. The data and information collected from this survey are used for program planning, policy development, and overall decision-making. PRAMS provides information that isn't available elsewhere and has been used extensively in Rhode Island to improve the health of mothers and infants. RI PRAMS data are used to identify areas of concern, the subpopulations at greatest risk, develop programs and policies to improve maternal and infant health, evaluate programs, and monitor trends. RI PRAMS data have also been relied upon to drive policy and decision making, such as extending Medicaid coverage for a year after giving birth, expanding teleconsulting access to meet perinatal mental health needs, and provide pharmacists with the authority to prescribe and dispense hormonal contraceptive patches and self-administered oral hormone contraceptives to improve state systems for reducing unintended pregnancies. RI PRAMS is the gold standard for maternal and infant data collection, and the only survey of its type where mothers can share their pregnancy, birthing, and postpartum experience.

10. Rhode Island has relied on CDC and FDA for their assistance in tobacco prevention and control, including the State Tobacco Activities Tracking and Evaluation (STATE) System, and resources for Rhode Island's tobacco quitline. On April 21, 2025 (one week prior to the start of the funding cycle), Rhode Island's sixth year supplemental application for its Tobacco Control Program was returned by the CDC, citing structural changes at HHS/CDC. Because that

application was not processed and approved, Rhode Island lost $1,383,858 in grant funding upon which we rely. These federal dollars provided 69% of the program's funding, including 80% of staff funding, 67% of quitline funding, and has negatively impacted ten community contracts.

11. Rhode Island has relied on CDC for its technical assistance in preventing and controlling HIV/AIDS, viral hepatitis, STIs, and tuberculosis. RIDOH relies on the ability to request CDC support for outbreaks in that CDC deploys epidemiologists, laboratorians, public health advisors, and disease intervention specialists to provide both virtual and on-the-ground support for outbreak response when RIDOH needs it. A recent Rhode Island multi-drug resistant case of tuberculosis who travelled across multiple jurisdictions has required CDC input and support. CDC also funds community-based and national organizations to complement RIDOH's prevention efforts, which foster collaborations with providers and clients to provide effective prevention programs and services and inform guidelines and policies, all of which are critically important given our recent increase in congenital syphilis and HIV cases, to prevent forward transmission. Rhode Island also relies heavily on CDC technical assistance in functions related to disease monitoring and surveillance that are used to identify and respond to emerging disease clusters and disease outbreaks at both the population and geographic levels.

12. Rhode Island has relied on CDC for its assistance in monitoring for and responding to threats in Environmental Health, including food safety, public health tracking, environmental health capacity and childhood blood lead poisoning prevention. Rhode Island is currently receiving the following grant support, which is now threatened due to the sudden elimination of staff within the CDC:

- Environmental Health Specialist Network: This grant is currently on year five of a five -year grant. RIDOH receives $192,587 per year;

- Environmental Public Health Tracking Network: This grant is currently in year three of five- year grant. RIDOH receives $550,000 per year;
- Childhood Blood Lead Poisoning Prevention: This grant is currently in year four of a five- year grant. RIDOH receives $500,000 per year;
- Environmental Health Capacity: This grant is currently on year five of a five-year grant. RIDOH Receives $140,050 per year.

Changes in HHS Data and Technical Assistance Since April 1, 2025

13. Since April 1, 2025, thousands of HHS personnel with irreplaceable knowledge and expertise and multiple resources upon which the State of Rhode Island has relied for years, vanished without warning and without transition or continuity plan or communication.

14. Since April 1, 2025, Rhode Island has experienced harm relating to CDC's removal of resources and staff which enabled RIDOH to fulfill its responsibilities to conduct maternal mortality review committees and other efforts to eliminate maternal mortality. On or around March 15, 2025, the CDC eliminated the majority of the resources that Rhode Island relies upon, including the report "Community Vital Signs," which specifies case ascertainment protocols and assists states in identifying maternal deaths in their jurisdiction. Without this information, Rhode Island is missing opportunities to prevent deaths to pregnant and postpartum women. The CDC removed SharePoint webpages with guidance on identifying and evaluating maternal deaths that Rhode Island relied upon to conduct and inform Maternal Mortality Review Committee (MMRC) work. The program had to cancel its MMRC meeting due to unavailability of guidance documents. Because of the elimination of CDC staff and programs focused on Reproductive Health, RIDOH has not been able to coordinate with federal staff to respond to pressing reporting concerns, approve budget redirections, or issue "needs assessment" guidance.

15. Since April 1, 2025, Rhode Island has experienced harm relating to CDC data relating to the health and well-being of pregnant people and babies, including the Pregnancy Risk Assessment Monitoring System (PRAMS). April 1, 2025, RI PRAMS received notice from our CDC Project Officer that all CDC PRAMS staff had received the RIF notice and were put on leave, effective immediately. On April 10, 2025, RI PRAMS received the Notice of Award (NOA) that would continue funding for the program from May 1, 2025 – April 30, 2026. In the NOA, there is language that depicts the degree to which CDC will have involvement with the project deliverables. An email was sent to CDC Grants Management Office letting them know that RI PRAMS would need the components listed in the NOA to continue the workplan submitted, and a response was returned indicating that grant staff were also on leave and more information would be sent once available. Based on the Cooperative Agreement between CDC PRAMS and RI PRAMS, there is significant involvement with federal partners that cannot be provided at this time due to the sudden layoffs. On April 30, 2025, CDC sent an email to RI PRAMS indicating the "CDC can no longer provide the scientific, technical, and information technology assistance resources as described in the Notice of Funding Opportunity RFA-DP-21-001 for the Pregnancy Risk Assessment Monitoring System (PRAMS). CDC will share guidance for revision of workplans and budget documents for the year 5 budget period starting May 1, 2025 through April 30, 2026 soon." If the CDC does not provide critical resources including adequate funding, scientific and technical support, and information technology assistance, Rhode Island will no longer be able to administer the survey, have weighted data, or contribute to national data trends.

16. Since April 1, 2025, Rhode Island has experienced harm relating to CDC and FDA's role in tobacco prevention and control in our state. Because our grant application was

returned and funding for our sixth-year cycle was not received, five community contacts were terminated, and at least two full-time staff members have been terminated by our contracted partners due to the funding loss related to the returned application. As a result of these actions, statewide coordination of cessation treatment resources for nicotine and tobacco will be lost; technical assistance for schools implementing tobacco-free policies and programming will be limited; Rhode Island will be unable to support communities in addressing health inequity due to known industry tactics; and we are unable to provide necessary treatment for those addicted to nicotine and subjected to forced cessation, for example those in the justice system.

17. In addition to the loss of state funding, the reduction in force of the CDC's Office of Smoking and Health has substantial impacts in Rhode Island. Rhode Island relied upon substantial resources and technical assistance provided by the Office of Smoking and Health to Rhode Island at no cost, such as: educational media campaign material (e.g., "*TIPS From Former Smokers")*; administration of the National Youth Tobacco Survey, which provided the first indicators of the dramatic increase in Electronic Nicotine Delivery Systems (ENDS) used by youth; preparation of factsheets, social media posts, and communication strategies; maintenance of a national toll-free number that allows texting and calls to be directed to the state-specific hotline cessation resources and counseling; and funding to assist with policy work and data briefs.

18. Since April 1, 2025, Rhode Island has experienced harm relating to CDC's role in infection control and prevention. As of last week, the CDC's Healthcare Infection Control Practices Advisory Committee (HIPAC) website has vanished, several committee members have been terminated leading to widespread concern that the committee will be terminated, which leaves Rhode Island without the wealth of information advanced by HIPAC that RIDOH relies

upon to carry out its mission. Created in 1991, HICPAC is a federal advisory committee to HHS and CDC comprised of leading non-federal experts in infectious diseases, epidemiology, nursing, microbiology, and public health. The group meets regularly to review emerging evidence and develop infection prevention recommendations that directly inform national healthcare policy. HICPAC provides the gold standard regarding the practice of infection control and strategies for surveillance, prevention, and control of healthcare-associated infections, antimicrobial resistance and related events in settings where healthcare is provided, including hospitals, outpatient settings, long-term care facilities, and home health agencies. HICPAC serves as a policy engine, translating new scientific evidence into practical, scalable recommendations adopted across U.S. healthcare, which ensures consistency and uniformity in infection control prevention practices that saves lives in Rhode Island.

19. As of April 1, 2025, Asthma Control Program staff at the CDC were either placed on administrative leave or were fired. This has caused chaos in Rhode Island, as there is no guidance on budgetary or programmatic-related questions, issues, or assistance with the required non-competitive funding application which provides funding for the next project period starting September 1, 2025. RIDOH met the deadline to submit the application, but without staff at the federal level to review it, there is uncertainty about whether funding will continue beyond August 31, 2025. Rhode Island relies upon this funding to reduce asthma-related emergency department visits and hospitalizations for children ages 2-17 with poorly-controlled asthma through the support of education and training for community health workers who conduct home visits to address asthma triggers and provide education, and for community-based agencies who work with families to address the burden of asthma among children ages 2 – 17.

20. Since April 1, 2025, Rhode Island has experienced harm relating to CDC's role in monitoring for and responding to Environmental Health, including food safety, public health tracking, environmental health capacity and childhood blood lead poisoning prevention. On April 1st, 2025, HHS announced that the majority of staff within the National Center for Environmental Health at CDC were put on administrative leave. RIDOH did not receive notification on the impacts of the reduction in force on funding; however, grant managers and project officers are no longer available to answer questions or process requests. RIDOH grant recipients received emails from CDC staff indicating, "this is my last communication," or "I am no longer going to be working for CDC." RIDOH's Environmental program staff have yet to receive guidance on four grants, which total $1.3 million in annual support relied upon by Rhode Island. RIDOH employs the equivalent of 9.5 FTEs with these grants. There are a total of 23 staff impacted, since many are partially funded for data analysis, communications, and other support services.

21. Since April 1, 2025, Rhode Island has experienced harm relating to the sudden reduction in force of the SAMHSA Region 1 Behavioral Health Teams. RIDOH's Violence and Injury Prevention Program (VIPP) staff met with the Region 1 team on a bi-monthly basis, along with the other New England states. The loss of SAMHSA organizational oversight conducted by experienced staff and reassignment to AHA Mental Health will have a devastating impact to suicide prevention efforts in Rhode Island by limiting opportunities to receive federal guidance and technical assistance regarding best practices and resource dissemination from subject matter experts in the field. RIDOH VIPP has relied upon SAMHSA technical assistance and continuous funding opportunities to support youth suicide prevention efforts in the state for over fifteen consecutive years.

22. Rhode Island relies upon the Women, Infants and Children (WIC) program, funded through USDA, which provides nutrition counseling, support for healthy development for pregnant women and young children, and food assistance to needy families in Rhode Island. In April 2025, Rhode Island's WIC fresh food Farmers Market Nutrition Program, was slashed without explanation. Previously, in 2024, RI received $138,648. This amount was cut by almost 75% to $36,547. If RI WIC is able to run the program at all with this reduced funding, it will significantly limit access to fresh food for families in Rhode Island who are most vulnerable and in need of nutritional support.

Conclusion

23. The changes to the staffing of HHS and resulting loss of programmatic support, expertise, resources, data and services will decimate the work of my agency and will jeopardize the health, safety and welfare of those who live in and visit the State of Rhode Island.

Jerome M. Larkin

[NAME] Dr. Jerome Larkin

Date: May 7, 2025

EXHIBIT 25

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF RHODE ISLAND

STATE OF NEW YORK, et al. Plaintiffs, v. ROBERT F. KENNEDY, JR., in his official capacity as SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., Defendants.	Case No. _____

DECLARATION OF ELI ROSENBERG

I, Eli S. Rosenberg, PhD, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the foregoing is true and correct:

1. I am the Director of the Office of Science at the New York State Department of Health (NYSDOH). I am familiar with the information in the statements set forth below either through personal knowledge, in consultation with NYSDOH staff, or from documents that have been provided to and reviewed by me.

2. I submit this Declaration in support of the Plaintiffs' Motion for a Preliminary Injunction.

Professional Background

3. I am the Director of the Office of Science at NYSDOH and I serve as a lead and advisor to the NYSDOH Commissioner for public health data, research, epidemiology, and surveillance activities at NYSDOH. In this capacity, I have also served as a liaison to Health and Human Services (HHS) agencies, principally the US Centers for Disease Control and Prevention (CDC), regarding matters related to our public health data and systems. I joined NYSDOH in

2021, as the Deputy Director of Science for the Office of Public Health (OPH), and as director of the Office of Science, which was part of OPH at that time. From 2017 to 2021, I was an Associate Professor in the Department of Epidemiology and Biostatistics at the University at Albany School of Public Health, part of the State University of New York, in Albany, New York. From the beginning of the COVID-19 pandemic in March 2020, I was on assignment to NYSDOH, helping to support research and public health surveillance activities, and served as an advisor to the governor's office regarding epidemiology and disease modeling for the pandemic. From 2013 to 2017, I was an Assistant Professor in the Department of Epidemiology at the Emory University Rollins School of Public Health in Atlanta, Georgia. As a professor in both universities, I taught graduate courses and conducted National Institutes of Health (NIH) and CDC-funded research studies focused on infectious disease epidemiology and data analytic methods. During this time, I also held guest appointments as a Senior Epidemiologist at CDC within two of its centers: the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention and the National Center for Emerging and Zoonotic Infectious Disease. I have authored or co-authored over 200 publications in the peer-reviewed literature on the topics of epidemiology and public health surveillance, particularly for infectious diseases such as HIV, sexually transmitted infections, polio, and COVID-19. I received my PhD in Epidemiology from Emory University Rollins School of Public Health and my BS in Biometry and Statistics from Cornell University's College of Agriculture and Life Sciences. Across these experiences I have built significant familiarity with the federal and state public health programs that are the subject of this case.

4. New York State Department of Health's mission is to protect and promote health and well-being for all, building on a foundation of health equity. The Office of Science, which

reports to the Commissioner's office of NYSDOH, provides epidemiologic, analytic and data capabilities to support data-driven decision making at NYSDOH and its programs. Office of Science focus areas are on leading data, research and informatics activities to support cross-cutting priority health topics, emerging threats, and population health. Relevant examples of this work include the production of surveillance data dashboards and reports, information technology development and support for the systems that collect and transmit data to HHS agencies, and the conduct of epidemiological programs such as the Pregnancy Risk Assessment Monitoring System and opioid and overdose surveillance. I, and the Office of Science, collaborate and coordinate with the other sections of NYSDOH whose work is described in this document. This includes the AIDS Institute, within the Office of Health Equity and Human Rights, and the Center for Environmental Health and the Center for Community Health, within the Office of Public Health.

5. I am providing this declaration to explain the impacts on New York State of the cuts to HHS, including cuts to CDC and the Substance Abuse and Mental Health Services Administration (SAMHSA).

Reliance on HHS Data and Technical Expertise

6. Prior to April 1, 2025, NYSDOH relied on data from, technical support from, and relationships with HHS agencies in order to conduct its federally- and state-supported work that serves New York's population, across numerous programs and topic areas. In some cases, data from HHS programs supplemented state-generated data in order to form a more complete picture of a condition that we are tracking and responding to. In other cases, our NYSDOH data are transmitted to HHS, along with those from other jurisdictions, and are not available for our use

until a finalized dataset is returned to us by the HHS program. Technical assistance provided by many HHS programs enables NYSDOH programs -- in forms such as documentation, guidance for surveys and data systems, and conference calls -- to operate more efficiently and in a coordinated fashion that enables comparability of data between New York and other jurisdictions. In some instances, project operations support provided by HHS agency programs is essential to the conduct of our NYSDOH programs, such that they cannot function absent the HHS program team. The relationships with HHS agencies for these data and technical support are established both formally via cooperative agreements and grant contracts, and less formally via working groups, initiatives, and individual relationships established by areas within HHS agencies with our NYSDOH programs.

7. New York State has relied on CDC for its assistance in ensuring that children are screened for hearing loss and receive appropriate interventions for hearing loss. The New York State Early Hearing Detection and Intervention program (NY EHDI) supports the US Surgeon General's Healthy People 2030 goals of increasing the proportion of newborns who are screened for hearing loss by no later than age one month, have audiologic evaluation by age three months, and are enrolled in appropriate intervention services no later than age six months. The CDC EHDI program provided substantial support to NY EHDI as part of a cooperative agreement, which included collaboration on enhancing and expanding outcomes surveillance activities, including the collection, management, analysis, and dissemination of EHDI data, collaboration to develop and implement strategies and evaluation plans and use evaluation findings, provision of technical assistance to define and operationalize performance measures and implement recipients' performance measurement plans, and collaboration on and co-authoring scientific

reports, manuscripts and other derivative works arising from data collected and analyzed for the N Y EHDI Program.

8. Further, New York State Public Health Law Section 2500-g requires all Article 28 health care facilities to report results to the New York Early Hearing Detection and Intervention Information System (NY EHDI-IS) when the provider performs newborn hearing screening and out-patient follow-up hearing screening or diagnostic audiological evaluation on infants less than six months of age. The CDC cooperative agreement is leveraged to support EHDI-IS.

9. New York State relied on CDC for data relating to the health and well-being of pregnant people and babies, including the Pregnancy Risk Assessment Monitoring System (PRAMS). PRAMS is a survey of state residents who have recently given birth to ask about behavior and experiences before, during, and immediately after pregnancy. These experiences may influence health outcomes such as infant development, illnesses, and maternal and infant mortality. Established in 1987, PRAMS is active in 50 U.S. jurisdictions and represents over 80% of all live births in the United States. The PRAMS survey is extremely valuable in that it provides information about pregnancy and the first few months after birth that are not available from other data sources. These data are used to identify groups of parents and infants at a high risk for health problems, measure progress towards goals for improving the health of families and infants, plan, evaluate and assess perinatal health programs, evaluate policy, report essential federal performance measures related to maternal and child health, and to meet state statutory reporting requirements.

10. The CDC Notice of Award to NYSDOH requires data be collected via the PRAMS Integrated Data Collection System (PIDS), which is an entirely CDC hosted and supported electronic system. Sites such as NYSDOH are not able to extract raw data collected

from PIDS. Rather, the CDC team must extract and send the weighted data (weights are statistical adjustments that help to ensure that sampled data represent the underlying population) to NYSDOH. CDC statisticians maintain the expertise to properly and consistently weight the data, and this function is not performed by NYSDOH. Thus, sites are dependent upon the CDC PRAMS Data Team to extract, clean, process, weight, and provide states the weighted data sets. Additionally, CDC PRAMS creates and maintains the national dataset for researchers to request and use data from all states that meet the required response rate.

11. PRAMS data are for essential monitoring and reporting for a number of activities and grants at NYSDOH. This includes the State Maternal Health Innovation (SMHI) grant that was awarded to the Division of Family Health by the Human Resources and Services Administration (HRSA) to improve maternal health outcomes and address health disparities in response to the ongoing maternal mortality crisis in New York State. As a core data innovation component, the SMHI program includes a project which involves the linkage of PRAMS data to other sources of maternal health information, such as hospital discharge data and vital records. The Maternal and Child Health Services Title V Block Grant (Title V) is funded through HRSA and provides $38 million annually to support essential maternal and child health programs and services across New York State. PRAMS is a core data source necessary for the successful completion of ongoing Title V reporting, monitoring, and evaluation activities. Title V includes several national outcome/national performance measures derived exclusively from PRAMS data, and reporting on at least one of these measures is a direct requirement of the Federal funder. The New York State Department of Health has also contracted with the New York State Office of Cannabis Management (OCM) since 2021 to collect information about cannabis consumption and provider screening about cannabis consumption during the perinatal period via the PRAMS

survey. These data are used to monitor key public safety outcomes among pregnant and breastfeeding women post-legalization of adult use cannabis in New York State in 2021. OCM uses these data in their statutorily- required reporting.

12. New York State has relied on CDC for their assistance in tobacco prevention and control. The NYS Tobacco Control Program has both an internal Tobacco Surveillance, Evaluation and Research Team and a legislatively-mandated independent evaluation, conducted by a NYSDOH-funded contractor. Both the internal and the independent teams rely on standards set by CDC's Office of Smoking and Health (OSH) to conduct effective evaluation and surveillance activities that monitor the effectiveness of the state's investment in tobacco prevention and control and contribute to the scientific evidence base in tobacco prevention and control. The National Youth Tobacco Survey (YTS), supported by OSH, informs question development for the New York Youth Tobacco Survey, and serves as a basis for comparison to understand NY trends in context. The National YTS findings help inform the broader conversation about NY's tobacco-related outcomes among decision makers, the media and public health practitioners; and helps to fill in the gaps in data for items that NY does not have in the NY YTS. OSH also supports the National Quitline Data Warehouse (NQDW). The independent evaluator has been able to conduct robust studies of the NY Quitline's reach and effectiveness because of the access we have to other state and national data via the NQDW. CDC's OSH disseminates several fact sheets and publications which serve as foundational evidence-based guides for tobacco control programs' interventions and evaluations. These publications set the stage for talking about emerging products, shifting trends and key priorities. The STATE system, also supported by OSH, helps NY to facilitate data analysis and evaluation and supports reporting from the Independent Evaluator to the NYS Department of Health.

13. New York State has relied on CDC for its assistance in preventing sexually transmitted infections (STI), viral hepatitis, and HIV/AIDS, across a number of activities outlined in the following sections. New York State has specifically relied on the STD Laboratory Reference Branch to develop novel sexually transmitted infection diagnostic tools to address the rising cases of reportable sexually transmitted infections. Further, New York State relied on the over 40 years of data and expertise from the STD Lab that supported national surveillance of antimicrobial resistant trends in *Neisseria gonorrhoeae* (N. gonorrhoeae; gonorrhea) and served as a repository of 50,000 *Neisseria gonorrhoeae* isolates. Gonorrhea is resistant to nearly all antibiotics making it an urgent public health threat; we are on the last line of effective antibiotics to treat the second most reported sexually transmitted infection in the country and in New York State. The State relied heavily on the STD Lab in 2023 when a multi-drug non-susceptible gonorrhea strain was reported in a resident in Massachusetts. Once alerted, the CDC STD Lab issued guidance on how to contact them for consultation and specimen processing. Subsequently, New York State issued a health advisory directing clinicians to notify CDC's STD Lab immediately for consultation if there was a suspected gonorrhea cephalosporin treatment failure or any N. gonorrhoeae specimen with decreased cephalosporin susceptibility. Lastly, New York State relied on the CDC STD Lab to provide the factual data for the evidence based-Sexually Transmitted Infection Treatment Guidelines promulgated by the CDC and underpinned New York State's own, state-focused, evidence-based STI and Sexual Health Treatment, Prevention, and Care Clinical Guidelines.

14. New York State has relied on the CDC Hepatitis Laboratory to support the investigation of hepatitis C virus (HCV) outbreaks. CDC scientists developed and maintained the Global Hepatitis Outbreak and Surveillance Technology (GHOST) system, which utilizes

advanced sequencing methodologies and analysis methods to characterize viral genotypes and transmission links among HCV cases, allowing for the identification of a common infection source. Identification of the source of infection is crucial for the interruption and prevention of outbreaks. In 2024, New York State used GHOST to establish genetic linkages between 20 new HCV cases from multiple healthcare facilities, likely caused by exposure to a single HCV-infected healthcare provider at a surgery center. The GHOST program and technical expertise of CDC scientists to help interpret the results were critical to that outbreak investigation and the success of measures taken in response to the findings.

15. The CDC provides coordinated national guidance for all aspects of HIV Surveillance and prevention. The agency develops and maintains standardized data collection tools and systems for collecting and storing data, including demographic, behavioral, diagnostic, and other HIV-related test information. In collaboration with funded programs, the CDC also provides training and technical support, produces technical guidance documents and benchmarks to measure progress towards timely, high quality, and nationally comparative data. These efforts help establish standards for data collection and ensure the security and confidentiality of HIV Surveillance information. The CDC provides expertise in specialty settings especially related to laboratory reporting and case ascertainment from other federal agencies, i.e., the Veterans Administration. Through training and technical guidance on quality assurance for laboratory reporting, the agency sets the standard on HIV-testing, reporting, and results interpretation, especially related to challenges cases. Without the CDC's expert input, New York State's progress toward ending the HIV epidemic would be significantly hindered.

16. A specific program of note is the CDC's HIV Medical Monitoring Project (MMP), which is a program that generates nationally representative estimates related to

behaviors, clinical outcomes, quality of care for people living with HIV and is conducted in 23 project areas around the United States, including in New York State. When I was a Senior Epidemiologist at CDC, I was embedded in the Behavioral and Clinical Surveillance Branch, within the National Center for HIV, Viral Hepatitis, STD, and Tuberculosis Prevention's Division of HIV/AIDS Prevention, that conducted MMP and am intimately familiar with its operations. Similar to PRAMS described above, the CDC team supporting MMP provides essential technical, operational, and statistical functions for the project, such that the program cannot fully function in funded project areas absent the CDC team. In New York State, the Medical Monitoring Project has been ongoing since 2005 and is one of few sources of representative data on people living with HIV. The State relies heavily on the Medical Monitoring Project to monitor trends, identify unmet healthcare needs, and assess access to ancillary care, and supportive services. The Medical Monitoring Project is also critical in locating individuals with HIV who are sampled but appear to be out of care, facilitating their re-linkage to HIV medical providers, and enumerating barriers to care. The Medical Monitoring Project is also the only data source within the State that measures HIV-related stigma among people living with the virus. New York State relies on MMP to track this Ending the Epidemic metric.

17. New York State has relied on CDC National Center for Environmental Health for its technical assistance with childhood lead poisoning prevention. Childhood lead poisoning remains a significant public health problem in New York State. Due to substantial state investment in secondary and primary prevention programs, cases have steadily declined since 1998, but New York State still has the greatest number of childhood lead poisoning cases in the nation. From 2016-2019, 16.5 per 1000 children under age 6 tested statewide had blood lead levels at or above 5 micrograms per deciliter. Thousands more are at risk due to other risk factors

in the State (e.g., poverty, old and deteriorating housing stock). New York State relies on CDC's nationwide surveillance through their Childhood Blood Lead Surveillance System to identify new sources of lead and inform targeted interventions at the State level. When there are programmatic emergent issues, CDC serves as a liaison with other states to develop nationwide guidance and strategies. In 2021, New York State medical providers experienced a shortage of a chelation medication; in response, CDC coordinated with other states to develop solutions and alternative approaches to medical treatment. Additionally, CDC's national response is critical to product safety awareness, particularly regarding new sources of lead-bearing products in the marketplace. New York State has relied for decades on CDC and other federal partners for their technical expertise to inform regulations and policy in the primary and secondary lead poisoning prevention efforts in children.

18. For decades, CDC's National Institute for Occupational Safety and Health (NIOSH) has served as a cornerstone for worker health and safety. New York State has been part of NIOSH's Adult Blood Lead Epidemiology and Surveillance (ABLES) program since 1994. We later expanded our relationship with NIOSH in the early 2000s with a cooperative agreement to conduct additional surveillance of a variety of other occupational health conditions including work-related respiratory conditions and workplace fatalities investigations. The ABLES program monitors work-related exposure in adults in the U.S. The data has been vital in monitoring workplace lead exposure trends and is used to guide interventions and prevent work-related lead exposures.

19. New York State has relied on CDC for their assistance addressing excessive alcohol use and its harms, including providing technical assistance and guidance for NY's Alcohol Surveillance and Epidemiology Program. The CDC Alcohol Program provided guidance

and technical assistance to states to build capacity to conduct alcohol surveillance and epidemiology, disseminate consistent messaging about the harms of alcohol use and promote information about evidence-based solutions. Specifically, they provided assistance in the form reviewing all NY-generated alcohol reports for accuracy/alignment with the evidence base, sharable graphics for messaging, and they developed, hosted and maintained key data systems like the Alcohol-Related Disease Impact (ARDI) application, which is the primary source for states about alcohol-attributable disease and death.

20. New York State also relies on SAMHSA, which funds the National Survey for Drug Use and Health, an annual nationwide survey involving interviews with approximately 70,000 randomly selected individuals, aged 12 years and older. This survey provides estimates on the use of tobacco products, alcohol, illicit drugs, and mental health in the United States (US). These data provide state and national estimates to track trends in the use of substances, assess the consequences of substance use and abuse, and identify those groups at high risk for Opioid Use Disorder. In New York State, the survey provides key indicators that allow New York State Department of Health to compare the national prevalence to New York State prevalence on specific substance use; allowing to observe trends in substance use and mental health, among other topics. Since 2018, when available data, from the survey has been included in the NYS Opioid Annual Report, a report that is legislatively mandated. These data are also included in the New York State Opioid Data Dashboard and the New York State key tracking indicators, which are both used for monitoring the opioid crisis in New York. NSDUH indicators are further prioritized and incorporated in the New York State Health Improvement Plan, known as the Prevention Agenda, to assist in monitoring progress of opioid and substance use interventions and programs throughout New York State.

21. New York State has relied on CDC for their assistance supporting our program related to STD/HIV Disease Intervention Training Centers (DITC). Health Research Incorporated as the grantee has been supporting these state-provided services for more than 15 years. The intent of this program was to improve the quality of disease intervention services provided by states in HHS Region II by providing training and technical assistance to regional jurisdictions. Disease Intervention Specialists function as the "on the ground" investigators of sexually transmitted infections in states and cities across the country. They provide an essential intervention limiting disease spread in New York State and throughout HHS Region II.

Changes in HHS Data and Technical Assistance Since April 1, 2025

22. Since April 1, 2025, changes at HHS have and will continue to impact our data and technical assistance received from HHS agencies, which in turn impedes numerous functions at NYSDOH. The discontinuation of HHS data and surveillance programs, because the personnel are no longer employed, will mean some national data will be unavailable to supplement our NYSDOH data, limiting our ability to track and respond to conditions. For other surveillance programs, we are unable to retrieve our own data submitted to HHS. The loss of whole teams at HHS agencies removed essential guidance and coordination needed to conduct our work and, in some cases, NYSDOH project operations have ceased because the HHS team conducted key steps in our program's operations. For some activities we have received notice that active awards are being discontinued, or recently submitted funding applications cannot be reviewed, because the HHS teams overseeing these awards and application review processes have been terminated.

23. Since April 1, 2025, New York State has experienced harm relating to CDC's role in helping to ensure that children are screened for hearing loss and receive appropriate interventions for hearing loss. We learned that, on April 1, the entire CDC branch for the Early

Hearing Detection and Intervention (EHDI) program was eliminated. Since that date, all technical assistance and the supports described above have been completely terminated, and New York State EHDI staff have been left without guidance or direction on how to proceed with activities described in the cooperative agreement, in which the CDC team substantially participated. The elimination of the CDC also has created uncertainty regarding our competitive Grant Application for July 1, 2025 - June 30, 2030 funding, which was recently submitted. Specifically, an April 24, 2025 e-mail sent to Health Research, Inc. from CDC indicated that there was no staff to review the recently submitted competitive application (CDC-DD-25-0157) for the above funding cycle, due to the federal RIF impact on the program. This puts a significant portion of the EHDI program's overall funding at risk, with no current alternative state funding available to absorb costs and staffing. A copy of this email is annexed hereto as **Exhibit A**.

24. Since April 1, 2025, New York State has experienced harm relating to CDC data that describe the health and well-being of pregnant people and babies, including the Pregnancy Risk Assessment Monitoring System (PRAMS). Starting January 31, 2025, the PIDS electronic data system has effectively been shut down. As PIDS is essential for data collection and operations, this pause abruptly ended the 2024 birth year data collection and resulted in over 20% reduction in the New York State 2024 sample. This reduction has serious implications for analysis, statistical power, and data publication and research products. On April 30, the Department received additional communication informing us that CDC could "no longer provide the scientific, technical, and information technology assistance resources as described in the Notice of Funding Opportunity". A copy of this email is annexed hereto as **Exhibit B**. This has serious implications for the future of data collection and places the timeline to receive prior year datasets for data collected by NYSDOH and transmitted to CDC. As described in section 9

above, the CDC PRAMS team is responsible for providing scientific and technical assistance including producing the weighted dataset. Without staff, or this technical assistance, it is unclear if, how, and when states will gain access to data that was already collected, such as the weighted 2024 dataset. Furthermore, continued outage of PIDS has a direct impact on operations. A normal schedule for beginning data collection of January 2025 births is April 2025. Any delay in 2025 data collection could result in a reduction of 2025 birth year sample. As sampled cases are no longer valid when the infant turns 9 months old, any delay to the start of data collection will limit the amount of time for collection, result in additional work to collect multiple sample batches at one time and put more strain on staff and increasing operations costs. The longer the delay, the greater and more costly the impact. This will additionally affect the ability to meet the requirements of the SMHI project, future Title V reporting, and the OCM contract, which are described in Section 9 above. Continued outage of the data collection platform and loss of CDC technical assistance to clean, process, and weight the data will have further impact on NY's continued ability to effectively identify high risk populations, measure progress towards goals for improving the health of families and infants, plan, evaluate and assess perinatal health programs, evaluate policy, report essential federal performance measures related to maternal and child health, and to meet certain state reporting requirements. The loss of PRAMS data would jeopardize the New York State Title V program's ability to meet reporting requirements and would also severely compromise the Department's ability to track progress on key maternal and child health goals and objectives outlined in the Title V State Action Plan, the New York State Title V Dashboard, the New York State Maternal and Child Health Dashboard, and the New York State Prevention Agenda. PRAMS data are crucial to understanding key factors that contribute to maternal and infant morbidity and mortality and our ability to monitor, intervene, and ultimately

protect mothers and infants and without PRAMS data in the future, efforts to reduce infant and maternal morbidity and mortality will be affected.

25. Since April 1, 2025, New York State has experienced harm relating to CDC's role in tobacco prevention and control. Staff at CDC established and maintain specifications for data systems needed to track measures of tobacco use for all 50 states, including New York. Furthermore, they maintain the case definitions of measures essential to monitoring progress in tobacco control, cigarette smoking, use of other tobacco products, vaping and quit attempts. Public health surveillance and epidemiology rely on stable data systems and standard case definitions. By firing the experts responsible for these central data systems and technical measure specifications, HHS did irreparable harm to all 50 states and US territories involved in tobacco control, including losing access to the technical advisors at CDC who provide guidance and feedback regarding state program evaluation and performance measurement plans. Without key staff at CDC's OSH, updates to the National Youth Tobacco Survey, the State Tobacco Activities Tracking and Evaluation (STATE) System, and resources for New York State's tobacco quit line are unlikely to occur, significantly hampering NY's efforts to effectively evaluate their tobacco prevention and control programming.

26. Since April 1, 2025, New York State has experienced harm relating to CDC's role in preventing HIV/AIDS, viral hepatitis, STIs, and tuberculosis. The elimination of the STD Laboratory Reference and Research Branch will imminently result in harm to New York State as there is no reference laboratory to provide a national picture of antibiotic-resistant gonorrhea to inform New York State's clinical response, serve as a consultant on suspected treatment failures and/or reduced susceptibility cases, or to provide technical assistance in such cases involving pregnant persons.

27. The closure of the CDC Hepatitis Laboratory has harmed New York State because we no longer have access to the GHOST analysis computer program nor the CDC scientists who provided technical assistance to interpret GHOST results. Without GHOST, outbreaks of hepatitis C virus will take longer to investigate, linkages between cases and clusters may remain undetected, and prevention interventions will be delayed, resulting in continued transmission of HCV and potentially increased morbidity and mortality from this lethal infection.

28. The CDC has provided essential national guidance, data systems, and technical support for HIV surveillance and prevention, ensuring consistent standards, data quality, and confidentiality across states. Its expertise, especially in laboratory reporting and interagency case ascertainment, is critical to New York's HIV response. Elimination of the Division of HIV Prevention's Behavioral and Clinical Surveillance Branch that housed the Medical Monitoring Project and the Quantitative Sciences Branch that produced HIV incidence and HIV status awareness estimates weakened CDC's involvement and has directly impaired the state's ability to effectively monitor, prevent, and respond to HIV.

29. We understand that the Behavioral and Clinical Surveillance Branch was terminated, including the team conducting the HIV Medical Monitoring Project (MMP). The current data collection cycle of the Medical Monitoring Project ends May 15, 2025. Due to these circumstances, the following harms have been realized:

30. The State has not received weighted data from the CDC for the two most recent years of data collection (i.e., the 2023-2024 and 2024-2025 data collection cycles). Without the weights, the samples are not truly representative of individuals living with HIV in New York State.Training and technical support for data collection activities (interviewers, data collectors) have gone unmet.

31. Technical assistance needs related to data quality and participant recruitment have gone unmet.

32. Training and technical support for data management and data analytics have ceased.

33. Reconciling differences and gaps in recruitment data between funded jurisdiction ceased; this cross jurisdictional activity was facilitated by the CDC.

34. The ability to detect changing and emerging trends among people living with HIV will be compromised, hindering timely and effect public health responses.

35. CDC's obligation to New York State as part of the current CDC HIV prevention and surveillance cooperative agreement notes substantial involvement to provide technical assistance to support HIV surveillance and prevention. (The first year one of the five year cycle is slated to end May 31st 2025 and pending a Notice of Award for year two, starting June 2025). This technical assistance is critical to calculate HIV incidence in New York State and percent of people with HIV aware of their status. These are two critical metrics included in New York State's efforts to end the HIV epidemic. On April 29, 2025, New York State was notified that "the publication of CDC's *HIV Surveillance Supplemental Report*: Estimated HIV Incidence and Prevalence in the United States, 2019–2023 has been delayed and that the *HIV Surveillance Supplemental Report*: Monitoring Selected National HIV Prevention and Care Objectives by Using HIV Surveillance Data—United States and 6 Territories and Freely Associated States, 2023 (this year's Monitoring Report) does not include data on PrEP coverage. In 2024, CDC paused PrEP coverage reporting for one year to update overall PrEP coverage estimates using newly available data sets and determine the best way to present PrEP coverage. However, CDC is unable to resume PrEP coverage reporting at this time, due to a reduction in force affecting the

Division of HIV Prevention (DHP). As part of this staffing reduction, the DHP branches that produced HIV incidence estimates and provided the statistical expertise needed to assess PrEP coverage were eliminated. CDC is currently evaluating plans and capacity to resume this work.

36. Since April 1, 2025, New York State has experienced harm relating to CDC's role in monitoring for and responding to lead poisoning, especially in children. Since April 2025, CDC has been unavailable and has not participated in our long-standing monthly technical assistance calls to review grant deliverables and discuss childhood lead poisoning prevention matters. At this time, CDC is not providing further technical assistance to New York State. New York State is currently pursuing an investigation into a recent discovery of lead contamination in baby food and CDC is unavailable to consult on the federal recall of this food or to provide information from other states as to their experience and response. New York State does not have a technical lead on the national level to consult during emerging issues that continue to rise and require prompt response to mitigate lead poisoning in children and the lifelong impact that such poisoning presents.

37. The recent federal restructuring has led to the dismantling of the CDC's National Institute for Occupational Safety and Health (NIOSH). It has been reported that nearly 900 staff positions and a wide range of critical programs have been eliminated. All but a few employees, primarily a few commissioned officers, will remain after June 2, 2025. The worker health data submitted and collected on a national level is at risk of being deleted and gone forever. Without NIOSH staff support, data, or funding to support our follow up with lead poisoned adults will be much more limited and our ability to continue the pregnant women collaborative program with the NYS Childhood Lead Prevention Program and county health departments, where we work to

ensure timely identification of lead poisoned pregnant women and follow-up of their at-risk newborn babies, will be extremely limited and most likely stopped altogether.

38. Since April 1, 2025, New York State has experienced harm relating to SAMHSA data about drug use. According to media reports and a public post from the National Survey for Drug Use and Health Director on LinkedIn from early April, the entire team overseeing National Survey for Drug User Health at the Office of Population Surveys at SAMHSA was laid off. As noted in Section 16 above, this survey provides estimates on the use of tobacco products, alcohol, illicit drugs, and mental health in the United States (US). The national and state estimates are used in key data products (also described in Section 16) that help New York State monitor trends and the loss of this data source would make it challenging for New York State to track progress, identify high-risk populations, and compare with national trends.

39. Since April 1, 2025, New York State has experienced harm relating to CDC data about alcohol use. According to news reports, the entire team overseeing the Alcohol Program at CDC's Division of Population Health was laid off. CDC's Alcohol Program measures the impact of excessive alcohol use and related harms in the United States. The program also develops resources to help people drink less alcohol and to help communities and states create healthier environments that support individuals in drinking less alcohol. The Alcohol Program funds states to build and maintain capacity to conduct epidemiologic and surveillance activities related to alcohol use. The CDC-funded contract supporting a TA center, which helps states to evaluate their efforts under their cooperative agreements with CDC, has been suspended. Staff at CDC who provided technical review of NY-developed alcohol reports are no longer available to provide review, ensure alignment with the evidence base and provide feedback for improvement.

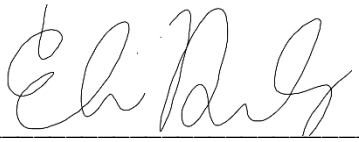
The CDC Alcohol Program provides support for the Alcohol Related Disease Impact (ARDI) application. ARDI is an online application that provides national and state estimates of alcohol-related health impacts, including deaths and years of potential life lost (YPLL). These estimates are calculated for 58 acute and chronic causes using alcohol-attributable fractions and are reported by age and sex. Without this application being updated, NY will lose its primary method for quantifying the health impact associated with alcohol use, which is a key risk factor for cancer and other acute and chronic health outcomes. Further, NY has been funded by CDC's Alcohol Program since 2021; this funding is the only support for NY's Alcohol Surveillance and Epidemiology Program. The future of that funding is uncertain.

40. On April 10, 2025, New York State has experienced harm related to the loss of program services following the abrupt termination of CDC-RFA-PS20-2003: STD/HIV Disease Intervention Training Centers (DITC). The reason given for the termination of funding was that CDC was "no longer able to provide programmatic technical assistance or project monitoring as required by law." Without this training center, there is increased risk of disease spread in New York State and throughout HHS Region II. A copy of the April 10, 2025 email stating the reason for the termination of funding is annexed hereto as **Exhibit C**.

Conclusion

41. As set forth in detail above, the significant cuts to HHS, the CDC, and SAMHSA have adversely impacted the work of NYSDOH and are preventing NYSDOH from carrying out its mission to protect and promote health and wellbeing of New Yorkers.

Date: 5/08/2025



ELI ROSENBERG

EXHIBIT 26

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF RHODE ISLAND

STATE OF NEW YORK, et al. Plaintiffs, v. ROBERT F. KENNEDY, JR., in his official capacity as SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., Defendants.	Case No. 1:25-cv-00196

DECLARATION OF JEFFREY A. BROWN

I, Jeffrey A. Brown, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the foregoing is true and correct:

1. I am the Acting Commissioner of the New Jersey Department of Health (NJDOH). The information in the statements set forth below were compiled through personal knowledge, through NJDOH personnel who have assisted in gathering this information, or from documents that have been provided to and reviewed by me.

2. I submit this Declaration in support of the States' Motion for a Preliminary Injunction.

Professional Background

3. I have been serving as the NJDOH Acting Commissioner since April of 2025. Prior to becoming NJDOH's Acting Commissioner, I served as the NJDOH Deputy Commissioner of Health Systems, overseeing inspections, licensing, and the enforcement of regulations for licensed New Jersey health care facilities, mental health and addiction services and programs, the Office of Health Care Affordability and Transparency, and major hospital

funding programs, including Charity Care. Prior to serving as the NJDOH Deputy Commissioner, I served as the first Executive Director of the New Jersey Cannabis Regulatory Commission (CRC), where I led and managed a newly created state commission. Prior to my position with the CRC, I served as Assistant Commissioner for Medical Marijuana within the NJDOH and worked within healthcare policy and healthcare quality improvement for the State of New Jersey. I graduated from Rutgers University and have devoted my career to serving the public.

4. NJDOH's mission is to protect the public's health, promote healthy communities, and continue to improve the quality of health care in New Jersey. NJDOH provides essential services and implements comprehensive measures to prioritize public health, including: preventing the spread of infectious diseases, educating the public to promote healthy lifestyles, preparing for emergencies and disasters, licensing and regulating health care facilities, collecting and analyzing health-related data, and addressing health disparities.

5. NJDOH has three primary branches: Public Health Services, Health Systems, and Integrated Health, all of which include divisions, offices, and programs. Each aspect of NJDOH works collaboratively to strengthen New Jersey's health system. NJDOH engages in a wide range of services including, but not limited to, communicable disease prevention, maternal and child health, and HIV care.

6. I am providing this declaration to explain the impacts on New Jersey of the cuts to the federal Health and Human Services agency (HHS), including but not limited to cuts to the Centers for Disease Control and Prevention (CDC) and the Food and Drug Administration (FDA).

Reliance on HHS Data and Technical Expertise

7. Prior to April 1, 2025, NJDOH worked closely with HHS to further its fundamental mission of promoting public health in the State of New Jersey. This included the use of HHS data to help improve health outcomes for maternal health patients, prevent the spread of communicable and drug-resistant diseases, reduce tobacco usage, and test and assist in the treatment of lead exposure in children. Federally-funded employees also provided training on the spread of Sexually Transmitted Infections (STIs) and other diseases.

8. Prior to April 1, 2025, NJDOH relied on the CDC for data relating to the health and well-being of pregnant people and babies, including the Pregnancy Risk Assessment Monitoring System (PRAMS). The PRAMS program is designed to identify groups of women and infants at high risk for health problems, to monitor changes in health status, and to measure progress towards goals in improving the health of mothers and infants.

9. The New Jersey PRAMS program relied on access to CDC data, technical knowledge, and assistance to determine the best use of its resources and how to best assist vulnerable communities in the State. PRAMS informs initiatives that improve the lives of birthing people during the perinatal period.

10. For example, in 2018, the New Jersey PRAMS team was able to utilize CDC data to find barriers to receiving prenatal care, experiencing stressful life events, attending postpartum visits, experiencing postpartum depression, breastfeeding, and bed sharing practices. This data showed that Black mothers had the lowest rates of postpartum checkups (82%) and breastfeeding initiation (81%). They also had the second highest rates of postpartum depression symptoms (14%) and reported "often or always" bed sharing (32%).

11. Utilizing this data, the NJDOH Commissioner appropriated $4.7 million per year in grant funding to community-based organizations for the first 2 years of the newly formed

Healthy Women, Healthy Families Initiative. As of June 2020, almost 49,000 women had received case management services, and over 25,000 women had been referred to programs such as home visiting and Healthy Start.

12. Prior to April 1, 2025, NJDOH also relied on the CDC and FDA for their assistance in tobacco prevention and control, including the State Tobacco Activities Tracking and Evaluation (STATE) System, and resources for New Jersey's tobacco Quitline, which offers several resources to help New Jersey residents, eighteen years of age and older, quit smoking. Data collected by the CDC was used to determine national trends in tobacco sales and products, which tend to focus on products that target children. NJDOH relied on this data to track tobacco use trends and evaluate policy effectiveness.

13. In addition to data collection, NJDOH relied on the CDC for funding related to tobacco prevention and control, including for NJDOH's core tobacco program, which includes the Quitline and Quit Centers, which are physical centers throughout the State where in-need individuals can receive in-person counseling, typically geared toward individuals who need more intensive services than the Quitline can provide. Funding provided by the CDC also supports a number of programs tied to community-based initiatives to prevent the use of cigarettes or other tobacco products, including new and developing products, as well as six staff members at NJDOH who are supported either fully or partially by CDC funds.

14. NJDOH also relied on the CDC's high-impact national media campaigns for smoking cessation. The loss of such national campaigns could reduce public motivation for tobacco cessation. The elimination on federal scientific research and policy recommendations to guide smoke-free laws, taxes and youth prevention efforts combined with the lack of centralized expertise may delay or weaken new tobacco control polices in the State.

15. Prior to April 1, 2025, NJDOH also relied on the CDC for its assistance in preventing HIV, viral hepatitis, STIs, and tuberculosis. In addition to being the recipient of grants for the Medical Monitoring Project (MMP) and the National HIV Behavioral Surveillance (NHBS), NJDOH also received vital data from the CDC for tracking treatments that are curative for gonorrhea, which is vital given the emergence of multidrug-resistant gonorrhea.

16. Also prior to April 1, 2025, NJDOH additionally relied on the CDC for its assistance in monitoring for and responding to lead poisoning, especially in children. Childhood lead funding from the CDC supports three full-time employees who staff the Childhood Lead Surveillance Team and perform duties including data entry, review, and assignment of all childhood lead test results to local health departments for investigations; review of childhood lead data to identify highly poisoned children in need of immediate medical treatment, high risk areas, and other emerging threats; and generation of the statutorily-required Childhood Lead Annual Report to the Governor and childhood lead datasets that are shared with other state agencies to effectuate their regulatory duties, such as sharing data with the Division of Community Affairs for housing rental laws and the Department of Human Services for Medicaid reimbursement.

Changes in HHS Data and Technical Assistance Since April 1, 2025

17. Since April 1, 2025, NJDOH has experienced significant disruptions as a result either of the restructuring at HHS or the Reduction In Force (RIF). NJDOH has been unable to access CDC-maintained data or technical assistance in many vital areas including maternal health, disease control, lead exposure, and STI prevention and treatment. Without access to updated data, NJDOH is unable to make data-driven decisions to best increase healthy outcomes and optimize the benefits of the limited resources available.

18. NJDOH has experienced harm as a result of CDC data disruptions related to the health and well-being of pregnant people and babies, including the PRAMS. As of January 31, 2025, New Jersey lost access to the most recent PRAMS data and the data collection portal, PIDS, and is therefore unable to collect the vital data to determine the best use of its resources to help improve maternal health outcomes in the State of New Jersey. NJDOH is committed to using research and data to end preventable morbidity, mortality, and birthing inequality in New Jersey. Without access to data, NJDOH will be unable to track trends in maternal care to meet those goals, and women across the state – especially those in vulnerable communities – will suffer.

19. Since April 1, 2025, New Jersey has also experienced harm and disruption related to the CDC's and FDA's role in tobacco prevention and control. As a result of the reorganization and RIF at HHS, NJDOH no longer has access to resources provided by the CDC related to tobacco prevention and control, including but not limited to individuals with institutional knowledge. NJDOH also no longer has any access to the STATE System. As a result, NJDOH is no longer able to monitor the latest national trends in tobacco usage or be prepared to address the ever-changing landscape of tobacco related products, which are increasingly targeting our nation's youth.

20. NJDOH's Quitline and Quit Centers are already dealing with the consequences of the loss of resources and contact with the CDC, including but not limited to the loss of information about funding. NJDOH's current grant cycle ended on April 28, 2025. Based on prior contacts with CDC partners, NJDOH expected to receive a one-year extension of the grant, which would have run from April 29, 2025 through April 28, 2026. One week before that extension began, with no notice, NJDOH was advised that instead it was going to receive a six-

month "no cost extension," which means the State would not receive additional funding for the upcoming grant year but would have six months to expend any carryover funds from previous years based on the scope of work from previous years.

21. In order to keep NJDOH's tobacco prevention and control programs running in light of the abrupt change from a one-year extension to a "no cost" extension that did not allocate any additional funding, NJDOH has been utilizing carry-over funds from prior years to keep its Quitline and Quit Centers running. But even these carry-over funds are insufficient to operate the programs at the same level they were operating prior to the cessation of funding from the grant. For example, as a result of the loss of the one-year grant extension, Quit Center services funded from State dollars has been reduced to reallocate funding to the Quitline, resulting in a reduction in services provided by State-allocated dollars. And even utilizing these carry-over funds, NJDOH has been forced to reduce the number of subgrants it provides to community-based services, resulting in a disruption and deterioration of services offered to New Jersey residents. Furthermore, these funds are only budgeted for six months. After the six-month extension expires, the services will not have funding to continue.

22. Since April 1, 2025, New Jersey has also experienced harm relating to the CDC's role in preventing HIV, viral hepatitis, STIs, and tuberculosis. NJDOH receives two grants from the CDC related to these services: the MMP)and the NHBS. MMP's project period expires on May 31, 2025. NHBS's budget period for year 4 of the 5-year project period ends December 31, 2025.

23. The MMP is a surveillance system designed to learn more about the experiences and needs of people who are living with HIV. It includes data collected through in-person or telephone interviews with participants, as well as a two-year medical chart abstraction for all

persons who have been in care. Because MMP's estimates are designed to be locally and nationally representative, the information gathered from MMP may be used by prevention planning groups, policy leaders, health care providers, and people living with HIV to highlight disparities in care and services and to advocate for needed resources.

24. NJDOH's MMP grant is used to interview and conduct medical record abstractions for 500 randomly-selected persons living with HIV in order to understand factors that impede their ability to stay in care. Any persons living with HIV who take their medications as directed cannot transmit HIV when they achieve viral load suppression for their HIV infection. In order to achieve the end of the HIV Epidemic, it is vital for anyone diagnosed with HIV to take their recommended medications on a daily basis.

25. NJDOH received $748,645 for the period of June 1, 2024 through May 31, 2025. MMP funds 4.25 NJDOH Full Time Equivalents (FTEs) and one contract position. Data collected from MMP includes extensive information, including information regarding insurance providers. Through this data, NJDOH is aware that 50.7% of the random sample receive medications via Medicaid, which underscores the important need for NJDOH to work closely with Medicaid to ensure HIV medications are available to prevent further spread of HIV.

26. In addition, approximately 27% of the random sample appears to be out of care and not taking medications or getting lab tests done routinely to monitor their infection. Data from MMP assists NJDOH in better understanding when laboratories may not be reporting all results to NJDOH; when patients may have moved to other states and need help finding medical care; and when people are still in New Jersey but may have lost their insurance without realizing that mechanisms exist to ensure they can continue receiving life-saving medications while between jobs to ensure they stay healthy and do not further spread HIV. Without the MMP and

the data collection it supports, NJDOH's ability to help connect persons living with HIV to needed care will be compromised because NJDOH will lack insight on which partnerships are critical to enable people to maintain their care.

27. The NHBS is a comprehensive system for bio-behavioral surveillance conducted since 2003 in populations disproportionately affected by HIV. NHBS collects data on behavioral risk factors for HIV, HIV testing behaviors, receipt of prevention services, and use of prevention strategies. All NHBS participants are offered an HIV test.

28. NJDOH's NHBS grant, which included $540,100 for the period of January 1, 2025 through December 31, 2025 and which funds 1.1 FTEs at NJDOH and one contractor, is used for understanding populations that have a high positivity of HIV and is critical to ensuring people are being diagnosed in a timely manner to prevent the spread of HIV to others. NHBS runs on an annual cycle that switches each year. In 2024, NJDOH recruited persons who inject drugs. In 2025, NJDOH is preparing to start a heterosexual cycle, and in 2026, NJDOH is scheduled to have a gay/bisexual men cycle. The goal is to collect 500 surveys per cycle, including HIV testing, to assess the level of HIV risk within each cohort and identify the characteristics of individuals at increased risk.

29. This data is essential for guiding the strategic focus of HIV testing programs, improving access to Pre-exposure prophylaxis (PrEP), and enhancing provider education. By leveraging this data-driven approach, NJDOH aims to reduce stigma, dismantle systemic barriers, and ensure all individuals can access the healthcare services they need with dignity and confidence.

30. For example, in the 2022 cycle, NJDOH collected data on persons who inject drugs. When collated with data from across the country, the prevalence of HIV among this

population was found to be 6%, but in the 12 months before being interviewed for NHBS, only 45% of people had ever been tested for HIV. This data helped NJDOH to support HIV testing services at Harm Reduction Centers for persons who inject drugs to ensure they more readily have access to HIV testing. Conversely, in 2023, NJDOH collected interviews among gay and bisexual men and learned that 78% reported having been tested for HIV in the previous 12 months, 23% tested positive for HIV, and over 93% had awareness of PrEP to prevent HIV infection; however, only 45% had ever taken PrEP. Using this data, NJDOH was able to support the continuation of the need for PrEP counselors to continue to aid this population in linking to PrEP for the purpose of preventing a potential subsequent HIV diagnosis.

31. The last communication NJDOH received from the CDC related to the MMP and NHBS grants was on April 3, 2025, advising NJDOH that the CDC had approximately half of its staff subject to the RIF but that there had been no changes to NJDOH's recipient status, and that NJDOH should continue implementing its work. Prior to that communication, NJDOH had submitted its non-competitive grant application for the next MMP five-year project period on February 3, 2025 and understood that project managers at the CDC were told to score the applications as soon as possible.

32. Normally, NJDOH would have expected to hear about the status of its grant application within about thirty days of its submission. In fact, the application document provided by the CDC stated the expected award date was May 1, 2025, for an expected start date of June 1, 2025. NJDOH has heard nothing to date.

33. Furthermore, because the entire CDC Division of HIV Prevention, Behavioral and Clinical Surveillance Branch related to this grant was subject to the RIF, NJDOH has no one to contact to confirm whether NJDOH can expect to receive this funding.

34. Without this funding, the MMP project will be sunset at NJDOH and information regarding unmet needs for mental health services and other social needs to help individuals remain in HIV care will be lost. For example, the data collected through the MMP project are critical for making improvements toward the National HIV/AIDS Strategy (NHAS) federal goals (https://www.hiv.gov/), including the goal of reaching 95% of people diagnosed with HIV who rate their overall health as good or better.

35. Currently, MMP data establishes that among people diagnosed with HIV, only 70% rate their overall health as good or better. This underscores the need for MMP to understand why people are not rating their overall health as good or better. During interviews conducted through the MMP program, NJDOH staff are able to gather in-depth details to help inform social services to raise self-reported health status.

36. In another example, the 2025 NHAS goal for the percentage of people diagnosed with HIV who have an unmet need for mental health services is set at 12%. Currently, as a whole, the MMP project is reporting that 27% of people living with HIV have an unmet need for mental health services. These data are critical for advocating for additional mental health services to help individuals stay healthy.

37. With respect to its NHBS grant, NJDOH has not had any communication with anyone at CDC save for the same April 3, 2025 communication referenced above. At this point in NJDOH's NHBS cycle, the CDC is typically active in protocol reviews to ensure NJDOH is on track for a June 2, 2025, start date, which includes beginning its grant deliverable of interviewing 500 persons with heterosexual exposure to HIV.

38. One of the key approvals needed to ensure NJDOH is able to start these interviews on June 2, 2025 is access to the HIV DCC DataPortal managed by ICF Macro

(https://training.dcc-dataportal.cdc.gov/w3c/Privacy.aspx). In communication with the DCC DataPortal team on April 18, 2025, NJDOH learned that DCC DataPortal still did not "have any information on the NHBS Interview OMB approval process (including the version of the interview sent to OMB), or specific timeline for the launch of the interview." In addition, DCC DataPortal reported that it is "also required to have CDC approval for the launch of the updated Coupon Manager Program, the Field Testing Form, and the HIV Test Log on the DCC data portal."

39. The CDC's lack of approval and communication will impede the start of NHBS. Delays in start are strongly correlated to not meeting the goals of NHBS recruitment. Therefore, unless the CDC begins communications again with grantees and the DCC DataPortal team, NJDOH will be at high risk of not meeting its grant deliverable of 500 interviews.

40. Since April 1, 2025, NJDOH has also been harmed by the loss of the CDC's data services related to the tracking and treatment of STIs. Among other impacts, the RIF resulted in the termination of one full-time employee, who had been employed with the CDC and assigned to New Jersey for over twenty years. This employee has assisted NJDOH in a number of ways, including calling at least ten providers for fifteen to twenty patients diagnosed with syphilis per workday in order to obtain the required information to diagnose and report the case to the CDC. This work has been reassigned to other staff to ensure that persons with syphilis are accurately investigated.

41. This employee also worked to train staff in contact tracing and to field follow-up for patients diagnosed with syphilis in order to find persons exposed and link them to care and treatment. For example, in the last year, this employee trained more than a dozen staff on field activities, including how to analyze surroundings to ensure they were safe, how to effectively

interview patients to get them to open up about their sex lives, and how to analyze the data provided to put forth initiatives to conduct screenings in communities where cases appeared to cluster together around related risk factors, like an uptick in cases reporting exchanging sex for drugs or money.

42. Since April 1, 2025, NJDOH has also been harmed by the closure of CDC laboratories. Specifically, NJDOH learned that the CDC laboratory for analyzing, tracking and testing complex STIs has been shut down. Among other crucial services, that laboratory had been studying drug-resistant gonorrhea by testing gonorrhea isolates for resistance patterns to identify working treatments.

43. As a result of the RIF at the CDC and the closure of the STI laboratory, there is no centralized provider monitoring potential changes to drug efficacy against STIs, which harms public healthcare. For example, NJDOH depends on the research and recommendations from the CDC to be up-to-date on resistance patterns to understand what treatments are working to stop the spread of gonorrhea. Without the STI laboratory conducting monthly testing to identify potentially drug-resistant strains, gonorrhea could now spread without warning, leaving New Jersey residents vulnerable.

44. NJDOH also learned that the CDC laboratory for performing hepatitis-related genotyping is currently not accepting specimens. The genomic sequencing conducted by this laboratory to track active hepatitis outbreaks is conducted by only a few other state public health laboratories, but none of these laboratories have definitively indicated capacity to sequence specimens from other jurisdictions.

45. The closure of the hepatitis laboratory has directly impacted NJDOH's ability to respond effectively to a current, ongoing outbreak of Hepatitis A. During previous Hepatitis A

outbreak investigations, genotyping and sequencing of clinical specimens through the CDC hepatitis laboratory were standard practice. While strong epidemiologic evidence suggests a common source of exposure for this outbreak in New Jersey, the loss of CDC laboratory sequencing capacity prevents NJDOH from confirming the connection through testing. This limits NJDOH's ability to definitively link cases to the source, initiate traceback investigations with full confidence, and provide targeted warnings to protect our community. Without sequencing, outbreak investigations become slower, less precise, and less effective, ultimately increasing the risk to public health. The loss of sequencing capacity at the CDC laboratory has significantly weakened the precision of NJDOH's outbreak response, elevated the risk of contaminated products remaining in circulation, and heightened the possibility that additional cases may arise.

46. In addition to all of these impacts, New Jersey has also experienced harm relating to the CDC's role in monitoring for and responding to lead poisoning, especially in children. NJDOH has historically relied on the CDC to assist by compiling lead exposure data from other states, allowing health departments to measure trends and develop sustainable policies. For example, New Jersey has relied on the CDC to help develop policies implementing universal blood lead screening for all children, regardless of risk; track new sources of lead exposure coming into the country, such as lead-contaminated toys; coordinate nation-wide investigations and product recalls, such as the 2024 nationwide recall of lead-contaminated applesauce pouches; and provide subject matter expertise to NJDOH and local health departments in areas related to lead exposure, lead poisoning, environmental health, and maternal and child health that would otherwise not be provided. This coordination and expertise ensure NJDOH, local health departments, and pediatricians can respond to the many complex factors that go into treating

children who have been exposed to toxic levels of lead and preventing cases before they happen, particularly because there is no safe level of lead in children and, once detected, the harmful effects cannot be reversed. The entire agency responsible for this program has disappeared overnight. Should any problems or questions arise, there is no one to go to for assistance.

Conclusion

47. The changes to the CDC as a result of the RIF and reorganization as described above, including the threatened loss of funding, the loss of institutional knowledge, the lack of communication from the CDC, and the loss of vital health data and testing, threaten to fundamentally inhibit NJDOH's ability carry out its obligations to the public.

Jeffrey A. Brown
Acting Commissioner
New Jersey Department of Health

Date: May 7, 2025

EXHIBIT 27

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF RHODE ISLAND

STATE OF NEW YORK, et al. Plaintiffs, v. ROBERT F. KENNEDY, JR., in his official capacity as SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., Defendants.	Case No. 1:25-cv-00196

Declaration of Katie Eilers

I, Katie Eilers, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the foregoing is true and correct:

1. I am over the age of 18, competent to testify as to the matters herein, and make this declaration based on my personal knowledge and the records of the Washington State Department of Health to which I have access.

2. I hold a Masters Degree in Public Health and a Masters of Science in Nursing, and am a Registered Nurse in the State of Washington. I have worked at the Department of Health in my role as Director of the Office of Family and Community Health Improvement for six years. This role involves strategic oversight of several bodies of public health surveillance, assessment, practice and public policy that benefit the health of women, children, families, and communities. I manage seven sections and about 94 FTEs.

3. The Washington State Department of Health is the public health agency of Washington State. It is created by Washington law in chapter 43.70 RCW. It has many duties delegated to it by the Washington State Legislature, including the preservation of public health,

monitoring health care costs, the maintenance of minimal standards for quality in health care delivery, and the general oversight and planning for all the state's activities as they relate to the health of its citizenry. The Department is also responsible for monitoring population health through surveillance and data analysis, management of infectious disease, disaster preparedness and response, and promotion of public health practice and policies that promote health and prevent disease. The Office of Family and Community Health Improvement, of which I am the Director, promotes health and well-being of individuals, families, and communities in the state of Washington through a range of programmatic and policy initiatives. This includes a special focus on identifying children with special health needs and assuring they receive the care and resources they need to be healthy. Many of our most impactful programs in our office leverage a combination of state and federal funding and rely on professional collaboration across the nation.

4. One program operated by the Washington State Department of Health (DOH) through the Office of Family and Community Health Improvement is the Pregnancy Risk Assessment Monitoring Systems (PRAMS). PRAMS is a joint surveillance project that collects detailed data on individuals' experiences during pregnancy, delivery and post-partum. Public health surveillance is important because it reveals emerging needs and challenges faced by the population, as well as indicates what intervention and services may be having a positive impact. These data guide interventions and policies that reduce maternal and infant morbidity and mortality. For example, PRAMS data on infant sleep practices prompted a Safe Sleep campaign educating providers and families about the best practices for infant sleep to reduce sudden unexplained infant death, which is one of the leading causes of death among infants younger than one year. Maternal health best practices that were guided by PRAMS data include a Medicaid waiver to cover longer hospitals stays based on early hospital discharges post-delivery and extending Medicaid coverage for

12 months postpartum due to postpartum health care access barriers reported in PRAMS. Annually approximately 1,200 individuals from Washington respond to the PRAMS survey, sharing their experiences with prenatal and postpartum care, challenges meeting basic needs, struggles with substance use or intimate partner violence, and mental health challenges and supports during and after pregnancy. This is the only source of self-reported data during the perinatal period that offers a comprehensive and contextualized window into a critical period for both mothers and infants.

5. PRAMS relies on financial, technical, scientific and system support from the Centers for Disease Control (CDC). Twenty percent of Washington's PRAMS budget is awarded annually from the CDC to support its operations. In-kind support provided by the CDC includes hosting the PRAMS Integrated Data System which all sites use for data collection and tracking of recruitment data, expert statistical data weighting, and technical guidance to ensure high quality surveillance data from each site. Per our cooperative agreement, Washington submits all of the PRAMS data to CDC, which cleans it and adds statistical weights before sending back a final annual dataset. Due to current reduction in force at CDC, our final dataset for 2024 has not been released. At a national level, the CDC plays a critical role leading the development and coordination of a standardized surveillance system with a core set of survey questions and standard survey protocol. This allows Washington to combine our data with other sites to produce a national surveillance system to monitor progress towards national goals and identify emerging needs. Participation in the national surveillance system affords us sufficient data to do more nuanced analyses to identify changes in trends, emerging risks and opportunities to understand the barriers to health. Without the national surveillance data from PRAMS, Washington alone would need to greatly expand our survey sample to be able to examine data geographically, by family income, or other characteristics which may have implications healthy outcomes. This is cost prohibitive.

6. On April 30, 2025, DOH received an email from the CDC indicating that it would no longer be providing this support. A true and correct copy of this email is attached to this declaration as **Exhibit 1**. Without support from the CDC to administer the PRAMS program, surveillance of Washingtonians' health during a critical lifecourse event will be severely compromised. There is no other comparable source of surveillance data for the perinatal period in Washington and no means to monitor health outcomes and goals during this period without creating our own system. Without CDC support, Washington will need to build an independent surveillance project with a data collection and management system to support mail, phone and web survey responses; develop survey weighting methodology for the complex survey design; and directly manage all data sharing agreements with public health partners and researchers. Creating a state-only PRAMS requires time for planning and implementation and would cause us to lose at least one year of data. Even if Washington were able to build this system without the CDC's leadership creating a unified surveillance project, we will lose the ability to combine data with other states for a national picture of the strengths and challenges faced by mothers and infants during the perinatal period.

7. Another program operated by the Washington State Department of Health through the Office of Family and Community Health Improvement is the Early Hearing Detection, Diagnosis, and Intervention (EHDDI) program. This program determines whether babies have hearing loss as soon as possible after birth so that families and providers can give them the best possible support for developing language and communication skills. Undetected hearing loss can lead to delays in speech and language development, challenges in interacting with others, and difficulties learning. This program allows all babies in Washington to be screened for hearing loss before hospital discharge, or by one month of age; have a diagnostic hearing evaluation by an audiologist by three months of age

if screenings indicate one is needed; and be enrolled in family-centered early intervention services by six months of age if the child is identified as deaf or hard of hearing (DHH).

8. Through data collection and outreach to health care providers, EHDDI helped to ensure that 99% of infants born in 2023 in Washington received a newborn hearing screening. 95% of infants were screened before one month of age. The program's outreach and support to midwives increased the percentage of out-of-hospital births receiving screenings from 17% in 2011 to 63% in 2023. Each year the EHDDI program identifies approximately 175 infants who are DHH. Through partnerships with providers and other agencies, 70% of infants identified as DHH in 2023 were enrolled in early intervention services, 63% of whom were enrolled by six months of age.

9. Through a cooperative agreement with the CDC, the EHDDI program relies on the CDC for funding and technical assistance to assess the quality and completeness of EHDDI data, identify gaps, suggest quality improvement strategies, and evaluate whether Washington is meeting national standards. The CDC Early Hearing Detection and Intervention (EHDI) team revises and implements data standards, allowing Washington to leverage existing best practices and focus resources on improving the EHDDI system and supporting families. CDC's work also ensures consistency of data collection and assessment across states. This allows Washington to compare its performance with other states, share strategies for improvement through national collaboration, and advocate for changes that support better outcomes for Washington families.

10. The CDC EHDI team also supports Washington in evaluating our state's hearing screening, diagnostic, and early intervention services, helping to identify trends and areas for improvement. For example, a recent CDC-supported analysis of Washington's EHDDI data identified young maternal age as a possible contributing factor to children not receiving screening,

diagnostic, and early intervention services. Based on these findings, we plan to explore specific strategies to address barriers among younger mothers.

11. In addition to offering collaboration with data reporting and analysis, the CDC EHDI team facilitates funding to the EHDDI program which helps support quality improvement efforts to address issues like challenges in linking infants to audiology services.

12. Washington's current cooperative agreement with CDC EHDI ends June 30, 2025, and the EHDDI program applied in March for funding under a new cooperative agreement cycle. The CDC EHDI team's expertise and support are essential for the review of this application, administrative management of the cooperative agreement if funded, and as previously discussed the technical assistance provided to Washington through the cooperative agreement.

13. On April 24, 2025, DOH received an email from the CDC indicating that the CDC was unable to continue providing support to the Washington EHDDI program. The email indicated that "all but one team member [of the team providing support for the Washington EHDDI program] is on administrative leave as a result of the federal reduction in force (RIF)." It further indicated that "the typical functions of project officers, health/data scientists and evaluation scientists are not occurring." A true and correct copy of this email is attached to this declaration as **Exhibit 2**.

14. The CDC EHDI staff have historically helped strengthen data quality, ensure consistency with national data standards, and identify gaps in Washington's hearing screening, diagnostic, and early intervention services. All states currently report standardized EHDDI data to the CDC. Without this centralized reporting, Washington would have diminished capacity to reliably compare data with other states, monitor national trends, and identify nationally-informed quality improvement needs. I am not aware of any other centralized resource which could effectively replace this role. Loss of funding would impact Washington DOH staffing levels and

could compromise our capacity to ensure timely data collection, data analysis, quality improvement activities, and integration of hospital electronic health records necessary to help streamline patient care. Over time, the absence of CDC support will place growing strain on Washington's EHDDI system, potentially resulting in increased challenges in identifying where families are experiencing delays and barriers in receiving services, coordinating follow-up for infants, and ensuring that all children receive timely and appropriate screening, diagnosis, and early intervention services. As a result, children who are DHH could be at increased risk for negative outcomes due to delays in identification and enrollment in needed support services.

15. In order to ensure that the PRAMS and EHDDI programs can continue to promote the best care for families, and to keep women and babies safe, our federal partners at CDC must be able to continue their work in technical assistance, convening of partners, best practices, and data collection and analysis.

16. I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

/s/ Katie Eilers

Katie Eilers, Director
Office of Family and Community Health Improvement
Washington State Department of Health

Date: May 8, 2025

Exhibit 1

From: Raman, Jayalakshmi (Jaya) (CDC/NCCDPHP/OD)
To: Brown, Natalie (CDC/NCCDPHP/OD); Kroelinger, Charlan (CDC/NCCDPHP/DRH)
Subject: PRAMS Update
Date: Wednesday, April 30, 2025 1:47:26 PM

External Email

Dear Recipient,

As you may be aware, CDC can no longer provide the scientific, technical, and information technology assistance resources as described in the Notice of Funding Opportunity RFA-DP-21-001 for the Pregnancy Risk Assessment Monitoring System (PRAMS). CDC will share guidance for revision of workplans and budget documents for the Year 5 budget period starting May 1, 2025 through April 30, 2026 soon.

Please also note that there are new requirements for requesting payments in the Payment Management System (PMS). Going forward, you will be required to provide a justification for each payment request. The justification must accompany the request and will be sent to the CDC for approval. To help expedite the approval process, please include the following information in your justification:

1. Notice of Funding Opportunity Number
2. Grant Number
3. Budget Period
4. Payment Request Justification: Examples: Payroll and Fringe for Staff Payment Justification: Subcontractor Payments to ABC Industries, DEFG Solutions Payment Justification: Supplies – copies, paper Payment Justification: Other – publications, insurance, professional services
5. Summary total of the requested cost (e.g. Salaries - $1,000; supplies - $100, etc.)

When submitting your PMS drawdowns, please avoid using the same response for multiple payment justification entries. It is important to provide adequate justification; otherwise, your request may be rejected. It's recommended that you separate your payment request by awarding agency to prevent approval delays. **If additional information is needed, the assigned GMS/GMO will contact you directly. Additionally, you may need to email supporting documents to your GMS on a case-by-case basis, so please ensure they are readily available if requested by the GMO.** (For research recipients, GMS/GMO may contact recipients directly for additional to be emailed as they are not able to upload into the GrantSolutions Grant Notes.)

Jayalakshmi Raman,
Health Scientist
Centers for Disease Control and Prevention (CDC)
Department of Health and Human Services (HHS)
770 488 6511

Exhibit 2

From: DHDD OD Requests (CDC)
Cc: EHDI Co-op (CDC)
Subject: Updates for DD20-2006 EHDI Recipients
Date: Thursday, April 24, 2025 6:29:42 AM
Attachments: DataSubmissionChecklist.docx
HSFS_iEHDI_2023.xlsx
iEHDI_DD2006_final_ExhibitA_0722.xlsx

External Email

Hello DD20-2006 EHDI Recipients,
The Division that housed the EHDI program, Division for Human Development and Disability (DHDD) is sending this message during what has been a challenging time for the CDC EHDI team. Prior messages have indicated that all but one team member is on administrative leave as a result of the federal reduction in force (RIF). This is still the case. In turn, the typical functions of project officers, health/data scientists and evaluation scientists are not occurring. However, a primary requirement of your program's receipt of federal funding through DD20-2006 (attached) is data submission. Here are a few notes of guidance that we can offer at this time:

Workplans and Reporting

- We ask that you continue to complete workplan activities until the end of the period of performance.
- As with previous EHDI notice of funding opportunities (NOFO), a close out will be due 120 days after the end of the performance period (120 days after June 30, 2025) for due date for final progress reports due 10/30/2025.
- SAMS is still functional, so you can submit 2023 iEHDI data. **Final 2023 iEHDI data is due May 23, 2025.**
    - Please note that CDC will not be able to return data quality reports.
    - The data dictionary and data checklist are attached.
    - If you are having issues with accessing SAMS, please contact Yvette Dominique yad4@cdc.gov. Yvette, is a senior leader in DHDD that is currently supporting all IT-related requests for the Center. Please be patient if there is a delay in her response.
- The ehdico-op@cdc.gov mailbox is still functional but may be checked less frequently. Please send emails to both ehdico-op@cdc.gov and dhddodrequests@cdc.gov when sending correspondences.

Data Quality Review with CDC Foundation

- You may remember that CDC EHDI hosted office hours where the CDC Foundation (CDCF) was introduced as a group funded to support technical assistance analyzing iEHDI data. The CDCF's workplan includes reaching out to states, providing with 1:1 technical assistance to review missingness and overall data quality. Caitlin worked closely with this team to create SAS code and a slide deck specific for each state. CDCF will share with you a summary of the 2022 iEHDI data that you submitted to CDC. CDCF has access to a limited analytic dataset (not the full dataset) on our secure server. As a result, CDC EHDI followed all agreements within the DUA. Please collaborate with this expert team to learn more about your iEHDI data.

Applications for DD25-0157

- As a result of the RIF, the objective review for DD25-0157 Enhancing Timely Data Reporting, Quality, and Use in EHDI Surveillance is on hold. It is unclear whether a

review of applications will occur.

This is all of the information we have to share at this time. If any funding-related changes occur, you will receive a notice in GMS. Thank you for your continued work and contributions to EHDI, even within the uncertainty. We appreciate your patience.

Sincerely,

DHDD Team

EXHIBIT 28

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF RHODE ISLAND

STATE OF NEW YORK, et al. Plaintiffs, v. ROBERT F. KENNEDY, JR., in his official capacity as SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., Defendants.	Case No. 25-cv-00196

DECLARATION OF NAOMI BIGGS

I, Naomi Biggs, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the foregoing is true and correct:

1. I am the Public Health Director of the Oregon Health Authority (OHA). I am familiar with the information in the statements set forth below either through personal knowledge, in consultation with directors, staff, and subject matter experts within OHA, or from documents that have been provided to and reviewed by me.

2. I submit this Declaration in support of the States' Motion for a Preliminary Injunction.

Professional Background

3. I have been employed in public health education, administration, and policy implementation in Oregon since 2022. I have been the Public Health Director since August 2024. My prior responsibilities include Local Public Health Administrator of Polk County, Oregon; Country Preparedness and International Health Regulations Officer for the Seychelles World Health Organization (WHO) Country Office; Medical Officer/Physician for the Ministry of

Health in Victoria, Seychelles; and WHO Consultant in Kigali, Rwanda and Port Louis, Mauritius.

4. OHA's mission is to promote and protect the physical, mental, and social health and wellbeing of Oregonians individually and in their communities. OHA administers multiple health policy and public health programs across all of Oregon's 36 counties, including extensive research and data analysis activities to support prevention and response to health threats.

5. OHA's Public Health Division includes the Center for Health Protection, the Center for Prevention and Health Promotion, the Center for Public Health Practice and the Office of the State Public Health Director. These Centers and Office in turn house dozens of programs that protect Oregonians from environmental contaminants, provide health education, collect data on health threats and health outcomes, license health professionals, and develop policy and procedure for responding to health threats. OHA identifies and addresses threats to the health of Oregonians whether from chronic health conditions, communicable diseases, occupational injuries, addiction, or violence.

6. I am providing this declaration to explain the impacts on Oregon of the cuts to HHS, including cuts to the Centers for Disease Control and Prevention (CDC), National Institute for Occupational Safety and Health (NIOSH), and the Substance Abuse and Mental Health Services Administration (SAMHSA).

Reliance on HHS Data and Technical Expertise

7. Prior to April 1, 2025, OHA had hundreds of partnerships with federal entities ranging from technical assistance, grant funding, research collaboration, and embedded staff to jointly administer public health programs. Approximately 37 percent of OHA funding comes through HHS grants. In addition, OHA relies on data collected and maintained in centralized

federal data sets in multiple areas vital to public health, including maternal and infant mortality and morbidity, use and misuse of controlled substances and substances other than prescribed, and infectious diseases and national or regional outbreaks, to name but a few.

8. Oregon's lead maternal child health epidemiologist was funded through a federal partnership with the CDC. This epidemiologist served a vital role in developing programing and conducting research in maternal, infant, child, and adolescent health, including assistance in maternal mortality review committees and other efforts to address maternal mortality.

9. Oregon partnered with the CDC in a Pregnancy Risk Assessment Monitoring System (PRAMS) cooperative agreement to support state-based safe motherhood and infant health initiative programs pursuant to 42 U.S.C 247b-12. CDC participation is critical for administration of the funded program not only to maintain approvals and provide jurisdiction-specific model procedures, but also to securely host and process the data and create the datasets for state use. CDC also provides technical assistance and program oversight.

10. Oregon relied on a grant from the CDC Division for Human Development and Disability for Early Hearing Detection and Intervention for funding, technical assistance, and data collection used in screening newborns and young children for hearing loss.

11. The Oregon State Public Health Lab requires NIOSH certified PPE and equipment, and other OHA programs rely on NIOSH staff for technical assistance as well as key data on workplace injuries and fatalities as part of Oregon's public health injury surveillance system.

12. Oregon relies on the CDC Office of Smoking and Health for assistance in tobacco prevention and control, including the State Tobacco Activities Tracking and Evaluation (STATE) System, and resources for Oregon's tobacco quitline. Oregon also receives guidance and

technical assistance for public health education on smoking cessation, data monitoring for emerging products and trends, policy best practices, communications campaigns and materials, and how to support prevention and cessation for populations most burdened with tobacco use.

13. Oregon relied on the Healthy Aging Branch in Division of Population & Health at CDC for technical assistance in implementing Healthy Aging programs responding to Alzheimer's Diseases and Related Dementia, arthritis, and other chronic diseases. Joint state and federal efforts are critical to developing community-clinical linkages for programs that provide safe, accessible physical activity, social connection, and opportunities to better manage chronic diseases of elder Oregonians.

14. Oregon relied on CDC for its assistance in monitoring for and responding to childhood lead poisoning.

15. Oregon relied on SAMHSA for regularly updated data about use and abuse of controlled substances. The National Survey on Drug Use and Health (NSDUH) provides key long-term trending data on drug use, tobacco use, alcohol use and mental health disorder prevalence and patterns in Oregon. It allows for comparing Oregon to other jurisdictions for coordination and planning.

16. The above OHA programs and others rely heavily on technical assistance from project officers, trained technical experts, and other HHS personnel in regional and national offices to administer programs in Oregon. Technical assistance may include trainings, consultations with subject matter experts, provision of written materials, advice and support for public health communications, data hosting and access to technology, coordination and collaboration with other states' programs and grant administration.

Changes in HHS Data and Technical Assistance Since April 1, 2025

17. Since April 1, 2025 technical assistance has been terminated for dozens of OHA programs including:

a. The OHA HIV/STD/TB Section that relied on the now-terminated National HIV Behavioral Surveillance unit and Medical Monitoring Project;

b. The Oregon Injury and Violence Prevention program that relied on National Center for Injury Prevention Control at CDC;

c. The Tobacco Prevention and Control Program that relied on the CDC Office on Smoking and Health;

d. Health Security and Preparedness and Response at OHA that relied on now-cancelled national webinars and technical assistance calls with the Administration for Strategic Preparedness and Response (ASPR);

e. Health Security Preparedness and Response at OHA experienced cancellation of ASPR Strategic National Stockpile on-site inspection and validation of Oregon's two officially designated Receiving, Storage and Shipping (RSS) warehouse sites which has been a requirement for approximately 15 years. These inspections enable Oregon to directly and timely receive shipments from the Strategic National Stockpile, such as PPE and other supplies, during an emergency event.

18. HHS terminated the Oregon-assigned CDC Maternal and Child Health Senior Epidemiologist on March 31, 2025. Loss of this vital role harms Oregon's work to advance the health of families and children in Oregon. The epidemiologist is a critical participant in Oregon's Maternal Mortality Review Committee, represents Oregon on the Science and Epidemiology Council and provides scientific support around E-cigarette or Vaping, Product Use-Associated

Lung Injury (EVALI) and during public health threats such as Zika virus, and the COVID-19 pandemic.

19. CDC possesses 2024 raw survey response data for participating states including Oregon. Since April 1, 2025, Oregon has experienced harm relating to its participation in the PRAMS Cooperative Agreement because Oregon cannot clean and weight raw survey response data without CDC engagement. Federal personnel experienced with PRAMS are required to produce the data sets for state use. PRAMS personnel are necessary to maintain ongoing OMB approvals and CDC approvals for projects that engage human subjects.

20. The CDC data portal for PRAMS (PIDS) is offline with no communication regarding expected return date. CDC also hosts and maintains the software system for use in data collection procedures and monitoring of PRAMS operational data. PRAMS personnel provide training and operations management on the use of CDC supported software and assist with presentation and formatting of data.

21. Without PRAMS personnel and the CDC PRAMS program as a whole, Oregon cannot develop further data collection to respond to emerging issues or adequately report out findings or collaborate with other states participating in PRAMS.

22. Since April 1, 2025, Oregon has experienced harm from loss of technical support from the Childhood Lead Poisoning Prevention Branch at the CDC. Since the elimination of this program, the OHA Environmental Public Health Section (EPH) has been unable to obtain program operational support or reach their Project Officer.

23. EPH no longer has access to Sentinel Event Notification System for Occupational Risks of Pesticides (SENSOR-Pesticides), or to SENSOR staff who provide technical assistance for state pesticide exposure surveillance programs. We can no longer provide Oregon pesticide

data to update pesticide safety information, surveillance methods and analyses that guide EPA regulation of pesticides and ultimately reduce Oregonians' exposure to pesticides.

24. EPH relies on FDA for technical assistance and expertise. The FDA has cancelled the regional annual conference where Oregon would collaborate with other states on food safety issues as well as learn current food science to safeguard the health of all Oregonians eating in licensed food service facilities statewide.

25. Since April 1, 2025, Oregon has experienced harm relating to loss of SAMHSA data and program support. Loss of NSDUH data has eliminated the source of key indicators used by OHA to track trends and progress on overdose prevention, tobacco prevention, alcohol prevention, and mental and behavioral health.

26. Attached as Exhibit 1 is a true and correct copy of an email (without original attachments) from the Division of Human Development and Disability to an OHA program contact for the Early Hearing Detection and Intervention grant stating the impact of the RIFs is "the typical functions of project officers, health/data scientists and evaluation scientists are not occurring".

27. Attached as Exhibit 2 is a true and correct copy of an email from the CDC received by Oregon's PRAMS team stating "CDC can no longer provide the scientific, technical, and information technology assistance resources as described in the Notice of Funding Opportunity RFA-DP-21-001 for the Pregnancy Risk Assessment Monitoring System (PRAMS)."

28. These changes risk significant harm to public health in Oregon because Oregon Health Authority does not have the personnel or expertise to replace hundreds of program officers, scientists, and subject matter experts across all the affected programs. As a result,

capacity to surveil, track, test for, prevent, and respond to infectious and other diseases will decline, less data will be available to inform public health action in Oregon, and public health officials will lose access to critical training and historical knowledge.

29. Each of the above-described programs affecting Oregonians from birth to old age will be less effective due to fewer resources and loss of expertise. The harms these programs seek to prevent include infectious diseases, maternal and infant mortality, tobacco addiction, and lead toxicity in children. Loss of capacity to test for infectious and foodborne disease, reduce contamination in air and water, evaluate risks and harms of chronic and acute conditions, and respond to health crises will lead to increased injury, illness, and premature, preventable death for Oregonians.

Naomi Biggs

Date: 5/8/25

Wilcox Cate S

From: DHDD OD Requests (CDC) <dhddodrequests@cdc.gov>
Sent: Thursday, April 24, 2025 6:29 AM
Cc: EHDI Co-op (CDC)
Subject: Updates for DD20-2006 EHDI Recipients
Attachments: DataSubmissionChecklist.docx; HSFS_iEHDI_2023.xlsx; iEHDI_DD2006_final_ExhibitA_0722.xlsx

before clicking on links or opening attachments. This email came from outside our organization and might not be safe. If you are not expecting an attachment, contact the sender before opening it.

Hello DD20-2006 EHDI Recipients,

The Division that housed the EHDI program, Division for Human Development and Disability (DHDD) is sending this message during what has been a challenging time for the CDC EHDI team. Prior messages have indicated that all but one team member is on administrative leave as a result of the federal reduction in force (RIF). This is still the case. In turn, the typical functions of project officers, health/data scientists and evaluation scientists are not occurring. However, a primary requirement of your program's receipt of federal funding through DD20-2006 (attached) is data submission. Here are a few notes of guidance that we can offer at this time:

We ask that you continue to complete workplan activities until the end of the period of performance. As with previous EHDI notice of funding opportunities (NOFO), a close out will be due 120 days after the end of the performance period (120 days after June 30, 2025) for due date for final progress reports due 10/30/2025.
SAMS is still functional, so you can submit 2023 iEHDI data.

- Please note that CDC will not be able to return data quality reports.
- The data dictionary and data checklist are attached.
- If you are having issues with accessing SAMS, please contact Yvette Dominique yad4@cdc.gov. Yvette, is a senior leader in DHDD that is currently supporting all IT-related requests for the Center. Please be patient if there is a delay in her response.

The ehdico-op@cdc.gov mailbox is still functional but may be checked less frequently. Please send emails to both ehdico-op@cdc.gov and dhddodrequests@cdc.gov when sending correspondences.

You may remember that CDC EHDI hosted office hours where the CDC Foundation (CDCF) was introduced as a group funded to support technical assistance analyzing iEHDI data. The CDCF's workplan includes reaching out to states, providing with 1:1 technical assistance to review missingness and overall data quality. Caitlin worked closely with this team to create SAS code and a slide deck specific for each state. CDCF will share with you a summary of the 2022 iEHDI data that you submitted to CDC. CDCF has access to a limited analytic dataset (not the full dataset) on our secure server. As a result, CDC EHDI followed all agreements within the DUA. Please collaborate with this expert team to learn more about your iEHDI data.

As a result of the RIF, the objective review for DD25-0157 Enhancing Timely Data Reporting, Quality, and Use in EHDI Surveillance is on hold. It is unclear whether a review of applications will occur.

This is all of the information we have to share at this time. If any funding-related changes occur, you will receive a notice in GMS. Thank you for your continued work and contributions to EHDI, even within the uncertainty. We appreciate your patience.

Sincerely,
DHDD Team

From: Raman, Jayalakshmi (Jaya) (CDC/NCCDPHP/OD) kva5@cdc.gov
Subject: FW: PRAMS Update
Date: Apr 30, 2025 at 2:03:20 PM
To: Brown, Natalie (CDC/NCCDPHP/OD) fmc7@cdc.gov, Kroelinger, Charlan (CDC/NCCDPHP/DRH) dwz8@cdc.gov

Think twice before clicking on links or opening attachments. This email came from outside our organization and might not be safe. If you are not expecting an attachment, contact the sender before opening it.

Dear Recipient,

As you may be aware, CDC can no longer provide the scientific, technical, and information technology assistance resources as described in the Notice of Funding Opportunity RFA-DP-21-001 for the Pregnancy Risk Assessment Monitoring System (PRAMS). CDC will share guidance for revision of workplans and budget documents for the Year 5 budget period starting May 1, 2025 through April 30, 2026 soon.

Please also note that there are new requirements for requesting payments in the Payment Management System (PMS). Going forward, you will be required to provide a justification for each payment request. The justification must accompany the request and will be sent to the CDC for approval. To help expedite the approval process, please include the following information in your justification:

1. Notice of Funding Opportunity Number
2. Grant Number
3. Budget Period
4. Payment Request Justification: Examples: Payroll and Fringe for Staff Payment Justification: Subcontractor Payments to ABC Industries, DEFG Solutions Payment Justification: Supplies – copies, paper Payment Justification: Other – publications, insurance, professional services
5. Summary total of the requested cost (e.g. Salaries - $1,000; supplies - $100, etc.)

When submitting your PMS drawdowns, please avoid using the same response for multiple payment justification entries. It is important to provide adequate justification; otherwise, your request may be rejected. It's recommended that you separate your payment request by awarding agency to prevent approval delays. **If additional information is needed, the assigned GMS/GMO will contact you directly. Additionally, you may need to email supporting documents to your GMS on a case-by-case basis, so please ensure they are readily available if requested by the GMO.** (For research recipients, GMS/GMO may

contact recipients directly for additional to be emailed as they are not able to upload into the GrantSolutions Grant Notes.)

Jayalakshmi Raman,
Health Scientist
Centers for Disease Control and Prevention (CDC)
Department of Health and Human Services (HHS)
770 488 6511

EXHIBIT 29

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF RHODE ISLAND

STATE OF NEW YORK, et al. Plaintiffs, v. ROBERT F. KENNEDY, JR., in his official capacity as SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., Defendants.	Case No. 1:25-cv-00196

DECLARATION OF JENNIFER EPSTEIN

I, Jennifer Epstein, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the foregoing is true and correct:

1. I am the Deputy Director of the Illinois Department of Public Health (IDPH). I have personal knowledge of the facts set forth in this declaration, and if required to testify, would and could competently do so.

2. I submit this Declaration in support of the States' Motion for a Preliminary Injunction.

Professional Background

3. I am the Deputy Director at the Office of Policy, Planning and Statistics (OPPS) at the Illinois Department of Public Health. I have over 20 years of experience in public health and a professional background that includes roles in both the nonprofit and public sectors in international and domestic settings. I joined IDPH in 2018 and have been the Deputy Director for OPPS since 2022. Ms. Epstein holds a Master of Science in Urban and Regional Planning from

the University of Wisconsin-Madison, with a concentration in community development, and a Bachelor of Arts from Macalester College in St. Paul, MN.

4. The OPPS mission is to collect, analyze, and evaluate information on health status, needs, and disease occurrence in Illinois; conduct epidemiologic studies; support health assessments and planning; and identify future needs for health care facilities, services, and personnel. OPPS preserves the state's records on births, deaths, marriages, civil unions, and dissolutions.

5. I am providing this declaration to explain the impacts on Illinois of the cuts to the U.S. Department of Health and Human Services (HHS), specifically cuts affecting the Pregnancy Risk Assessment Monitoring System (PRAMS).

Reliance on HHS Data and Technical Expertise

6. IDPH staff conduct PRAMS surveys of birthing parents of babies born in Illinois in the past three months. IDPH staff members entered data from these surveys into the PRAMS Integrated Data System (PIDS), which was maintained by the Division of Reproductive Health (DRH) in one of the Centers for Disease Control and Prevention (CDC).

7. PRAMS collected nationwide data on maternal and infant health outcomes, weighted the data for each site, and made it available to grantees. PRAMS was designed to identify groups of infants and pregnant people at high risk for health problems and to monitor progress towards the goal of improving maternal and infant health.

8. IDPH is a state-level partner and grantee for PRAMS. It has received grant funding to collect data for PRAMS on maternal and infant health: $175,000 per year from the CDC PRAMS Grant, and approximately $65,000 per year from the CDC Preventive Health and

Health Services (PHHS) Block Grant. Federal grants make up more than half (about 65%) of total funding for Illinois PRAMS.

9. IDPH received technical support, monitoring, and general assistance to carry out the grant award.

10. The fifteen-person team at HHS that was responsible for PRAMS was eliminated in the mass Reduction in Force (RIF) conducted on April 1, 2025, in furtherance of the March 27 Directive for HHS.

Changes in HHS Data and Technical Assistance Since April 1, 2025

11. Since April 1, 2025, IDPH has lost access to technical services for PRAMS.

12. Data collection from PRAMS ended early this year because the CDC closed off PIDS for all sites, including Illinois. PIDS was reopened in April, but only for one week to allow for final data entry and closure activities.

13. 2024 weighted data have not been released to the states, including Illinois, and PIDS remains inaccessible at this time. No guidance has been provided on how to proceed, except for a notice regarding questions that will need to be scrubbed from the survey.

14. The CDC has also closed access to its online data request system. As a result, Illinois PRAMS staff have received more direct data requests than usual, increasing the burden on IDPH employees.

15. Our program grant officer was laid off as a result of the April 1, 2025, RIF, and we have not been assigned another.

16. On April 30, 2025, we received a message through eRA Commons (a system for National Institutes of Health grantees and grant applicants) that the CDC can no longer provide

the scientific, technical, and information technology assistance resources as described in the Notice of Funding Opportunity RFA-DP-21-001 and they would share guidance for revising workplans and budget documents for this budget period. We have not received any further guidance or clarification since that date.

17. If PIDS is not reopened, Illinois will need to build a new data collection system from the ground up in order to replicate the valuable data gleaned from the PRAMS surveys. Nationwide data might not be available at all or might not be comparable from state to state.

18. The State of Illinois would need to replace the federal grants for PRAMS (at a total cost of $240,000) to continue funding the internal IDPH staff who complete the PRAMS surveys or contract with outside personnel to do so.

19. Furthermore, it would need to contract with an outside entity to accomplish the weighing function currently provided by the CDC.

20. These changes threaten significant harm to public health in Illinois because without the technical services and access to nationwide data provided by the federal PRAMS staff who are now no longer employed by HHS, it will be difficult if not impossible for Illinois to identify trends in maternal and infant health outcomes and to measure progress towards our state's objectives in this area.

Jennifer Epstein

Jennifer Epstein

Date: 05/07/2025

EXHIBIT 30

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF RHODE ISLAND

STATE OF NEW YORK, et al. Plaintiffs, v. ROBERT F. KENNEDY, JR., in his official capacity as SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., Defendants.	Case No. _

DECLARATION OF STEVEN BLESSING

I, Steven Blessing, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the foregoing is true and correct:

1. I am the Director of the Delaware Division of Public Health. I am familiar with the information in the statements set forth below either through personal knowledge, in consultation with the Delaware Division of Public Health's staff, or from documents that have been provided to and reviewed by me.

2. I submit this Declaration in support of the States' Motion for a Preliminary Injunction.

Professional Background

3. I am the Division Director at the Delaware Division of Public Health. I have over 30 years of public health experience, including academic research and administration of a wide range of public health programs. I hold an undergraduate and graduate degrees in political science and business.

4. Delaware Division of Public Health's mission is to protect and promote the health of all people in Delaware.

5. The Delaware Division of Public Health, centrally located in Dover, Delaware, administers more than 300 public health programs, oversees a workforce of over 800 personnel, and manages millions of dollars in state and federal funding.

6. I am providing this declaration to outline the serious impacts that funding reductions have on Delaware's public health system. These cuts hinder our ability to identify, test for, and respond to emerging infectious diseases, and they threaten critical prevention efforts, such as reducing tobacco and vaping use among youth, which have long-term implications for chronic disease and population health. Additionally, cutting funds for the PRAMS program significantly weakens our capacity to collect essential data on maternal and infant health, data that guides evidence-based policies, programs, and interventions designed to improve health outcomes for mothers and babies across the state.

Reliance on HHS Data and Technical Expertise

7. Prior to April 1, 2025, Delaware's Division of Public Health relied heavily on HHS and CDC for data, guidance, and support to address maternal and infant health. Programs like the Maternal Mortality Review Committees and PRAMS provide critical information that helps us identify risks, guide prevention efforts, and improve health outcomes for mothers and babies across the state.

8. Delaware's Division of Public Health relied heavily on technical guidance and programmatic support from US Department of Health and Social Services (HHS), including the Center for Disease and Prevention (CDC) for its assistance in maternal mortality review committees and other efforts to eliminate maternal mortality. The information provided

through the Maternal Mortality Review process provides critical information on maternal deaths that occur during labor and delivery and up to one year postpartum. This data is used to inform evidence-based public health on women's health care delivery and access, coordination of care and services (i.e. physical care, behavioral health, home visiting services, etc.) that can prevent maternal morbidity and mortality and improve wellness. Maternal Mortality Review Committees (MMRC) have shown that two out of every three pregnancy-related deaths are preventable, underscoring the importance of this work.

9. Delaware's Division of Public Health relied on HHS, including the CDC, for data relating to the health and well-being of pregnant people and babies, including the Pregnancy Risk Assessment Monitoring System (PRAMS). This population-based surveillance system is designed to identify women and infants at high risk for health problems, to monitor changes in health status, monitor changes in maternal and child health indicators (i.e. prenatal care, breastfeeding, smoking, infant safe sleep), to measure progress in improving the health of mothers and babies, and reduce infant morbidity and mortality.

Changes in HHS Data and Technical Assistance Since April 1, 2025

10. Since April 1, 2025, Delaware's Division of Public Health has experienced harm relating to CDC's role in maternal mortality review committees and other efforts to eliminate maternal mortality. Specifically, without a maternal and mortality review process, Delaware lacks critical data driven recommendations and evidence on health care practice, screenings, patient education, lack of information on the need for services to address prenatal care, chronic diseases (i.e. diabetes), mental health, hypertension, substance use disorder, patient safety, how to reduce maternal morbidity and eliminate preventable maternal deaths.

11. Since April 1, 2025, Delaware's Division of Public Health has experienced harm relating to CDC data relating to the health and well-being of pregnant people and babies, including the Pregnancy Risk Assessment Monitoring System (PRAMS). Specifically, this surveillance program provides critical information on mothers and babies to inform and enhance our work in women's health care delivery, before, during and in between pregnancies, information on low birth weight and premature births, social needs (i.e. access to food, transportation, and housing) to prevent maternal and infant deaths and address poor health outcomes.

Conclusion

12. The Pregnancy Risk Assessment Monitoring System (PRAMS), supported by HHS and the CDC, is a vital population-based surveillance tool used by the Delaware Division of Public Health to monitor the health and well-being of pregnant people and their infants. PRAMS collects critical data on prenatal care, breastfeeding, smoking, safe sleep practices, and other key indicators to identify at-risk populations and track changes in maternal and child health over time. This information is essential for shaping evidence-based programs and policies aimed at reducing infant and maternal morbidity and mortality and improving long-term health outcomes.

Steven Blessing

Steven L. Blessing, MA
Division of Public Health, Director

Date: May 7, 2025

EXHIBIT 31

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF RHODE ISLAND

STATE OF NEW YORK, et al. Plaintiffs, v. ROBERT F. KENNEDY, JR., in his official capacity as SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., Defendants.	Case No. 1:25-cv-00196

DECLARATION OF DR. CHRISTOPHER SIMPSON

I, Christopher Simpson, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the foregoing is true and correct:

1. I have personal knowledge of the facts set forth in this declaration, and if required to testify, would and could competently do so.

2. I submit this Declaration in support of the States' Motion for a Preliminary Injunction.

3. I am the Director of the Northwest Center for Occupational Health and Safety (NWCOHS), and the Deputy Director for the Pacific Northwest Agricultural Safety and Health Center (PNASH) at the University of Washington in Seattle, WA. I am also a Professor and Assistant Chair for Research and Faculty Engagement in the UW Department of Environmental & Occupational Health Sciences (DEOHS). I am currently the Principal Investigator or a co-investigator on four investigator-initiated research grants from NIOSH, and I have received multiple additional research grants from NIOSH over the past 20 years. I am also co-director of the Exposure Assessment, Biomarkers and Environmental Sensing Core of the Interdisciplinary

Center for Exposures, Diseases, Genomics and Environment, also part of DEOHS. I received my PhD from the University of British Columbia, Canada, and my Master of Science from the University of Waikato in New Zealand.

4. The NWCOHS, established in 1977, is one of the eighteen extramural Education and Research Centers (ERCs) funded by grants from the National Institute for Occupational Safety and Health (NIOSH), housed within HHS' Centers for Disease Control and Prevention (CDC).[1] The centers exist to fulfill NIOSH's statutory requirement under the Occupational Safety and Health Act of 1970 to provide an adequate supply of qualified personnel to implement the Act by training the next generation of occupational health specialists. 29 U.S.C. § 670(a) (directing NIOSH to conduct either directly or with grants, "education programs to provide an adequate supply of qualified personnel to carry out the purposes" of this Act).

5. The NWCOHS receives $1.8M per year from NIOSH. It is the only ERC with a specific mission to serve the workforce needs in the federal region which includes the states of Washington, Oregon, Idaho and Alaska. The NWCOHS prepares graduate students for careers in occupational health and safety through MS, MPH, and PhD academic training programs, significant financial support, and applied research opportunities. Our graduate training programs include six core occupational health and safety disciplines: (1) Industrial Hygiene/Exposure Science; (2) Occupational Health Nursing; (3) Occupational Medicine Residency; (4) Occupational Health Services Research; (5) Occupational Health at the Human-Animal Interface; and (6) Work and Health Graduate Certificate. Additionally, we provide professional continuing education to over 1,000 working professionals each year through occupational health and safety focused short courses and certificate programs. We also partner with dozens of academic

[1] *NIOSH Extramural Research and Training, Education and Research Centers*, CDC (Dec. 16, 2024) https://www.cdc.gov/niosh/extramural-programs/php/about/ercs.html.

institutions, community-based organizations, nonprofits, governments and others on shared research and training activities.

6. The NWCOHS is funded by NIOSH under the Federal Training Grant T42OH008433.

7. Similarly, the Pacific Northwest Center for Agricultural Safety and Health (PNASH), established in 1996, is one of twelve Centers for Agricultural Safety and Health funded by NIOSH, which focus on addressing pressing health and safety problems in the agriculture, forestry, and fishing sector. PNASH receives approximately $1.6M per year from NIOSH. PNASH conducts research and promotes best occupational health and safety practices for Pacific Northwest farming, fishing and forestry, working throughout Washington, Idaho, Oregon, and Alaska, and integrating expertise from multiple integrated disciplines, institutions and community partners.

8. The PNASH Center is funded through a cooperative agreement with NIOSH, # U54 OH 007544A. The current funding cycle was awarded in 2022 under the Funding Opportunity Announcement RFA-OH-22-002, with a performance period from September 30, 2022, to September 29, 2027. However, funds beyond September 2025 have not yet been dispersed.

9. It is my understanding and belief that as a result of the massive reduction in force across HHS, over 90% of the staff of the National Institute for Occupational Safety and Health, housed Centers for Disease Control and Prevention, have been placed on administrative leave and will be permanently terminated on or after June 1, 2025.

10. Consistent with this reduction in force, we are greatly concerned that with the gutting of NIOSH, we will lose access to critical funding we need to keep our centers operational. Since April 1, 2025, both the NWCOHS and the PNASH have seen significant changes in its dealings with NIOSH.

Northwest Center for Occupational Health and Safety (NWCOHS)

11. In December of 2024, and in response to RFA-OH-25-002 issued by NIOSH, the NWCOHS, together with the other four ERCs who were approaching the end of their current 5-year award period, submitted our competing renewal applications requesting renewal of our funding for the period July 2025 to June 2030. Those applications were received by NIOSH, and the review meeting for those applications was scheduled for February 2025, as listed on the eRA commons website that is used by HHS for communicating with extramural awardees.

12. In early February 2025, the date for that review meeting was removed from eRA commons and, to our understanding, NIOSH was placed under a communications embargo. One of the outside experts whom NIOSH asked to review our applications later informed us that the review meeting had been cancelled, though we did not receive any official word from NIOSH to that effect.

13. In early March 2025 the eRA commons website was updated to show that the review meeting for our competing renewal application had been rescheduled for April 2025.

14. At my instruction, on March 26 NWCOHS staff subsequently contacted the program official for the ERCs at NIOSH, Dr. Elizabeth Maples, by email inquiring as to the status of our renewal application, and how to file a no-cost extension to our award, which would allow us to continue to spend any funds that remained at the end of our current award period—(June 30, 2025) in the event that cancellation of the review meeting prevented NIOSH from issuing a new award prior to the end of the current award. Dr. Maples responded the next day (March 27, 2025), with instructions on how to file the no-cost extension. On March 28, 2025, Dr. Maples (who retired effective March 31, 2025) was replaced by Dr. Eduardo O'Neil, who advised us that we had "expanded authorities" so our "request" for a no-cost extension was in fact

a notification of intent to proceed with a no cost extension, not a "true request." A true and correct copy of this e-mail chain is attached hereto as **Exhibit 1**.

15. Acting on these instructions from CDC/NIOSH, NWCOHS filed its request/notification for a no-cost extension on April 2, 2025 with the CDC.

16. We soon discovered that the already-rescheduled April 2025 meeting with our program official was also removed from eRA commons. We only discovered this when we logged in and checked ourselves; we did not receive word directly from NIOSH or CDC that the meeting was cancelled.

17. With our current award running out and having heard no response to our inquiries, on April 16, 2025, I called Dr. O'Neil at NIOSH and asked him when I could expect that the NWCOHS competing renewal application would be reviewed. He stated that he was not aware of any plans to review any of the five ERC competing renewal applications that had been submitted in December 2024—which would effectively terminate those ERCs. This review is required in order to renew the NWCOHS for an additional 5-year period. The program official also stated that due to the communications embargo he could not send emails to us to confirm this position, and could only answer the phone when directly called.

18. NWCOHS continued to reach out to the CDC to request a status update on our request for/notification of a no-cost extension. Finally, on May 2, 2025, a CDC Supervisory Grants Management Specialist wrote back and informed us that "***at the present time there is a pause on all NIOSH activities***" (emphasis added). She also informed us that we should "reach out to [our] project officer for additional guidance." A true and correct copy of this e-mail chain is attached hereto as **Exhibit 2**.

19. Despite CDC's insistence we simply "reach out" to our project officer, NIOSH remained under a communications embargo, making such outreach impractical, as our April 16 phone conversation demonstrated. CDC/NIOSH did not, for instance, inform us of the cancellation of the review meeting for April 2025. The NWCOHS has not received a response from NIOSH to our official request for concurrence with our no-cost extension request/notification, nor have we received responses to subsequent prior approval requests that we have submitted, including time-sensitive requests for approval for foreign travel on our award.

20. Funding for the NWCOHS ends June 30, 2025, and our request for a no-cost extension has not been authorized.

21. NWCOHS is already experiencing grave harms as a result of this inaction. Due to the cancellation of the review meeting for our competing renewal application and other indications that on-time renewal of funding for the NWCOHS was unlikely, we were unable to provide funded offers of admission for trainees entering our graduate programs in Fall, 2025. Consequently, only one occupational medicine resident has been admitted for the 2025–26 academic year. No new trainees have been admitted into our other training programs (Industrial Hygiene/Exposure Science, Occupational Health Nursing, Occupational Health Services Research, Occupational Health at the Human-Animal Interface and Work and Health Graduate Certificate). Furthermore, continuing trainees in these programs who were counting on NWCOHS funding to cover their stipend and tuition will no longer receive this support. Several of them are likely to change the focus of their research away from occupational safety and health to other disciplines where opportunities for financial support are better. Some of the trainees may be forced to prematurely terminate their graduate degrees altogether.

22. There is already a shortage of appropriately qualified OH&S professionals in the U.S. The loss of this year's cohort of OH&S trainees, and the negative effects on recruitment of future cohorts who will have been discouraged from entering this field due to the elimination of support will exacerbate the shortage of trained OH&S professionals and put American workers at increased risk for work related injury, illness and fatalities.

23. Due the loss of the incoming cohort of OH&S students, we expect that several of our OH&S focused graduate courses will be canceled for the upcoming year. Several key NWCOHS staff will have to be laid off effective July 1, 2025, or shortly thereafter. Other NWCOHS staff will be offered reduced FTE appointments, but we are likely to lose their expertise also. These layoffs will also affect our continuing education (CE) program—the loss of NIOSH funding will mean that we are able to offer fewer CE classes, and we will have limited capacity to develop new CE courses in response to emerging OH&S hazards. This will translate to fewer opportunities for working professionals to receive the critical OH&S training that they need to stay safe at work, and will inevitably lead to increased rates of work-related injury and illness, and consequent increased costs to both workers and employers. Unless funding is received by July 1, 2025—an action that requires qualified personnel at NIOSH to approve our application—the NWCOHS will have to shutter all operations.

Pacific Northwest Agricultural Safety and Health Center (PNASH)

24. The PNASH Center is still operating under the Notice of Award (NOA) terms and conditions received in 2022, when the grant was first awarded. We have not received any amendment to the performance period. We have also not received any formal communication detailing the termination or suspension of the NIOSH extramural Agriculture, Forestry and Fishing program (AgFF). We have also not been notified of any written justification for any administrative

decisions that might affect our award, nor have we been given the opportunity to respond to any decisions that have been taken. We submitted a prior approval request on March 18 on our current funding award and a Research Performance Progress Report (RPPR) on April 8th requesting carry-forward of funds, but we have not received any responses to the administrative budget actions related to these submissions.

25. As of April 2025, the NIOSH program official for PNASH, Dr. Steve Dearwent, is no longer available for regular communication, and monthly meetings between NIOSH staff and AgFF Center Directors have ceased. Efforts to contact NIOSH staff have been unsuccessful. Compounding these concerns, the AgFF funding line has been removed from the proposed FY2026 federal budget. We are now unable to engage with NIOSH program officers on critical administrative matters, including sub-award approvals, carry-forward requests, and confirmation of receipt or review of our RPPR for the current budget year. The lack of timely budget approvals and carry-forward request has resulted in the PNASH center suspending new subawards to pilot projects and some subcontractors.

26. Funding for PNASH will run out by September 29, 2025, without further action by HHS.

27. Given this unprecedented breakdown in communication and the absence of acknowledgment of our submitted materials, we are increasingly concerned that funding for PNASH Year 4 (October 1, 2025–September 29, 2026) will not be released, despite no formal notice to that effect. Most urgently, we are concerned that the lack of transparency and engagement will prevent the University of Washington, on behalf of the PNASH Center, from providing the timely information that could inform HHS leadership and potentially avert long-term harm to worker safety efforts in agriculture, forestry, and fishing across Region 10.

28. If in fact HHS has decided to terminate the AgFF program, without informing the recipients including PNASH, the repercussions will be felt immediately following our September 29, 2025 year-end. If we do not receive our Year 4 of funding, as detailed in our Notice of Award, we will be forced to lay off key staff, including those who have established partnerships with stakeholders across the region that help us to achieve our mission. There is no current funding available that would allow us to continue operating PNASH.

29. Some specific losses that affect the PNASH Center include a loss of $359,281 in carryforward funding from year 2 of the PNASH award as NIOSH staff have not taken the action necessary to approve this carryforward funding, which in previous years would have been done without delay. Similarly, NIOSH administrative staff have not been available to respond to a prior approval request to establish two new subawards: one with Alaska Marine Safety and Education Association for a pilot project to evaluate Project Gabe, an opioid overdose prevention program for commercial fishermen in Alaska and another with the University of Iowa for the RISC project, which aims to track regional occupational injury and illness in the agriculture, forestry, and fishing sectors. Although these projects utilize funds already awarded to PNASH, without receiving the prior approval notice from NIOSH the sub-awards cannot be set up and the projects will be cancelled.

30. Similar to NWCOHS, a delay or cessation in funding to the PNASH Center would immediately halt ongoing research, training, and outreach activities across agriculture, forestry, and fishing sectors in the Pacific Northwest. Practical safety resources developed for pesticide handlers, including widely used guides and training courses, would no longer be updated or disseminated. Forestry safety projects focused on mechanization and remote worksite hazards would be suspended, leaving regional employers and workers without technical support during a

period of rapid operational change. Heat illness prevention efforts, including bilingual education toolkits aligned with Washington State's occupational heat rules, would be discontinued just as employers are required to effectively ensure heat illness prevention programs in the workplace. In commercial fishing, life-saving interventions developed through the FLIPP program and Project Gabe, including overdose prevention tools and outreach in Alaska Native communities, would end abruptly, reversing years of progress. The dismantling of the PNASH Outreach Core would cause immediate and lasting harm by eliminating the region's primary mechanism for translating occupational health and safety research into effective, culturally tailored protections for rural workers. This action would sever long-standing, trusted partnerships with agricultural, forestry, and fishing communities, disrupt proven injury prevention programs, and erode the region's coordinated capacity to rapidly respond to emergent safety and health threats. The abrupt loss of this function would leave safety professionals, educators, and employers without up-to-date training materials or technical assistance during wildfire season, harvest periods, and peak fishing operations.

31. Because of what appears to be the wholesale elimination of NIOSH's extramural programs, in addition to all of NIOSH intramural programs except for the World Trade Center program and the Division of Compensation Analysis and Support, and the loss of personnel to administer NIOSH grants, I believe that both the NWCOHS and PNASH are at imminent risk of losing their funding. If nothing changes from NIOSH's current inactive status, NWCOHS will have to immediately start to wind down operations, and PNASH will likely have to do so in the late summer or fall of this year.

32. Even if funding is ultimately restored to either NWCOHS or PNASH by a department other than NIOSH, losing NIOSH itself would be devastating for the operations and

missions of NWCOHS and PNASH. For instance, many of PNASH's research initiatives are informed by data from NIOSH-funded surveillance programs. These include the Fatality Assessment and Control Evaluation (FACE) program and the Sentinel Event Notification System for Occupational Risks (SENSOR) Pesticides program. The FACE program investigates work-related fatalities to identify contributing factors and recommend effective prevention strategies. The SENSOR Pesticides program tracks acute occupational pesticide illnesses through collaboration with state health departments.

Effects of Losing NIOSH Intramural Programs

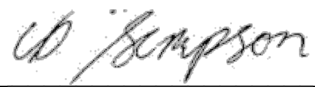
33. PNASH also draws on information from the broader NIOSH Occupational Health Surveillance Program, which supports states in collecting and analyzing data on occupational injuries, illnesses, and exposures. In addition, PNASH and the NWCOHS use national data sources such as the Census of Fatal Occupational Injuries and the Survey of Occupational Injuries and Illnesses, which help identify trends and evaluate the effectiveness of workplace interventions. The elimination of these surveillance programs, combined with the closure of PNASH and the NWCOHS, would severely limit the region's ability to detect emerging hazards, guide research priorities, and protect workers in agriculture, forestry, and fishing.

34. DEOHS at the University of Washington also receives support from the State of Washington through the State's Medical Aid and Accident fund (MAAF) to conduct research, training and service in occupational health and safety and occupational medicine, in order to prevent occupational disease among workers, and promote safer working environments. The approximately $4M–$5M annually that DEOHS receives from NIOSH via NWCOHS, PNASH and various investigator-initiated research grants compliment and leverage the MAAF funding

from Washington State. In the absence of these funds from NIOSH, DEOHS' capacity to conduct applied research and training in occupational health and safety will be substantially reduced.

35. Ultimately, NWCOHS and PNASH are one part of a larger ecosystem that supports the health and safety of underserved workers and their communities, including farmworker communities. This ecosystem is increasingly under strain. As federal funding declines across key sectors, the foundational infrastructure for underserved workers is beginning to erode, from migrant health centers and community-based organizations to the research institutions that support them. Universities play a critical role in this ecosystem by producing research that helps identify risks, guides education and outreach, and informs policy. Our work doesn't stand alone and it strengthens the capacity of those on the front lines to protect workers and their families.

36. I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.



Dr. Christopher Simpson
Director, Northwest Center for Occupational Health and Safety
University of Washington

Date: May 7, 2025

Exhibit 1

Tuesday, May 6, 2025 at 4:53:28 PM Pacific Daylight Time

Subject: RE: Unobligated funds for Renewal ERCs, Grant #8433
Date: Friday, March 28, 2025 at 1:06:45 PM Pacific Daylight Time
From: Mallory Thomas <malloryt@uw.edu>
To: O'Neill, Eduardo (CDC/NIOSH/OD/OECSP) <fzt4@cdc.gov>
CC: Christopher Simpson <simpson1@uw.edu>

Good afternoon Eddie,

Thank you for your help. We will move forward with notifying the no-cost extension first.

Have a wonderful weekend.

Best,
Mallory

A. Mallory Thomas, MS
Training Grants Manager
Department of Environmental & Occupational Health Sciences
Pronouns: She/her/hers
Mon-Fri: on-campus, 8:30a - 4:45p

malloryt@uw.edu | 206-685-2185
Roosevelt One Building
4225 Roosevelt Way NE, Seattle, WA 98105

From: O'Neill, Eduardo (CDC/NIOSH/OD/OECSP) <fzt4@cdc.gov>
Sent: Friday, March 28, 2025 12:09 PM
To: Mallory Thomas <malloryt@uw.edu>
Cc: Christopher Simpson <simpson1@uw.edu>
Subject: RE: Unobligated funds for Renewal ERCs, Grant #8433

Dear Mallory
Thank you for reaching out.
First notify the no-cost extension. I say notify because you have expanded authorities so it is not a true request. OGS might ask you to send a budget revision but I would recommend not to send initially to make this simpler.
Eddie

From: Mallory Thomas <malloryt@uw.edu>
Sent: Thursday, March 27, 2025 2:19 PM
To: O'Neill, Eduardo (CDC/NIOSH/OD/OECSP) <fzt4@cdc.gov>
Cc: Christopher Simpson <simpson1@uw.edu>
Subject: FW: Unobligated funds for Renewal ERCs, Grant #8433

CAUTION: This email originated from outside of the organization. Do not click links or open attachments unless you recognize the sender and know the content is safe.

Good morning Eddie,

It was wonderful to meet you virtually. My name is Mallory Thomas, and I am the Center Manager for the Northwest Center for Occupational Health and Science (NWCOHS). I had reached out to Elizabeth Maples about some confusion regarding our request for a no-cost extension. I am in the process of completing the request for a no-cost extension for the NWCOHS ERC. I was using the information here as guidance from CDC. I wanted to double check with you about the "Budget revision." In the document, it is stated that "Budget revision(s) should be completed prior to submitting a No-Cost Extension (on page 4)." However, under the list of required Documentation, the budget is listed as only required for "non-competitive supplement action (on page 2)." We were a little confused on which direction to follow. Should we include a budget revision to our request for a no-cost extension?

Best,
Mallory

A. Mallory Thomas, MS
Training Grants Manager
Department of Environmental & Occupational Health Sciences
Pronouns: She/her/hers
Mon-Fri: on-campus, 8:30a - 4:45p

malloryt@uw.edu | 206-685-2185
Roosevelt One Building
4225 Roosevelt Way NE, Seattle, WA 98105

From: Maples, Elizabeth (CDC/NIOSH/OD/OECSP) <elm9@cdc.gov>
Sent: Thursday, March 27, 2025 10:02 AM
To: Mallory Thomas <malloryt@uw.edu>
Cc: Christopher Simpson <simpson1@uw.edu>; O'Neill, Eduardo (CDC/NIOSH/OD/OECSP) fzt4@cdc.gov
Subject: RE: Unobligated funds for Renewal ERCs, Grant #8433

Hello Mallory – thank you for your message. Submit a NCE at this time.

You may be asked by CDC to submit a budget revision – and Eddie will help you with that if needed.

You will be in good hands with Eddie.

One tip for you – always include your grant # in the subject line. That will help Eddie tremendously.

We have updated the ERC Deputy Directors and Administrators distribution list, and your name is there (finally).

Thank you and all the best to you and all at UW.

Elizabeth

From: Mallory Thomas <malloryt@uw.edu>
Sent: Wednesday, March 26, 2025 3:08 PM
To: Maples, Elizabeth (CDC/NIOSH/OD/OECSP) <elm9@cdc.gov>
Cc: Christopher Simpson <simpson1@uw.edu>
Subject: Unobligated funds for Renewal ERCs

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Good afternoon Elizabeth,

I hope that your week is going well. I am in the process of completing the request for a no-cost extension for the NWCOHS ERC. I was using the information here as guidance from CDC. I wanted to double check with you would the "Budget revision." In the document, it is stated that "Budget revision(s) should be completed prior to submitting a No-Cost Extension." However, under the list of required Documentation, the budget is listed as only required for "non-competitive supplement action." We were a little confused on which direction to follow. Should we include a budget revision to our request for a no-cost extension?

Best,
Mallory

A. Mallory Thomas, MS
Training Grants Manager
Department of Environmental & Occupational Health Sciences
Pronouns: She/her/hers
Mon-Fri: on-campus, 8:30a - 4:45p

malloryt@uw.edu | 206-685-2185
Roosevelt One Building
4225 Roosevelt Way NE, Seattle, WA 98105

Exhibit 2

Tuesday, May 6, 2025 at 4:54:12 PM Pacific Daylight Time

Subject:	Re: No Cost extension concurrence request letter for Award #5 T42OH008433-20-00; PI Christopher Simpson
Date:	Thursday, May 1, 2025 at 12:37:20 PM Pacific Daylight Time
From:	Anderson-Rana, Brownie (CDC/OCOO/OFR/OGS) <fli2@cdc.gov>
To:	S. Cola <snc2@uw.edu>
CC:	Park, Christina (CDC/OCOO/OFR/OGS) <lsk1@cdc.gov>, PRISM (CDC) <PRISM@cdc.gov>, O'Neill, Eduardo (CDC/NIOSH/OD/OECSP) <fzt4@cdc.gov>, Shanahan, Mary Pat (CDC/NIOSH/OD/OECSP) <mpu0@cdc.gov>, Christopher Simpson <simpson1@uw.edu>, Craig Gabriel <cgabriel@uw.edu>, Mallory Thomas <malloryt@uw.edu>
Attachments:	image001.png

Good afternoon Sascha, at the present time there is a pause on all NIOSH activities. We will add the letter to your official file along with this correspondence. Please reach out to your project officer for additional guidance.

Respectfully,

Brownie Anderson-Rana,
Supervisory Grants Management Specialist
Centers for Disease Control and Prevention
Department of Health & Human Services
770-488-2771 (Office)

From: S. Cola <snc2@uw.edu>
Sent: Thursday, May 1, 2025 1:17 PM
To: Anderson-Rana, Brownie (CDC/OCOO/OFR/OGS) <fli2@cdc.gov>
Cc: Park, Christina (CDC/OCOO/OFR/OGS) <lsk1@cdc.gov>; PRISM (CDC) <PRISM@cdc.gov>; O'Neill, Eduardo (CDC/NIOSH/OD/OECSP) <fzt4@cdc.gov>; Shanahan, Mary Pat (CDC/NIOSH/OD/OECSP) <mpu0@cdc.gov>; Christopher Simpson <simpson1@uw.edu>; Craig Gabriel <cgabriel@uw.edu>; Mallory Thomas <malloryt@uw.edu>
Subject: RE: No Cost extension concurrence request letter for Award #5 T42OH008433-20-00; PI Christopher Simpson

CAUTION: This email originated from outside of the organization. Do not click links or open attachments unless you recognize the sender and know the content is safe.

Dear Brownie Anderson-Rana,

I am following up on my below email and the attached no cost extension concurrence request letter.

Thank you for your assistance,

Sascha Colabella
Program Coordinator, Proposal and Awards
Office of Sponsored Programs
University of Washington
4333 Brooklyn Ave NE
Box 359472, Seattle, WA 98195-9472
Direct: 206-543-1523
Email: snc2@uw.edu
Office Hrs: M-F 8:00 AM – 5:00 PM
pronouns: she, her, hers
UW Ref# MOD48339 (A149102) - AWD-003805

From: S. Cola
Sent: Tuesday, April 15, 2025 2:20 PM
To: fli2@cdc.gov
Cc: lsk1@cdc.gov; fli2@cdc.gov; fzt4@cdc.gov; mshanahan@cdc.gov; Christopher Simpson <simpson1@uw.edu>; Craig Gabriel <cgabriel@uw.edu>; Mallory Thomas <malloryt@uw.edu>
Subject: RE: No Cost extension concurrence request letter for Award #5 T42OH008433-20-00; PI Christopher Simpson

Dear Brownie Anderson-Rana,

I am following up on my below email and the attached no cost extension concurrence request letter.

Thank you for your assistance,

Sascha Colabella
Program Coordinator, Proposal and Awards
Office of Sponsored Programs
University of Washington
4333 Brooklyn Ave NE
Box 359472, Seattle, WA 98195-9472
Direct: 206-543-1523
Email: snc2@uw.edu
Office Hrs: M-F 8:00 AM – 5:00 PM
pronouns: she, her, hers
UW Ref# MOD48339 (A149102) - AWD-003805

From: S. Cola
Sent: Wednesday, April 2, 2025 12:09 PM
To: 'fli2@cdc.gov' <fli2@cdc.gov>
Cc: 'lsk1@cdc.gov' <lsk1@cdc.gov>; 'fli2@cdc.gov' <fli2@cdc.gov>; 'fzt4@cdc.gov'

<fzt4@cdc.gov>; 'mshanahan@cdc.gov' <mshanahan@cdc.gov>; Christopher Simpson <simpson1@uw.edu>; Craig Gabriel <cgabriel@uw.edu>; Mallory Thomas <malloryt@uw.edu>
Subject: RE: No Cost extension concurrence request letter for Award #5 T42OH008433-20-00; PI Christopher Simpson

Dear Brownie Anderson-Rana,

I received Christina Park's out of office email until May 12, 2025 and to contact you. Please see below email.

We would like to request a No Cost Extension through 6/30/2026 for Award # 5 T42OH008433-20-00; PI Christopher Simpson. Please find attached the No Cost Extension request letter which has been countersigned by an Authorized Signing Official of the University of Washington's Office of Sponsored Programs.

Please let me know if you require any additional information regarding this request.

Thank you for your assistance,

Very Best Regards,

Sascha Colabella
Program Coordinator, Proposal and Awards
Office of Sponsored Programs
University of Washington
4333 Brooklyn Ave NE
Box 359472, Seattle, WA 98195-9472
Direct: 206-543-1523
Email: snc2@uw.edu
Office Hrs: M-F 8:00 AM – 5:00 PM
pronouns: she, her, hers
UW Ref# MOD48339 (A149102) - AWD-003805

From: S. Cola
Sent: Wednesday, April 2, 2025 12:00 PM
To: lsk1@cdc.gov
Cc: fli2@cdc.gov; fzt4@cdc.gov; mshanahan@cdc.gov; Christopher Simpson <simpson1@uw.edu>; Craig Gabriel <cgabriel@uw.edu>; Mallory Thomas <malloryt@uw.edu>
Subject: No Cost extension concurrence request letter for Award #5 T42OH008433-20-00; PI Christopher Simpson

Dear Christina Park,

We would like to request a No Cost Extension through 6/30/2026 for Award # 5 T42OH008433-20-00; PI Christopher Simpson. Please find attached the No Cost

Extension request letter which has been countersigned by an Authorized Signing Official of the University of Washington's Office of Sponsored Programs.

Please let me know if you require any additional information regarding this request.

Thank you,

Sascha Colabella
Program Coordinator, Proposal and Awards
Office of Sponsored Programs
University of Washington
4333 Brooklyn Ave NE
Box 359472, Seattle, WA 98195-9472
Direct: 206-543-1523
Email: snc2@uw.edu
Office Hrs: M-F 8:00 AM – 5:00 PM
pronouns: she, her, hers
UW Ref# MOD48339 (A149102) - AWD-003805

EXHIBIT 32

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF RHODE ISLAND

STATE OF NEW YORK, et al. Plaintiffs, v. ROBERT F. KENNEDY, JR., in his official capacity as SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., Defendants.	Case No. 1:25-cv-00196

DECLARATION OF DR. DAVID BONAUTO

I, David Bonauto, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the foregoing is true and correct:

1. I am over the age of eighteen, and am otherwise competent to testify. I have compiled the information in the statements set forth below through personal knowledge, through L&I's personnel and legal counsel who have assisted me in gathering this information from our institution, and on the basis of documents that have been provided to and reviewed by me.

2. I submit this Declaration in support of the Plaintiff's Motion for Preliminary Injunction. Specifically, I submit this Declaration to explain the importance to Washington, and my agency, of the National Institute of Occupational Safet and Health (NIOSH), which is housed within the Centers for Disease Control (CDC) and the Department of Health and Human Services (HHS).

3. I have worked for the State of Washington, Department of Labor & Industries (L&I) for 25 years. I have worked with L&I's Safety and Health Assessment and Research for Prevention (SHARP) program since 2000, initially as the Associate Medical Director, and currently as the

Research Director. Within L&I, I also chair the Advisory Committee on Occupational Disease Presumptions.

4. I am also the Principal Investigator on Washington State's NIOSH Cooperative Agreement for State-based Occupational Safety and Health Surveillance. I have also served on the NIOSH Board of Scientific Counselors, and have participated on NORA Sector Councils. Because of this and my other relevant experience working with NIOSH, I have personal knowledge of the importance of NIOSH to the Washington programs and agency I work for.

5. Immediately prior to joining L&I, I was a resident in occupational medicine at the University of Washington's Northwest Center for Occupational Health and Safety (NWCOHS), a NIOSH-funded Education and Research Center. My past work and educational history includes being a hospital physician in Bremerton, Washington, and completing my medical school and residency training in internal medicine.

6. I have an A.B in Chemistry from Bowdoin College, a M.D. from the Columbia University College of Physicians and Surgeons, and a M.P.H. in Occupational Medicine from the University of Washington.

The Impacts to Washington of Losing NIOSH

7. Washington State's workforce faces dangerous work environments every day. Washington's employers and workers don't just want evidence-based practices for preventing workplace injuries and controlling hazardous exposures—they depend on them. When research gaps exist, we turn to experts for consensus recommendations to safeguard workers' lives and create hazard-free workplaces. Every decision to allocate our limited state resources relies on comprehensive occupational injury data that drives our workers' compensation programs, state OSHA initiatives, and prevention strategies.

8. The potential elimination of NIOSH would devastate Washington State's occupational safety infrastructure. As America's only federal agency dedicated exclusively to worker health and safety research, NIOSH's disappearance would create catastrophic consequences.

9. Without NIOSH, Washington, and all other states, lose the primary and vast engine driving evidence-based workplace safety recommendations. The specialized research addressing unique threats in Washington's vital industries—from agriculture to aerospace, maritime to forestry—would vanish. Critical funding for our state-specific research partnerships and university programs would disappear, leaving our workers vulnerable to preventable dangers.

10. NIOSH provides Washington employers with access to world-class scientific evaluation of workplace hazards. This loss would eliminate sophisticated analytical methods for identifying complex exposure risks and remove crucial field investigation expertise when unusual workplace health incidents occur. This is irreplaceable. The NIOSH science-based recommendations that form the backbone (and brain and heart) of Washington's workplace safety regulations would be virtually eliminated.

11. The dismantling of training programs for future occupational safety professionals would result in inadequate evaluation of workplace hazards, poor evidence-based decision making on causation, and worse post injury employment outcomes. Workers will suffer the burden of workplace injuries and the social and economic outcomes that manifest, and employers will have increased workers compensation costs and the indirect costs associated with hiring and training of replacement workers.

12. Washington State nor any state can replace NIOSH's irreplaceable contributions. The consequences for Washington’s workers' health, safety, and livelihoods will be severe.

Several State Programs Directly Depend on NIOSH

13. The loss of NIOSH would be felt, most immediately, by the numerous Washington state programs that interface or receive funding directly from NIOSH.

14. ***Washington State Surveillance Programs****:* NIOSH-funded programs provide surveillance data to inform public health actions. Allowing allocation of scarce public health resources to where they are most needed. Without data and science, we will falsely rely on anecdote. Without surveillance programs, there would be misallocation of prevention resources, misdirected research priorities and inefficiencies in our already strained public health system. Absent surveillance, trends in occupational injury and illness would be unknown, deaths on the job and serious exposures to respiratory hazards would not be counted or characterized, and in the end, no accountability for those required to provide safe and healthy workplaces.

15. *First*, Washington State is one of 23 U.S. States with a cooperative agreement with NIOSH for state-based surveillance of occupational injuries and illnesses.[1] Washington L&I's Cooperative (NIOSH/CDC U60OH008487—Washington Occupational Injury and Illness Surveillance Program) conducts research to prevent workplace fatalities, occupational respiratory disease, and adult occupational lead exposure.

16. Because the staff at NIOSH who could process grants appear to be subject to the reduction in force, NIOSH will effectively end this grant on June 30, 2025. Although this grant nominally has a grant period between July 1, 2021 and June 30, 2026, Washington must submit an "Annual Research Performance Progress Report/Non-Competing Continuation Application" (RPPR) in order to receive funds for that year. Washington L&I timely submitted their RPPR February 27, 2025 for the budget period of 7/1/2025 through 6/30/2026, but has not heard any

[1] *NIOSH Extramural Research and Training, State Occupational Safety and Health Surveillance Program*, CDC (Jan. 8, 2024) https://www.cdc.gov/niosh/extramural-programs/php/about/state-surveillance.html.

response from NIOSH or anyone else at HHS. If the grant award is not made by June 30, 2025, work under this cooperative agreement will be discontinued and staff will likely be reassigned. Eliminating this agreement will diminish Washington State's capacity to track serious workplace injuries, illnesses and hazards.

17. *Second*, Washington is one of eight states that receives funding from NIOSH to track fatal work-related traumatic injuries via the NIOSH Fatality Assessment and Control Evaluation (FACE) program.[2] The grant funds an evaluation of the root cause of injury fatalities in high-risk industries of agriculture, forestry, fishing, construction, transportation, and warehousing, as well as other selected topic areas, such as young workers. These evaluations lead to the development of information to prevent workplace fatalities, such fatality narratives and fatality investigation reports. This information is publicly available on L&I and NIOSH's websites for any employer or worker in Washington. Employers regularly rely on this information to comply with regulations and implement the safety regulations and take steps above minimum regulatory compliance to prevent serious injuries and fatalities. But without NIOSH staff present to process funding for this program, it will not be able to survive.

18. Ensuring we have a thorough and unbiased review of the root causes of traumatic workplace fatalities from qualified and competent investigators not connected to a regulatory enforcement rule is critical to reducing and eliminating preventable workplace serious injuries and fatalities. The trend in Washington State's occupational injury fatality rate over the last twenty years has decreased, in part due to the efforts of this program. The information from Washington fatality narratives as well as fatality narratives produced by other NIOSH FACE Programs informs

[2] *NIOSH FACE Program, Fatality Assessment and Control Evaluation™ (FACE) Program*, CDC (Dec. 10, 2024) https://www.cdc.gov/niosh/face/about/index.html.

opportunities for changes to current occupational safety and health regulations to address gaps or provide improved clarity to more effectively prevent such incidents from happening again.

19. *Third*, NIOSH's Adult Blood Lead Epidemiology Surveillance (ABLES) program is another state program that focuses identifies adults with elevated blood lead levels.[3] Washington is one of 37 participating ABLES program states tracking occupational lead exposures. Workers with elevated lead levels are provided educational information regarding lead exposure, its effect on their health, how to understand their blood lead test, and their employer's responsibilities to prevent lead exposure. Workers also receive information regarding how to prevent "take home" exposures to lead. Lead contamination from the workplace may be carried home from the workplace on protective clothing, shoes and thus expose those at home to lead. Children and pregnant women are particularly susceptible to lead exposure and should be protected from such exposure. Without NIOSH as a centralized hub for these data submissions, all participating states (including Washington) are denied the informational benefits of the program, which provides critical data on what jobs and industries have lead exposures that need to be addressed.

20. *Fourth*, Washington is one of four NIOSH-funded states participating in the NIOSH state-based surveillance program for occupational respiratory diseases.[4] Occupational respiratory diseases are caused or made worse by the work environment within their state-based occupational injury and illness surveillance program. This program tracks conditions such as occupational asthma, chronic obstructive pulmonary disease, silicosis, asbestosis, and toxic inhalations. Breathing in vapors, gas, dusts and fumes at work creates risk for developing a work-related lung

[3] *NIOSH Lead in the Workplace, Adult Blood Lead Epidemiology and Surveillance (ABLES)*, CDC (April 22, 2024) https://www.cdc.gov/niosh/lead/programs/index.html.

[4] *NIOSH Worker Health and Safety Surveillance, Occupational Respiratory Disease*, CDC (Jan. 19, 2024) https://www.cdc.gov/niosh/surveillance/respiratorydisease/index.html#:~:text=State%2Dbased%20surveillance%20is%20a,the%20state%20and%20local%20level.

problem. Washington's occupational respiratory disease surveillance program has detected new harmful exposures in workplaces that cause respiratory disease, specifically hop dust and cannabis dust. Washington's occupational respiratory disease surveillance programs identified occupations at risk for respiratory infections from COVID-19 and coccidiomycosis (valley fever). The occupational respiratory disease surveillance program creates educational materials warning employers and workers of potential harmful exposure, advising on control strategies to prevent exposures, and preventing additional disease.

21. *Fifth,* Washington's surveillance programs also depend greatly on the non-monetary support provided by NIOSH intramural programs and subject matter experts. NIOSH supports Washington and other state-based surveillance programs by setting uniform case definitions for diseases under surveillance. NIOSH develops tools to convert unstructured data to structured data useful for systematic analyses, such as the NIOSH Industry and Occupation Computerized Coding System, a free web application that converts industry and occupation free text into numeric codes on surveys and medical records.[5] NIOSH establishes collaborations across states to combine data and build capacity in US states where there is little occupational safety and health capacity. These activities are organized through a NIOSH collaborative agreement with the Council of State and Territorial Epidemiologists, which builds a cohesive network and structure for information sharing and collaborations across states.

22. Additionally, losing NIOSH would also decimate L&I's SHARP program, which represents Washington's only dedicated occupational safety and health research unit, serving Washington's employers and workers as a resource for workplace injury and illness prevention.[6]

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[5] *NIOSH, About NIOCCS,* CDC (Dec. 13, 2022) https://csams.cdc.gov/nioccs/About.aspx.

[6] *Washington State Department of Labor & Industries, About SHARP,* https://www.lni.wa.gov/safety-health/safety-research/about-sharp (last visited May 7, 2025).

SHARP is separate from the regulatory programs at L&I (the workers compensation and DOSH programs), and is wholly unique to Washington. SHARP researchers collect and analyze occupational injury data to recognize emerging risks and troubling patterns that require intervention. The program develops evidence-based educational materials and practical guidance for both employers and workers to create safer workplaces. The program exemplifies Washington's commitment to using scientific approaches for preventing work-related injuries and illnesses. SHARP provides locally relevant research and solutions that complement the national work conducted by NIOSH. Together, these programs form a crucial safety net protecting Washington's workforce from preventable harm. But without NIOSH, its functionality is greatly hindered, and Washington workers will suffer.

Losing NIOSH Will Hurt Washington's Workers

23. Even outside of the direct harms to NIOSH-interfacing state programs, losing NIOSH will hurt these programs indirectly by removing one of the key federal pillars to protecting Washington workers from occupational injuries, including the many Washington laws that depend on NIOSH data for their efficacy.

24. For instance, NIOSH's demise means that the NIOSH Spokane facility will be closing. The Spokane Mining Research Division (SMRD) employs Washington residents and contributes to Washington's economy. Washington L&I has collaborated with researchers at the NIOSH Spokane facility by sharing L&I data related to workers' compensation injuries in Washington's mining sector. The data are confidential, contain personal information regarding workers and their work-related injuries and since employees at the NIOSH facility are non-responsive—the fate and security of these data are unknown. Risk of disclosure or loss of these data represents a financial and reputational risk to L&I and a privacy breach for Washington

workers within L&I. L&I has also benefitted from consultations with NIOSH SMRD employees on issues related to approaching safety from a risk management perspective, and understanding heat stress and physical activity, again the loss of subject matter expertise makes Washington recommendations weaker and less impactful.

25. NIOSH's Western States Division (WSD), also located at the Spokane NIOSH facility and also subject to a complete or near-complete elimination, focuses on occupational safety and health issues more common to the Western United States, among them Oil and Gas Extraction; Transportation, Warehousing and Utilities; Maritime Safety; Motor vehicle safety; and Wildland firefighting safety and health. Their work directly contributes to Washingtonians' safety by informing Washington's own local rules on specific dangerous workplaces.

Losing NIOSH Destroys Integral Governmental and Industry Partnerships

26. The essential elimination of NIOSH, its leadership, stature and authority to guide the nation, states, and communities in a coordinated effort to advance worker safety and health and assist employers in providing a workplace free of hazards, will harm workers in almost every industry sector across the nation.

27. Among the many activities NIOSH conducts, they bring together business, labor, academia, professional associations, other federal agencies, states and other stakeholders in partnerships to coordinate and optimize research and prevention in occupational safety and health. Most visibly this is embodied in the NIOSH National Occupational Research Agenda (NORA), which has developed research agendas for all industry sectors, combined with research agendas that focus on major safety and health issues affecting workers in the United States.[7] The NORA

[7] *NORA,* CDC (May 3, 2025) https://www.cdc.gov/nora/default.html.

program, which has existed since 1996, utilizes these public and commercial partnerships to stimulate innovative research and improved workplace practices.

28. The partnerships formed from NORA lead to actionable publications that combine the perspectives of the many stakeholders in occupational safety and health. For example, the NORA Services Sector Council recently produced a draft publication titled "Protecting Temporary Workers: Best Practices for Host Employers," which was coauthored by NIOSH, NORA, the American Society of Safety Professionals, the American Staffing Association, and Washington L&I's Safety and Health Assessment and Research for Prevention program.[8] This document provided a set of best practices for host employers to follow to better protect the safety and health of temporary workers. Without NIOSH, states lack the weight, authority, and breadth to replicate these comprehensive partnerships, priorities, and agendas for industries and major safety and health issues. Without NORA and other coordination by NIOSH, research and prevention opportunities for states will be missed, workers and employers don't gain the benefit of coordinated efforts to eliminate hazards in their workplace.

29. I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

/s/ David Bonauto
Dr. David Bonauto
SHARP Director
Washington Department of Labor & Industries

Date: May 8, 2025

[8] *NIOSH*, *Protecting temporary workers: best practices for host employers*, CDC (July 6, 2022) https://www.cdc.gov/niosh/docs/2022-126/default.html.

EXHIBIT 33

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF RHODE ISLAND

STATE OF NEW YORK, et al. Plaintiffs, v. ROBERT F. KENNEDY, JR., in his official capacity as SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., Defendants.	Case No. 1:25-cv-00196

DECLARATION OF CHRISTINA TAN

I, Christina Tan, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the foregoing is true and correct:

1. I am the State Epidemiologist and Assistant Commissioner of the Division of Epidemiology, Environmental, and Occupational Health at the New Jersey Department of Health (NJDOH). The information in the statements set forth below were compiled through personal knowledge, through NJDOH personnel who have assisted in gathering this information, or from documents that have been provided to and reviewed by me.

2. I submit this Declaration in support of the States' Motion for a Preliminary Injunction.

3. I am an Assistant Commissioner at the NJDOH, where I have been serving as the State Epidemiologist and Assistant Commissioner since 2009 and previously served as the Medical Director of the Communicable Disease Service since 2002. During this time, I have directed investigations, public health responses, and planning efforts regarding numerous emerging issues such as West Nile virus, bioterrorism-related anthrax, SARS, pandemic H1N1

influenza, post Hurricane Sandy efforts, vinyl chloride release associated with a train derailment, imported viral hemorrhagic fever cases, Zika, e-cigarette/vaping product use-associated lung injuries, and COVID-19. I am board-certified in internal medicine and completed an applied epidemiology fellowship with the US Centers for Disease Control and Prevention.

4. NJDOH's Consumer, Environmental, and Occupational Health Service (CEOHS) serves New Jersey communities and workers through activities aimed at improving the health and well-being of all residents. At the core of its mission are preventive initiatives to decrease disease and injury by reducing exposure to chemical, physical and biological hazards. Its activities are organized into three programs, including Environmental and Occupational Health Surveillance, Public Health and Food Protection, and Environmental and Occupational Health Assessment. Its services include child care center health assessments, hazardous site health evaluation, food and drug safety, asbestos and lead training and certification, and environmental and occupational disease surveillance.

5. CEOHS regularly partners with NIOSH to fulfill its mission. It relies on NIOSH to:

a. Provide support in developing the ability to monitor work-related injuries, illnesses, exposures, and fatalities among New Jersey workers and develop interventions to reduce diseases and injuries.

b. Provide assistance in establishing systems for the collection of information concerning the nature and frequency of occupational injuries and diseases. For example, NIOSH provided guidance in the implementation of the NIOSH Industry and Occupation Computerized Coding System (NIOSCCS) in the

NJDOH Communicable Disease Reporting and Surveillance System (CDRSS) to autocode industry and occupational for all disease conditions collected.

c. Provide technical assistance from NIOSH's Health Hazard Evaluation (HHE) unit to conduct investigations and develop intervention strategies and recommendations for workers exposed to hazardous substances.

d. Identify priority areas based on state level surveillance data and case studies, resulting in the development of recommendations for worker protection and developing public health interventions at the state level.

e. Provide a forum for states to discuss recommendations to protect workers during emergent events such as COVID-19 and avian influenza.

6. It is my understanding and belief that as a result of the massive reduction in force across HHS, over 90% of the staff of the National Institute for Occupational Safety and Health (NIOSH), housed in the Centers for Disease Control and Prevention (CDC), have been placed on administrative leave and will be permanently terminated on or after June 1, 2025.

7. Since April 1, 2025, NJDOH has seen significant changes in its interactions with NIOSH. CEOHS lost all contact with NIOSH following the April 1, 2025 Reduction In Force (RIF). The Project Officer role, which had been primarily responsible for ensuring grant deliverables were met, providing information on when annual and progress reports were due as well as information on new grant applications, was eliminated as a result of the RIF. CEOHS has received no information on whether or if this position will be replaced.

8. The gutting of NIOSH staff overall has and will continue to harm New Jersey. For years, NJDOH has regularly partnered with NIOSH for surveillance and outreach related to workplace injuries and illnesses. NIOSH compiles data on occupational injuries, illnesses, and

fatalities nationwide. This is critical because NIOSH's compilation of state-level data provides states, including New Jersey, more insight into occupational health issues and emerging trends. For example, NIOSH recently compiled data on silica exposure from sanding granite countertops that proved essential for New Jersey to develop its response and strategy.

9. NIOSH is also one of the few programs within CDC that conducts industry-specific research on work-related illnesses and injuries that is not performed at the state level. Data and publications from these projects conducted by NIOSH will not be available, making it difficult for NJDOH to create recommendations and outreach material for certain New Jersey working populations. This is particularly notable for industries such as fire protection and healthcare, which rely on NIOSH to ensure their respirators, and other personal protective equipment, are certified.

10. Without NIOSH staff in place, NJDOH also will not be able to access data that NIOSH compiles on a national level. For example, the NIOSH Industry and Occupation Computerized Coding System (NIOCCS), which is a web-based software tool created to translate industry and occupation text into standardized industry and occupation codes, will no longer be maintained. NIOCCS is used to code industry and occupation of all disease conditions in NJDOH's CDRSS. As a result of the elimination of NIOCCS, standardization of the collection of work-related injuries and illnesses to identify at risk industries and occupations will be impacted. Efforts to rapidly identify worker populations most at risk for all diseases will be compromised. Additionally, data from NIOSH's investigations of fire fighter fatalities to formulate recommendations for prevention of future deaths and injuries will not be available. These data are used to create outreach materials for protecting New Jersey fire fighters, and fire departments across the state will not have access to findings and recommendations.

11. With respect to personal protective equipment, the loss of the National Personal Protective Technology Laboratory will also have an impact on worker protection in New Jersey. The National Personal Protective Technology Laboratory certifies the self-contained breathing apparatus, which prevents using unapproved aftermarket parts, such as air cylinders.

12. Beyond compiling data, the loss of NIOSH staff and expertise will have extensive impacts on NJDOH. NIOSH staff lead discussions with state partners on priority areas and case studies based on the compilation of state-level surveillance data from throughout the country. These discussions have resulted in recommendations for worker protection at the state level against the avian influenza, chemical and toxic substances exposure, and youth worker injuries and fatalities. The gutting of NIOSH means New Jersey will lose this critical partnership and actionable recommendations from NIOSH that protect New Jersey workers. Additionally, NIOSH staff collaborate with states on publishing key findings based on state surveillance data to report on emergent events and sentinel events to raise awareness and develop intervention strategies nationally.

13. Without NIOSH staff in place, NJDOH will also no longer be able to request technical assistance from NIOSH's Health Hazard Evaluation (HHE) unit to investigate and develop intervention strategies and recommendations for workers exposed to hazardous substances. Recent examples of the HHE's work in New Jersey include responding to and evaluating a municipal building in Princeton for mold exposure and concerns about cancer incidence, a metals processing facility in Deptford where employees were being exposed to lead, and a train derailment in Gloucester County, where first responders were exposed to vinyl chloride.

14. NJDOH's partnership with NIOSH's HHE has been critical to respond to workplace hazardous material exposures. The NIOSH HHE is able to provide authoritative assistance in evaluating new and recurring workplace health hazards. The HHE also allows a more hands-on approach to working directly with employers in New Jersey to help keep their workers safe, which usually cannot be provided by NJDOH alone. NIOSH can go onsite and evaluate the workplace, identify and make recommendations to interrupt exposure pathways where federal Occupational Safety and Health Administration (OSHA) and state Public Employees Occupational Safety and Health (PEOSH) regulatory authority is limited. This means that NIOSH can identify more nuanced and complex exposure pathways beyond those identifiable by NJDOH, OSHA, or PEOSH, and ultimately, drawing on its expertise in current research and innovative best practices, provide immediate feedback and recommendations for worker health and safety. Indeed, where NJDOH and other federal entities would encounter extensive regulatory delay, NIOSH HHE is able to immediately provide authoritative assistance in evaluating new and recurring workplace health hazards. NIOSH HHE can work directly with employers in New Jersey to keep their workers safe through onsite evaluation and detailed recommendations to respond quickly to any emergent issue. A recent example includes the above-mentioned metals processing facility. Without NIOSH's assistance, NJDOH's ability to respond to new hazards will be meaningfully impeded.

15. In addition to the loss of on-site partnership and the ability to rely on industry-specific data, the loss of NIOSH funding will also significantly and negatively impact New Jersey. NJDOH is currently in Year Four of a five-year program award. On April 24, 2025, NJDOH received a communication from a NIOSH-funded Education and Research Center who indicated they were asked to notify states that the end date of our program had been changed

from June 30, 2026 to June 30, 2025. Based on this communication, NJDOH does not expect to receive funding for the fifth year of its program as it had expected, and all NIOSH funding is expected to end at the end of the current budget cycle on June 30, 2025. Lack of NIOSH funding will harm New Jersey directly because NJDOH has relied on NIOSH funding to track and address occupational injuries, illnesses, and fatalities. With NIOSH funding, NJDOH has tracked and addressed adult lead poisoning, lung diseases such as silicosis and asbestosis, extreme weather events, and other communicable diseases. NIOSH funding also supports 47% of a full-time employee Research Scientist 2 within NJDOH.

16. Losing NIOSH has been and will be devastating for NJDOH. NIOSH has developed subject-matter expertise that is irreplaceable and critical to NJDOH's mission to protect the health and wellbeing of New Jersey residents. Without access to NIOSH's Subject Matter Experts, and without being able to predict what next crisis may occur, NJDOH will struggle to effectively respond to crises by having to figure out where specific expertise may lie while simultaneously being forced to find alternative funding for staff as well as surveillance systems and applications.

17. I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed on May 7, 2025, at Trenton, New Jersey.

Christina Tan

Christina Tan

EXHIBIT 34

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF RHODE ISLAND

STATE OF NEW YORK, et al. Plaintiffs, v. ROBERT F. KENNEDY, JR., in his official capacity as SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., Defendants.	Case No. 1:25-cv-00196

DECLARATION OF DR. ARTHUR MILLER

I, Arthur Miller, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the foregoing is true and correct:

1. I have personal knowledge of the facts set forth in this declaration, and if required to testify, would and could competently do so.

2. I submit this Declaration in support of the States' Motion for a Preliminary Injunction.

3. I am a retired Senior Research Engineer of the National Institute for Occupational Safety and Health (NIOSH), where I worked for fifteen years in the Spokane Research Lab in Spokane, Washington. I retired from my formal position at NIOSH three years ago, but I was working as a private consultant with the NIOSH Spokane Lab between my retirement and the termination of my consultant contract in February 2025. During my time at NIOSH, I led a number of different projects largely aimed at air quality and improving the health and safety of mine workers. At NIOSH, I authored over sixty publications in the areas of occupational safety and health in numerous medical and scientific journals, many focused on miner safety and air quality.

4. Given my senior role and extensive experience working within and with NIOSH, I believe I am very familiar with the operations, structure, and local impact of the NIOSH Spokane Research Lab.

5. Part of what drew me to NIOSH was the ability to use my experience and expertise for good. Prior to joining NIOSH, I worked as an aircraft mechanic and pilot, researched turbulence at the Technical University of Berlin, and spent nearly ten years in engineering and research with the United States Bureau of Mines in Minneapolis, Minnesota. I went back to school and received my doctorate in Mechanical Engineering from the University of Minnesota in 2005, where my research focused on diesel emissions and nanoparticle formation. I was thrilled to bring that research and engineering expertise to NIOSH, and especially the coal mining research and safety projects at the NIOSH Spokane Lab.

The Gutting of NIOSH

6. NIOSH is the only federal agency responsible for conducting research and making recommendations for preventing work-related injuries and illnesses. The agency seeks to improve worker health and safety across all types of workplaces, including mines, fire departments, oil and gas wells, construction sites, factories, toxicology labs, shipyards, boats, small businesses, and hospitals. The agency conducts investigations of occupational health and safety concerns, often at the request of businesses and other organizations for free, researches occupational hazards, develops guidance to address those hazards, and provides graduate and post-graduate training on occupational health and safety through its Education and Research Centers. Its functions are enshrined in statutes like the Occupational Safety and Health Act, 29 U.S.C. §§ 669–71, among others. NIOSH employees are based primarily in research laboratories and offices in Cincinnati,

Ohio; Morgantown, West Virginia; Pittsburgh, Pennsylvania; Spokane, Washington; Washington, D.C.; Atlanta, Georgia; and Denver, Colorado.

7. When I retired three years ago, I quickly found out that NIOSH was not able to easily replace my experience and expertise. I then contracted with my old team to continue working with them as a consultant, because the NIOSH Spokane Lab had hired some new people and needed me to get them up to speed. I was performing these mentorship and training tasks, as well as other research tasks, in my consultant role until my contract ended abruptly in February of this year. I initially found out about the termination of my contract when I tried to open my government e-mail one day and could not access it. I wrote to one of my contacts at HHS as to whether my loss of access was a glitch or not, and was informed that all government contracts of my type were being cancelled. At the time, I only had $1,000 left on my $50,000 consulting contract.

8. On April 1, 2025, I became aware, both through news reports and conversations with my NIOSH colleagues, of reporting that the vast majority of NIOSH staff was being laid off (placed on administrative leave and then officially separated June 2, 2025) as a result of the HHS' "restructuring." This included most of my colleagues in the NIOSH Spokane Research Laboratory (SRL). I later became aware of additional reporting that on April 30, 2025, most of the remaining NIOSH employees were also being placed on administrative leave, to be officially separated July 2, 2025. The only employees remaining would be a scattered few in certain programs, such as the World Trade Center Health Program. The NIOSH SRL, for instance, as well as all mining research across NIOSH, would be shuttered.

History and Function of the NIOSH Spokane Facility

9. The NIOSH Spokane Research Laboratory opened in 1951 as a field location for the U.S. Bureau of Mines (USBM) Northwest Electro-development Laboratory in Albany, Oregon.

Increased mining activity at the deep underground lead and silver mines in the nearby Coeur d'Alene Mining District in northern Idaho made the Spokane location ideal for working with these mines while providing the infrastructure the facility would need to conduct its research. Early research at the facility focused on issues related to deep underground hard rock mining including developing better ground support technologies, waste disposal techniques, and prevention of rock bursts (rapid failure of rock structures in deep hard rock mines due to pressure exerted by the weight of the mountain). These topics expanded in 1977 with the passing of the Federal Mine Safety and Health Amendments Act which extended USBM's research mandate to all sectors of the mining industry. Work in this era included research on mobile roof support systems for underground coal mines and environmental work on issues like acid mine drainage.

10. In 1996, the USBM was closed by Congress, and many employees of the Spokane Research Lab were transferred to NIOSH. The focus of SRL's research also shifted to purely topics affecting health and safety of the nation's miners.

11. In 2015, the mining safety researchers at NIOSH Spokane were joined by the staff of the newly-formed Western States Division (WSD). WSD is headquartered at the SRL, but also has staff at offices in Denver, Colorado and Anchorage, Alaska. The division focuses on occupational safety and health issues primarily in the Western United States through research conducted under programs focused on (1) oil and gas extraction, including silica exposure assessment and control, hydrocarbon gas and vapor exposure associated with manual tank gauging, motor vehicle safety, and developing an industry-specific workplace fatality surveillance system; (2) maritime safety and health, including fatal and nonfatal traumatic injury analysis, cumulative musculoskeletal injuries in commercial fishing and seafood processing, design of engineering interventions to prevent winch entanglements on commercial fishing vessels, analyses of factors

associated with vessel casualties and disasters, and identification of relevant prevention strategies, and assessment of exposures associated with coatings removal methods in shipyards; and (3) Western Region outreach and epidemiology, including programs on wildland firefighting, aviation safety, and health.

12. In 2016, the Spokane Mining Research Division (SMRD) initiated the Miner Health Program. This program was established to conduct research related to miner health and workplace exposures, understand the role of work and non-work factors, and transfer findings to the mining community. The addition of public health and medical staff to the division, along with a newly constructed industrial hygiene laboratory, were important steps toward the goals of understanding miner health risk factors and improving their ability to maintain their health while working and in retirement. Until last month, current research under this program included developing interventions to monitor and mitigate heat stress and fatigue and studying miner health and occupational exposure data to target future efforts.

Impacts to Washington of Losing NIOSH

13. NIOSH is the only government agency statutorily authorized to conduct workplace health and safety research. Other government agencies do not have the ability (expertise, unique facilities, established partnerships) to take on the vast majority of NIOSH's work. Losing NIOSH would likely mean the end of these critical programs.

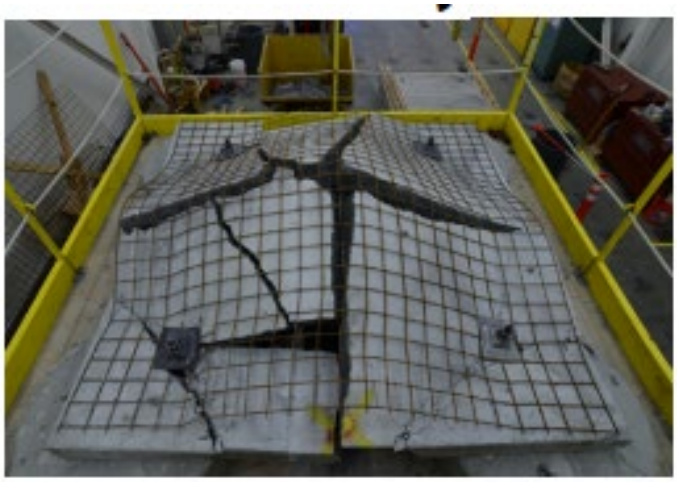
Mining Safety and Miner Health

14. The work of NIOSH's Spokane Research Laboratory is critical to miner safety and health. It is the home and only location for the Spokane Mining Research Division. The SMRD is relied on by surface and underground mines in the United States. to conduct research on a variety of mining safety and health topics. SMRD focuses research efforts on hardrock mines (but also

has several research projects with coal mines) and has many research partners in the western United States. Aside from the NIOSH facility in Pittsburgh (also closing as a result of the HHS reductions in force), it is the only facility of its kind doing this type of specialized research.

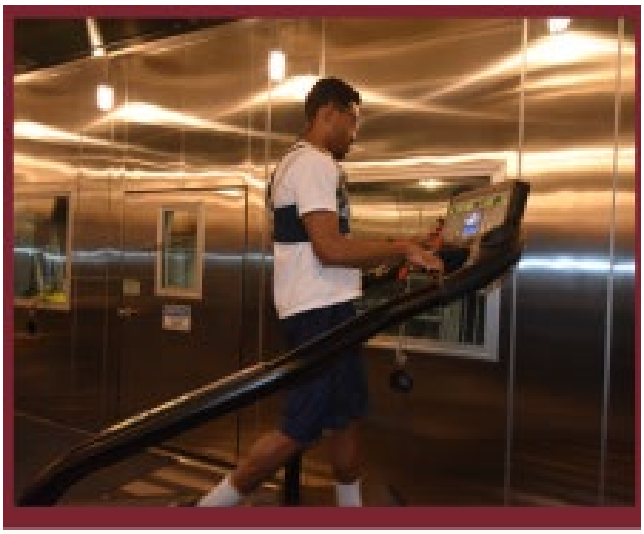
15. In order to carry out its unique mining research functions, the NIOSH Spokane Research Lab houses specialized machinery, most of which take at least a year of training in order to safely operate. This includes specialized equipment like (1) a large heat stress chamber designed for voluntary human subject research; (2) a network of seismic sensor arrays designed to provide seismic monitoring for mines, widely distributed throughout the region and some of which is located on private property; (3) large equipment testing support structures in mines to prevent mine collapse; and (4) large scale direct shear test frames designed to test soil and rock samples, simulating ground stresses to test a sample's strength characteristics.

16. Some of this equipment, like the machinery used to test the strength and deformation characteristics of a combination of mine structure support types (bolts, steel mesh, and shotcrete) is incredibly large, immobile, and built directly onto the foundation of the NIOSH Spokane building:[1]



[1] *Spokane Mining Research Division, National Institute for Occupational Safety & Health*, CDC (June 2022), https://stacks.cdc.gov/view/cdc/118353/cdc_118353_DS1.pdf.

17. Similarly, NIOSH Spokane's large and immobile environmental chamber can use various temperature and humidity settings to simulate mining conditions to study health effects such as heat stress:



This data has been used in multiple studies and informs rules and regulations concerning miner safety—including several fact sheets that offer science-based practical information about working in hot mining conditions.[2] The laboratory also contains an industrial hygiene setting that prepares and analyzes field samples to understand and characterize exposure to respiratory and other health hazards.

18. Without trained personnel, the specialized equipment and machinery at the NIOSH SRL will be rendered inoperable. As noted above, this machinery is largely immobile and could not be sold or transferred in its current form without being destroyed. Even in some equipment could be partially dismantled, much of this laboratory technology, being unique to mining research, cannot simply or easily be resold or transferred; the mining industry simply does not seem to place the same value on large-scale mining safety research as NIOSH did. If the NIOSH

[2] T. Victoroff & K. Yeoman, *Mining Product: Heat Stress: A Series of Fact Sheets for Promoting Safe Work in Hot Mining Settings*, National Institute for Occupational Safety & Health, CDC (last updated June 28, 2024), https://www.cdc.gov/niosh/docs/mining/works/coversheet1943.html.

layoffs become final, and the NIOSH SRL is shut down, this machinery and technology will have to be demolished, their functionality lost, and their ability to produce industry-critical research findings permanently lost.

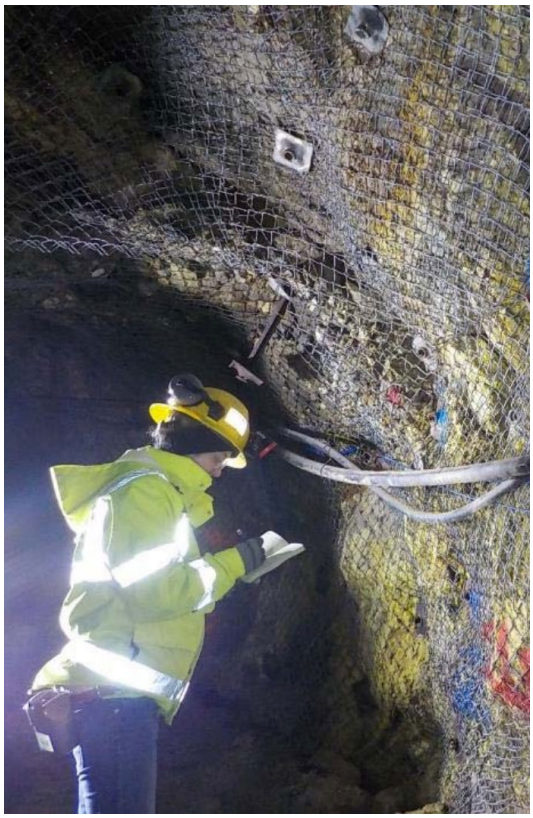
19. Even the off-site technology requires trained personnel from NIOSH Spokane for maintenance and reliable operation. For instance, NIOSH Spokane has installed a large network of specialized seismic sensor arrays (the Distributed Acoustic Sensing Array) that monitors seismic activity in the region ad around mining sites, and feeds real time data back to the NIOSH Spokane Lab.[3]

NIOSH can then compile and provide data to help engineers better understand and manage rockburst and other risks. Without NIOSH operating as a central data hub, mine operators and miners are often in the dark on these types of seismic risks, as seismic monitoring is neither required nor common on a mine-specific basis. And in a state like Washington, with active

[3] Derrick Chambers, M.S. & Shawn Boltz, M.S., *The Sound of Rockbursts: A New Monitoring Approach for Longwall Coal Mines*, NIOSH Science Blog, CDC (July 7, 2023), https://blogs.cdc.gov/niosh-science-blog/2023/07/07/rockbursts/.

volcanoes and unique fault zones, having real-time seismic data is critical to ensuring regional mine safety.

20. NIOSH's off-site research is not limited to stationary equipment, however. NIOSH Spokane employees frequently visit mining sites across Washington and other states to collect data from both miners and mines alike. For instance, one of NIOSH Spokane's recent focuses has been on mining structural stability, including the effects of corrosion on bolts, mesh, and other support structures. NIOSH Spokane sends experienced teams with specialized equipment to test support structures in numerous mines and shares the resulting findings publicly for all:[4]



21. SMRD's research leads it into productive partnerships with the private sector. For instance, SMRD researchers recently identified the need for better dust control techniques at mine

[4] Amy J. Chambers, *Corrosion in Underground Metal Mines*, NIOSH Mining Program, CDC, https://www.mtech.edu/mwtp/presentations/docs/amy-chambers.pdf (last visited May 6, 2025).

sites that employ crushers, shakers and conveyors to process ore. They collaborated with two industry partners (Benetech Inc. and Central Premix) to design, build and deploy a "hybrid dust control system that proved to reduce airborne silica dust by 93% at a mine site near Spokane, Washington. SMRD's research has also resulted in the launch of several mining safety products. For instance, NIOSH Spokane developed Ground Support Factor of Safety Calculator software,[5] which determines the deadweight factor of safety for an underground mining excavation's ground support design based on user inputs and established methods. NIOSH has also developed open-source software libraries to automate and improve analysis of seismic data related to the effect of mining on ground stability, and released them for free.

22. In addition to laboratory and field research, the SMRD also manages the Miner Health Program, a long-term, systematic effort to understand and improve the health and well-being of all miners. It supports this effort not only through integration of research, active collaboration with the mining community, and data transfer, but through a number of miner-focused programs such as the mobile surveillance programs, where NIOSH workers travel to different mining or mining-adjacent sites and test for common diseases like black lung. Aside from the mobile surveillance program offered by NIOSH, I an unaware of any other program that tracks the prevalence of black lung and other respiratory diseases in miners at such a scale, either regional or national.

23. The loss of the NIOSH mining safety research and programs would come at a critically inopportune time, as the Administration is implementing the President's Executive Orders calling for increased domestic coal mining, oil and gas extraction, and rare earth mineral

[5] S. Warren, et al., *Mining Product: Ground Support Factor of Safety Calculator*, National Institute for Occupational Safety & Health, CDC (Oct. 2020), https://www.cdc.gov/niosh/docs/mining/works/coversheet2163.html.

mining. Mining is a dangerous job—dozens of Washington miners have died in coal mining disasters, including the Roslyn No. 1 Mine explosion in 1892 and the Blue Canyon Coal Mine explosion in 1895. Aside from the real risk of explosions and cave-ins, mining also has a high prevalence of occupational respiratory and other types of disease, as workers are frequently exposed to coal mine dust, other chemical and respiratory hazards, and excessive noise. As a result of the reductions in force, NIOSH will not be able to conduct this important research or develop guidance to prevent and reduce these serious illnesses and injuries for miners—an area where NIOSH has produced hundreds of research articles, presentations, and industry guidance. The loss of the entire apparatus of mining research and miner health programs at NIOSH Spokane would undoubtedly put the health of our nation's miners at great risk.

24. While Washington does not currently contain as many miners as other coal-heavy states such as West Virgina, there are still approximately 2,000 miners in Washington. Most of these are mines focusing on metallic and nonmetallic minerals, with newer mines focusing on extraction of gold, lead, zinc, magnesium, and aluminum. There is one operational gold mine in Okanogan County, the Buckhorn Mountain Gold Mine, though several others are permitted.

25. Coal has been mined in Washington since 1853, but as of 2007 there are currently no active coal mines in the state. Coal production in Washington hit a high in 2003 with an estimated total production of 6,232,000 short tons, but essentially paused when the Centralia Coal Mine in Lewis County shut down operations.[6] However, it is my understanding that there are currently plans to open new coal mines that draw on some of Washington's numerous coal

[6] *Coal, Metallic, and Mineral Resources*, Washington State Department of Natural Resources, https://www.dnr.wa.gov/programs-and-services/geology/energy-mining-and-minerals/coal-metallic-and-mineral-resources#:~:text=Coal%20production%20in%20Washington%20hit,northeastern%20portion%20of%20the%20state (last visited May 6, 2025).

reserves, necessitating the employment of additional miners. I greatly fear for their safety if NIOSH's mining research is terminated.

WSD's Impacts on Safety in Commercial Fishing, Shipyards, Oil and Gas Extraction, and Other Industries

26. As noted above, the NIOSH Spokane facility also houses the NIOSH Western States Division. It is my understanding that all of the NIOSH employees working in the WSD will be separated in either June or July as a result of this reduction in force. Losing the WSD would be hugely detrimental to our region.

27. For instance, one WSD project, the NIOSH commercial fishing safety program, has been working for over 30 years to make commercial fishing safer. The program has worked in Alaska, Washington, Oregon, and the Gulf Coast in Southeastern states. The WSD maintains the Commercial Fishing Incident Database, which tracks commercial fishing fatalities and provides statistics by region, fishery, type of vessel, and type of incident. This is the only national source for a detailed breakdown of commercial fishing fatalities. Neither the Bureau of Labor Statistics nor the U.S. Coast Guard report this type of information. It is a unique function of NIOSH that will be lost with these reductions in force.

28. WSD research has resulted in the development of numerous techniques advancing the safety for commercial fishermen in our region. For instance, WSD developed engineering interventions to prevent winch entanglements on commercial fishing boats in the Pacific Northwest and Alaska, including commercial salmon boats, and also commercial shrimp boats in the southern coastal states from Texas to North Carolina. It's no small stretch to credit the techniques developed at NIOSH with saving fishermen's lives.

29. WSD is also a frequent collaborator with Washington tribal communities to improve tribal workplace safety. WSD has collaborated with the Columbia River Inter-Tribal Fish

Commission to prevent drownings among commercial fishermen along the Columbia River, promoting life jacket use among tribal fishermen. WSD had a project working with the Northwest Tribal Emergency Management Council to understand to assess mental and physical health issues among tribal emergency response workers in Washington, Oregon, and Idaho. After the reductions in force, all of its ongoing projects appear to be halted.

30. WSD also had active collaborations with naval shipyards at two sites in Washington to assess toxic inhalation exposures to workers applying and removing marine coatings from vessels: (1) the U.S. Navy's Trident Retrofit Facility near Bangor, Washington; and (2) the Puget Sound Naval shipyard. Without NIOSH workers, these assessments will not be completed, and NIOSH's expertise in finding and solving hazards within these workplaces

31. An extension of WSD shipyard research also applied to hydroelectric dams in Washington State. NIOSH recently had a scheduled field site visit (now cancelled) to evaluate toxic exposures from rehabilitation of hydroelectric turbines on the Snake River in Southeast Washington - specifically, the Little Goose Dam. This was in partnership with the U.S. Army Corps of Engineers. The project is now likely doomed.

32. NIOSH also regularly publishes evidence-based recommendations and trainings that ensure worker safety during oil and gas extraction. Over the years, NIOSH and its partners have completed numerous research projects to address safety and health issues in the oil and gas extraction industry. Projects cut across a number of important issues including motor vehicle safety, falls, fatigue, and health hazards such as silica, hydrocarbon gases and vapors, and noise. NIOSH publishes industry trainings and videos that have over 60,000 views, and maintains the Fatalities in Oil and Gas (FOG) database to better study the causes of deaths in oil and gas

extraction.[7] Without NIOSH, the industry is largely left to its own devices to research workplace safety and implement its findings—a task often at odds with maximizing profit.

Other Workplace Safety Impacts

33. The impacts of NIOSH closing extend far beyond the industries that are the primary focus of NIOSH Spokane's research efforts. For instance, NIOSH, including several employees in NIOSH Spokane, earlier this year published the draft version of a comprehensive hazard assessment on the impacts of exposure to wildland fire smoke among outdoor workers; NIOSH did so to solicit public comment before finalizing its industry-specific recommendations.[8] This assessment would have presented detailed findings of the relevant health effects of wildfire smoke and present evidence-based recommendations to protect outdoor workers, including farm workers, construction workers, oil and gas workers, park rangers, emergency responders, and others from the adverse health effects of occupational exposure to wildland fire smoke. If these employees are officially separated and their office is eliminated, this document will never be finalized, and I am aware of no other governmental agency that has the expertise or authority to finish such a document. This has an impact on outdoor workers in Washington as the document can be used to support and potentially make revisions to the Washington Smoke Rule.

34. The reduction in force across NIOSH is similarly delaying, and likely eliminating, the implementation of rules from other agencies relating to silica dust exposure. For instance, the Department of Labor's Mine Health Safety Administration (MSHA), in partnership with NIOSH, was set to begin in April 2025 implementation of a rule regulating the time and amount, and

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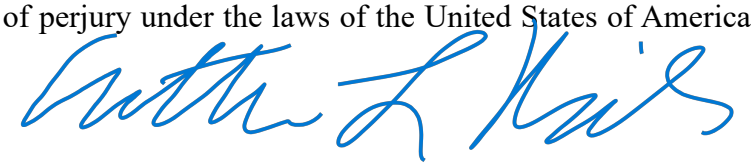
[77] *Oil and Gas Extraction Program*, NIOSH Research Programs, CDC (Mar. 15, 2024), https://www.cdc.gov/niosh/research-programs/portfolio/oil-gas-extraction.html.

[8] *Draft Hazard Review: Wildland Fire Smoke Exposure Among Farmworkers and Other Outdoor Workers*, National Institute for Occupational Safety & Health, CDC, https://www.cdc.gov/niosh/docket/review/docket352a/default.html (last visited May 6, 2025).

required respiratory equipment, for miners working with toxic silica dust. Lowering Miners' Exposure to Respirable Crystalline Silica and Improving Respiratory Protection, 89 Fed. Reg. 28,218 (Apr. 18, 2024) (the Silica Rule). Now, due to what MSHA calls "the unforeseen NIOSH restructuring, and other technical reasons," namely the closure of the National Personal Protective Technology Laboratory (NPPTL) and its effect on "the supply of approved and certified respirators and personal dust monitors," MSHA announced it was postponing the compliance deadline for the Silica Rule until August 18, 2025. If the NPPTL remains closed (as it currently is after the reduction in force), I cannot see how this rule, or any rule that relies on NIOSH's extensive research into airborne silica dust, is ever implemented. This would greatly hinder efforts to adequately control silica exposure not just in coal or metallic/nonmetallic mines in Washington and elsewhere, but across a number of different workplace settings, including construction and factory work.

35. This Declaration covers only a small portion of the critically important research and services provided by NIOSH Spokane, and NIOSH as a whole. If the reductions in force are not reversed, workplaces in Washington and the rest of nation, especially those in mines, shipyards, and fighting fires, would be significantly more dangerous.

36. I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.



Dr. Arthur Miller

Date: May 7, 2025

EXHIBIT 35

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF RHODE ISLAND

STATE OF NEW YORK, et al. Plaintiffs, v. ROBERT F. KENNEDY, JR., in his official capacity as SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., Defendants.	Case No. 1:25-cv-00196

DECLARATION OF MARGARET LELAND

I, Margaret Leland, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the foregoing is true and correct:

1. I am over the age of eighteen, and am otherwise competent to testify. I am familiar with the information in the statements set forth below either through personal knowledge, in consultation with the staff at Washington's Department of Labor & Industries (L&I) staff, or from documents that have been provided to and reviewed by me.

2. I am the Policy Director at L&I working in the Government Affairs and Policy Division under the Director's Office. I have worked L&I for 15 years. I have worked with the L&I Government Affairs and Policy Division since July 2013, initially as a Senior Policy Advisor and currently as the Policy Director. Prior to those positions, I held roles in Division of Occupational Safety and Health (DOSH) within L&I, including as the Legislative and Laboratory Programs Manager from June 2011 to July 2013 and as the Special Assistant to the Deputy Assistant Director who heads the division. Prior to joining L&I, I was an Assistant Attorney General providing legal support to L&I, including litigation and advice.

3. I have J.D. from Seattle University School of Law, an M.S.P.H. in Industrial Hygiene from the Graduate School of Public Health from San Diego State University, and B.S. in Environmental Policy and Assessment at Western Washington. Prior to entering public service, I worked as an Occupational Health Specialist, Industrial Hygienist/Technician, and as a Safety Administrator for several companies as well as a for a local public health department.

4. L&I's is a diverse state agency dedicated to the safety, health, and protection of Washington's 3.3 million workers along with the public and is one of the largest providers of workers' compensation coverage in the country. Our mission is to "Keep Washington Safe and Working". Our key responsibilities administration of workplace safety and health laws and administration of Washington's workers' compensation system.

5. Washington L&I's Division of Occupational Safety and Health (DOSH) administers chapter 49.17 RCW, the Washington Industrial Safety and Health Act (WISHA). DOSH ensures employers meet safety and health standards via workplace inspections, on-site consultations. DOSH also develops and enforce rules that protect workers from hazardous job conditions, thus decreasing the risk and occurrence of occupational injuries and illnesses. L&I is one of 22 OSHA-approved State Plan by the Occupational Safety and Health Administration (OSHA) pursuant to 29 U.S.C. § 667 with jurisdiction over most private sector employers and all state and local government workers

6. L&I's Division of Industrial Insurance administers the state's workers compensation insurance system according to Title 51 RCW, Washington Industrial Insurance Act. In this capacity, L&I is the workers' compensation insurer for more than 99% of Washington's 200,000 employers, providing medical and limited wage replacement coverage to workers who suffer job related injuries and illness. In the event of an injury or illness leading to a workers'

permanent total disability, L&I workers' compensation provides a lifetime pension benefit, or in the event of a worker's death a lifetime benefit to their survivors. Under Washington's Industrial Insurance Act, employers must obtain workers' compensation coverage from L&I unless certified by L&I to be self-insured. Both employers and employees pay premiums to L&I, with on average, employers paying 75% of the premium and employees paying 25% through payroll deductions.

7. It is my understanding and belief that as a result of the massive reduction in force across HHS, over 90% of the staff of the National Institute for Occupational Safety and Health ("NIOSH"), housed within the Centers for Disease Control and Prevention ("CDC"), have been placed on administrative leave and will be permanently terminated on or after either June 1, 2025, or July 2, 2025.

8. As authorized under the federal Occupational Safety and Health (OSH) Act pursuant to 29 U.S.C. § 671, NIOSH is the only US federal agency mandated to conduct research and making recommendations for the prevention of work-related injury and illness. NIOSH conducts research, disseminates information and supports education in the field of occupational safety and health. NIOSH achieves their mission through a combination of intramural (research conducted by NIOSH with its own employees) and extramural programs (research conducted outside NIOSH by researchers and institutions funded by NIOSH). It is my understanding that terminations include those program staff in the NIOSH Office of Extramural Program and as such all NIOSH Extramural Research programs and grants will not be continued.

9. Losing NIOSH, both the intermural and extramural programs. would be devastating for L&I, and for Washington. Broadly, L&I relies on NIOSH for research on the recognition and control of workplace physical, biological, chemical and psychosocial hazards which will reduce the burden of occupational injury and illness and promote worker well-being. In fiscal year 2023,

$2.6 billion was paid for workers' compensation benefits to workers in Washington State. Indirect costs of occupational injuries and illnesses are estimated to up to 4 times the direct costs and include loss of productivity, administrative costs, overtime, training of replacement workers, and administrative costs, presenteeism, decrease in quality of life, and household and community effects.

Losing NIOSH Hinders Development of Washington Workplace Safety Regulations

10. The elimination of NIOSH will directly impact the development and effectiveness of workplace safety and health regulations in Washington, many of which directly depend on NIOSH findings and actions.

11. Washington's DOSH, a state OSHA plan, has authority to adopt workplace safety and health regulations pursuant to WISHA, that exceed the requirements of federal workplace regulations. Regulatory development relies on research to determine hazardous levels of exposure, health effects of that exposure, and adequacy of control measures for the exposure. WISHA, similar to OSHA, mandates L&I to set health and safety standard to control conditions in the workplace concerning toxic materials and harmful physical agents that "most adequately assures, to the extent feasible, on the basis of the best available evidence, that no employee will suffer material impairment of health or functional capacity." (RCW 49.17.050(4) and 29 U.SC § 655(5)). NIOSH, directly and by grant, is the largest producer of occupational safety and health research in the United States.

12. For example, NIOSH's Criteria for a Recommended Standard: Occupational Exposure to Heat and Hot Environments,[1] informed the updated of Washington's 'Outdoor Heat

[1]NIOSH [2016]. NIOSH criteria for a recommended standard: occupational exposure to heat and hot environments. By Jacklitsch B, Williams WJ, Musolin K, Coca A, Kim J-H, Turner N. Cincinnati, OH: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Institute for Occupational Safety and Health, DHHS (NIOSH) Publication 2016-106.

Exposure' regulation[2] adopted in 2023. Absent research, workplace safety regulations may lead to incomplete, ineffective rules. Ineffective rules likely impose an unnecessary burden on employers while not having the benefit of worker protection and diminished worker injuries and illness.

13. The Washington State Legislature explicitly recognized the value of NIOSH's expertise and guidance in producing recommended workplace standards and enacted RCW 49.17.465 in 2011 requiring L&I adopt rules for exposures to hazardous drugs, such as chemotherapeutic agents, in healthcare that are consistent with NIOSH's 2004 alert on preventing occupational exposures to antineoplastic and other hazardous drugs in health care settings as updated in 2010. The Washington State Legislature defined "hazardous drugs," in part, as any hazardous drug identified by NIOSH.[3] NIOSH has published and updates a lists of hazardous drugs in 2004, 2010, 2012, and 2014, As described in the "NIOSH List of Antineoplastic and Other Drugs in Healthcare Settings, 2016" document, part of NIOSH's effort to identify hazardous drugs includes an initial review by an internal committee of all new FDA drug approvals and new warnings on existing drugs for a two-year period, followed by review of an expert panel consisting of peer reviewers and stakeholder review followed by notice in the Federal Register requesting public comment.[4]

14. The elimination of NIOSH diminishes the information available to establish safe workplaces in Washington. Washington L&I DOSH relies on NIOSH to provide authoritative information for employers, workers and state worker safety and health agencies.

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[2] Washington Administrative Code 296-62-095

[3] RCW 49.17.460(2)

[4] NIOSH [2016]. NIOSH list of antineoplastic and other hazardous drugs in healthcare settings, 2016. By Connor TH, MacKenzie BA, DeBord DG, Trout DB, O'Callaghan JP. Cincinnati, OH: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Institute for Occupational Safety and Health, DHHS (NIOSH) Publication Number 2016-161 (Supersedes 2014-138).

15. For example. hazardous and harmful exposures to workplace chemicals can occur below the regulatory standards adopted by OSHA and WISHA. NIOSH publishes Recommended Exposure Limits (NIOSH RELs). NIOSH RELs provide exposure limits to hazardous substances in the workplace to protect workers from any harm. NIOSH RELs are developed through a comprehensive data review. NIOSH RELs are published in the NIOSH Pocket Guide to Chemical Hazards. In the absence of OSHA regulations for specific chemicals, NIOSH RELS can be helpful to employers to provide guidance on safe exposure levels. The personnel and resource demands to develop a comprehensive set of RELs are not available in state labor or health agencies. Some L&I safety and health rules explicitly reference the NIOSH Pocket Guide as a means of determining whether a legally-actionable workplace safety condition exists. WAC 296-842-19005 (relying on NIOSH Pocket Guide to Chemical Hazards to determine whether immediately dangerous to life or health conditions exist).

16. NIOSH publishes the NIOSH Manual of Analytical Methods (NMAM). NMAM is a collection of sampling and analytical methods for workplace exposure monitoring. It includes methods for workplace air, surfaces, and blood and urine. NIOSH and its partners have developed or adapted the methods included in the NMAM. NIOSH evaluates the methods according to established protocols and performance criteria. NIOSH recommends using the best method available for making each measurement. L&I DOSH inspectors and consultants take samples of chemicals, dusts or other hazardous matter during worksite compliance inspections or consultations. The samples are collected according to sampling protocols based on corresponding NIOSH developed protocols. The samples are sent to DOSH's lab in Tumwater, Washington. The DOSH lab analyzes these samples according to analytical method developed by NIOSH to determine if hazardous chemicals or materials are present and, if so, the amount to which

employees may have been exposed. If analytic samples exceed regulatory thresholds, control measures may be instituted and in the context of an enforcement inspection, the employer may be given a citation and a monetary penalty. NMAM thus provides standardized, authoritative methods for the collection and analysis of these samples across the United States, including Washington.

17. The loss of NIOSH means the inability to update NMAM, inability to test and develop analytic methods with greater sensitivity to lower levels of exposures and develop new analytic methods for emerging exposures and hazards. NMAM will become obsolete. The number of methods developed and in need of updating far exceeds the capacity of one state or even multiple states and as such the loss of NIOSH, the loss of NMAM, will create confusion, with the application of inconsistent methods across states.

Losing NIOSH Facilities and Programs Makes Washington's Workplaces Less Safe

18. In addition to the regulatory effect of losing access to NIOSH, there are several NIOSH-run programs that significantly affect Washingtonians and their workplace safety. All of the programs below now appear to be halted and may be forever lost if the reductions in force go into full effect.

19. ***Respiratory Equipment Certification***: NIOSH's National Personal Protective Technology Laboratory in Pittsburgh, PA, which is required to vet and approve personal protective equipment, including N95 respirators, lost all or nearly all their employees. No other federal facility may issue these approvals.[5] Nor can any state facility. Unfortunately, NIOSH's website

[5] Ian Karbal, *Federal cuts threaten to close Pennsylvania lab that certifies N95s and other respirators in June*, Pennsylvania Capital-Star (April 17, 2024) https://penncapital-star.com/health-care/federal-cuts-threaten-to-close-pennsylvania-lab-that-certifies-n95s-and-other-respirators-in-june/.

confirms reports of the respirator approval program's demise, noting "[d]ue to the reduction in force across NIOSH, no new respirator approval applications can be accepted."[6]

[6] *NIOSH, Personal Protective equipment*, https://www.cdc.gov/niosh/ppe/index.html (last accessed April 28, 2025); *NIOSH, Respirator Approval Program,* https://www.cdc.gov/niosh/rap/index.html (last accessed April 28, 2025).

20. The loss of the NPPTL, and thus NIOSH's approval program for respirators and PPE, will profoundly impact the safety of Washington's workers and the work of L&I DOSH. NIOSH NPPTL is responsible for the testing and certification of respiratory protective equipment in the United States.

21. For certification of respirators, NIOSH conducts comprehensive testing of respirators to ensure they meet established safety and performance standards before granting approval. The NIOSH approval process is codified under 42 C.F.R. § 84. They perform ongoing audits and testing of approved respirators to ensure continued compliance with standards. They participate in creating and updating standards for respiratory protection equipment. They conduct research to improve respiratory protection technology and standards. They provide information and resources about proper respirator selection, use, and maintenance. The NIOSH approval number on certified respirators indicates the product has passed these tests and meet the required protection standards. Since the NIOSH NPPTL certification process is comprehensive and rigorous, the workforce can be assured that a NIOSH certified respirator will perform to standard.

22. During the COVID-19 pandemic and the scarcity of N-95 respirators, counterfeit respirators and respirators that misrepresented approval were introduced to the market. Loss of NPPTL creates a real risk of faulty respirators appearing on the market, especially if there is scarcity of NIOSH certified respirators. Further, innovation in developing novel methods for production of respirators, developing new types of respirators, e.g. for wildland firefighters, cannot gain NIOSH approvals.

23. Additionally, all L&I DOSH rules that require employers ensure workers wear respirators to protect workers from hazardous airborne exposures, such as firefighters and healthcare workers, mandate the use of NIOSH certified respirators and respirator filters. *See, e.g.*,

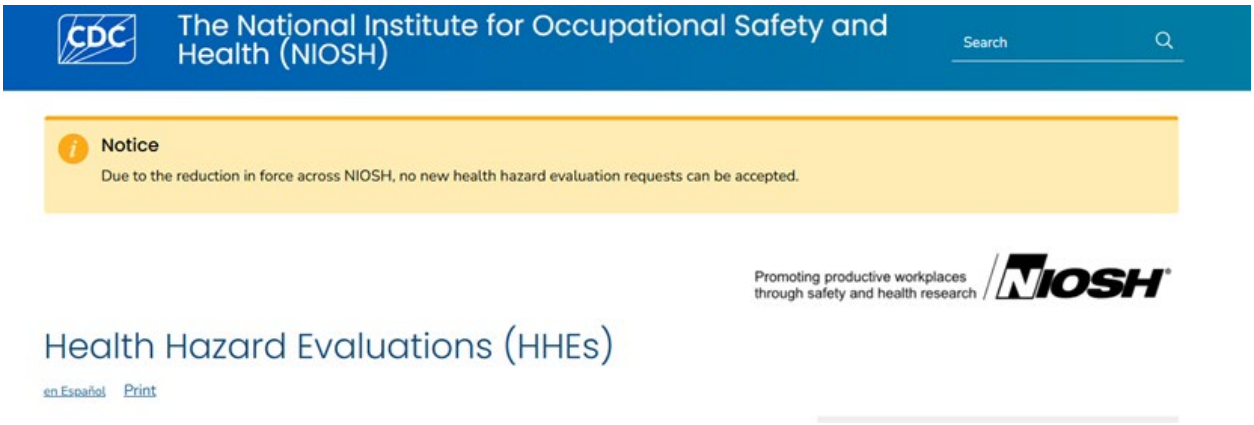
WAC 296-305-04001 (requiring firefighters' self-contained breathing apparatus to be NIOSH certified); WAC 296-842-11005 (relying on NIOSH certification for respirator selection for workplaces; noting "[i]f a respirator is not certified by NIOSH, you have no guarantee that it meets minimum design and performance standards for workplace use"); WAC 296-842-13005 Table 6 (requiring air-purifying respirators with filters certified to be at 95% efficient as certified by NIOSH for exposures to particulates). The requirement to use NIOSH certified respirators and filters is consistent with OSHA's requirement for respirator usage and all state plans must have a similar provision to be at least as effective as OSHA. The loss of the NPPTL means that list of existing approved respirators becomes static but also removes the important oversight over existing respirator certifications as NIOSH will no longer be able to conduct audits and revoke approval for cause outlined in 42 C.F.R. § 84.34. For example, in December 2024, NIOSH revoked six approvals for a respirator manufacturer on the basis that they failed to maintain their quality management system.[7] Absent this critical safeguard, there is risk of harmful exposure despite efforts by L&I, employers, and workers to ensure workers are wearing appropriate NIOSH certified respirators and filters.

24. ***Health Hazard Evaluation Program***: NIOSH's Health Hazard Evaluation (HHE) program was created by Section 20(a)(6) of the Occupational Safety and Health Act of 1970, and Sections 301 and 501 of the Federal Mine Safety and Health Act of 1977. 29 U.S.C. § 669(a)(6); 30 U.S.C. § 951(a)(11). As part of its implementing regulations, NIOSH must conduct investigations upon request of possible safety and health hazards and conduct inspections resulting from employee or committee reports of unsafe of unhealthful working conditions. 29 C.F.R. §

[7] *NIOSH CA 2024-1089*, *NIOSH Respiratory Device Information CAN Revocation of Six Aegle PPE 1 LLC Approvals*, CDC (Dec. 2024) https://www.cdc.gov/niosh/media/pdfs/2025/03/CA-2024-1089-P.pdf.

1960.35(a). NIOSH is also required to provide a hazard evaluation program for all federal agencies. 29 C.F.R. § 1960.35(b).

25. According to NIOSH's website, "[d]ue to the reduction in force across NIOSH, no new health hazard evaluation requests can be accepted."[8]



26. The elimination of the NIOSH Health Hazard Evaluation (HHE) program undermines the ability to detect new workplace hazards and characterize harmful exposures. Among HHE's many purposes, HHE's evaluate workplaces where workers have an illness with an unknown cause, and evaluate exposures to a novel new or previously unrecognized hazard. HHE's serve the purpose of an objective, science-based exploration of the risks posed by workplace exposures on human health. HHE's can be requested by employers, unions, and workers. They are performed at public and private sector employers. Employers nor workers are charged for a NIOSH HHE. Washington has had more than 40 HHEs from 1973 through 2025.

27. A 2021 HHE of the Washington State's State Toxicological Laboratory evaluated concerns regarding potential exposures to illicit drugs, including methamphetamine, among

[8] *NIOSH, Health Hazard Evaluations (HHEs),* CDC (July 22, 2024) https://www.cdc.gov/niosh/hhe/default.html.

workers at the lab.[9] Detectable levels of methamphetamine, cocaine, fentanyl, and heroin were found on surfaces but levels were not significant to trigger mandated cleanup and workers did not report symptoms. Observations regarding improved use of PPE were made.

28. Another example is the 2004 HHE conducted following a confidential request from employees working at the Hanford Tank Farm and a subsequent request from the United States Department of Energy to evaluate the potential for exposures and health effects of vapors emitted from hazardous waste storage tanks at the Hanford Site in Richland, Washington.[10]

29. While Washington directly benefits from the HHE's performed in Washington, the national compilation of HHE helps Washington for rulemaking and to assist employers in providing a safe workplace, for example identifying ergonomic risks in warehousing, exposures to lead in bullet recycling, and evaluations of silica exposures in various workplace settings. No other local, state, or federal program has the level of expertise in hazard identification, exposure assessment, symptom surveys, medical testing and engineering controls for a diverse and complex exposure issues as the NIOSH HHE program. Absence of the HHE program can lead to an increased burden of unnecessary workplace illnesses, employee and employer anxiety and stress regarding unknown hazards, failure to intervene early to identify harmful effects of exposures throughout an industry and loss of the knowledge gained from worksite evaluations in the real world.

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[9] NIOSH [2023]. Evaluation of occupational exposures to illicit drugs in forensic laboratories. By Li JF, Shi D, Neu DT, Chiu S, Charles M. Cincinnati, OH: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Institute for Occupational Safety and Health, Health Hazard Evaluation Report 2021-0115-3388, https://www.cdc.gov/niosh/hhe/reports/pdfs/2021-0115-3388.pdf.

[10] NIOSH [2004]. Health hazard evaluation report: CH2M Hill Hanford Group, Inc. and United States Department of Energy, Office of River Protection, Richland, WA. By Boudreau Y, Cardarelli J, Burr G. Cincinnati, OH: U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention, National Institute for Occupational Safety and Health, NIOSH HETA Report No. 2004–0145–2941, https://www.cdc.gov/niosh/hhe/reports/pdfs/2004-0145-2941.pdf

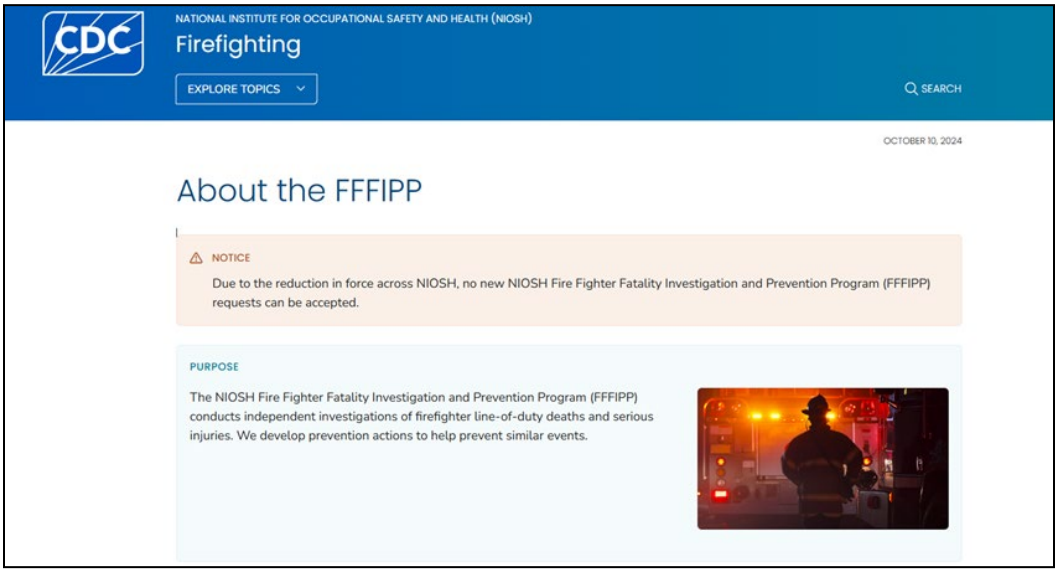
30. ***Coal Miner Programs***: NIOSH's Coal Workers Health Surveillance Program (CWHSP) provides black lung screenings to coal miners at no cost to miners. Its existence is mandated by Coal Mine Health and Safety Act of 1969, later amended by the federal Mine Safety and Health Act of 1977. 30 U.S.C. § 843. But because of the destruction of NIOSH, this program has stopped operating, according to NIOSH's website:

31. While there are currently no active coal mines in Washington, coal mining did occur in Washington prior to 2007, thus there are likely workers alive in Washington still eligible for services under the CWHSP. Moreover, if coal mining is expanded in Washington as a result of federal administrative priorities, the number of otherwise-eligible Washington miners will undoubtedly grow—but the program will not exist by then.

32. ***Firefighter Programs***: NIOSH also operates a number of firefighter-specific programs, such as the Fire Fighter Fatality Investigation and Prevention Program (FFFIPP), which takes submissions and conducts investigations of select career and volunteer firefighter medical and traumatic injury line-of-duty deaths, and the National Firefighter Registry for Cancer, which

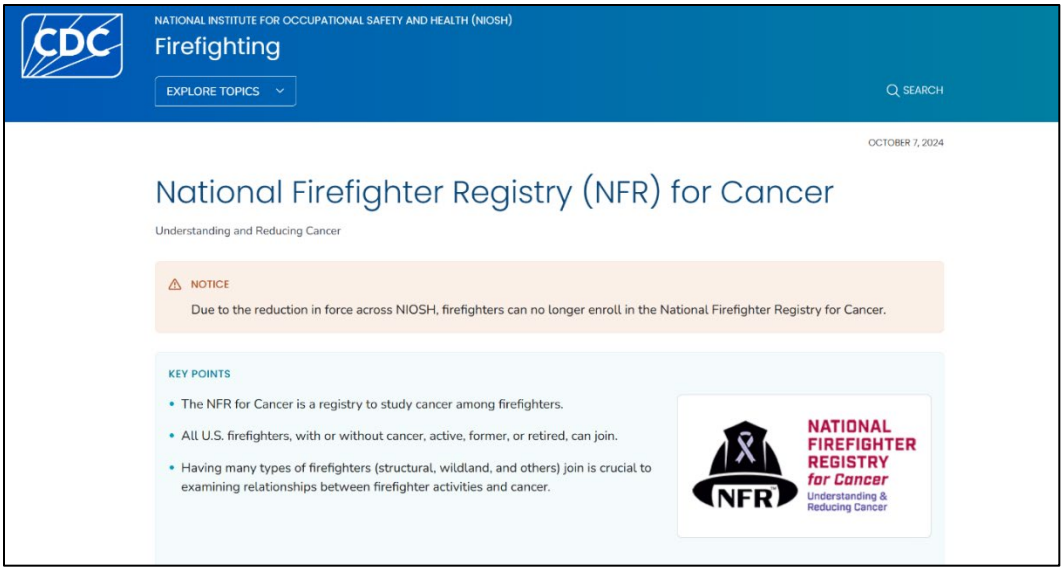
collects history and occupational information that can be used to determine the incidence of cancer among firefighters.[11]

33. Despite recent media reports that "some" of the laid-off NIOSH workers in these programs would be brought back on a "temporary" basis, on a practical level these firefighter-focused programs have ceased all activity. Both programs have been effectively halted, their websites updated that they will not be accepting new submissions "[d]ue to the reduction in force across NIOSH."[12]



[11] This Registry is mandated by the Firefighter Cancer Registry Act of 2018, which was signed by then-President Trump on July 9, 2018, 2 U.S.C. § 280e-5.

[12] *NIOSH Firefighting, About the FFFIPP* https://www.cdc.gov/niosh/firefighters/fffipp/about.html; *NIOSH Firefighting, National Firefighter Registry (NFR) for Cancer*, CDC (Oct. 7, 2024) https://www.cdc.gov/niosh/firefighters/registry/index.html.



34. The loss of the NIOSH firefighting programs lessens our scientific knowledge of the causes of work-related injuries and diseases, such as cancer and mental health disorders, associated with firefighting. Aside from making our firefighters less safe, this directly impacts Washington law. For instance, Washington, like many states, presume that specific health conditions are occupational diseases for purposes of workers compensation. This includes RCW 51.32.185, which establishes this presumption for firefighters. Current occupational disease presumptions for firefighters include for respiratory disease, heart problems, specific cancers, specific infectious diseases and post-traumatic stress disorder. This list of disease presumptions are informed by the data provided by NIOSH's Center for Firefighter Safety, Health, and Well-being,[13] which includes the National Firefighter Registry for Cancer, and the National Firefighter Fatality Investigation and Prevention Program

35. As the expectation of the Washington Legislature is to have evidence-based recommendations for modification of Washington's occupational disease presumption law, NIOSH

[13] *NIOSH, Center for Firefighter Safety, Health and Well-being*, CDC (Oct. 23, 2024) https://www.cdc.gov/niosh/centers/firefighter-safety-and-health.html

demise suggests fewer, if any conditions, will be added to the Washington occupational disease presumption law.

36. ***Extramural Programs***: NIOSH also directly funds, through grants, several organizations at the University of Washington, including the Northwest Center for Occupational Health and Safety (NWCOHS), an Educational Research Center (ERC), and the Pacific Northwest Center for Agricultural Safety and Health (PNASH), a Center for Agricultural Safety. Both are wholly supported by NIOSH grants—both would be shuttered in NIOSH no longer exists.

37. NIOSH is mandated to provide an adequate supply of qualified personnel to carry out the purposes of the OSH Act (29 U.S.C. § 670(a)) and NIOSH funded ERCs are the means to comply with this mandate. Losing these centers would be devastating not just for the faculty and students at the University of Washington, but also for Washington, its local communities, and the safety of its workers.

38. Ending funding for the NWCOHS ERC, and the other 17 ERCs across the nation, jeopardizes the supply of trained occupational safety and health professionals. ERC trainees, include occupational medicine physicians, occupational nurses, industrial hygienists and occupational safety specialists, the professions that can identify hazards in the workplace and establish causal links between the workers illness and workplace exposures. Workers compensation in Washington relies on occupational medicine physicians and nurses among other medical providers to initiate claims, provide evidence based treatment for injured workers, evaluate their disabilities, and promote return to work.

39. Shuttering NIOSH ERCs diminishes the supply of these well-trained professionals, likely leading to less evidence-based care of injured workers, prolonged disability and diminished return to work. NIOSH ERC trained industrial hygienists evaluate workplaces for chemical

exposures, build controls that may include ventilation, substitution of hazardous chemicals with less hazardous chemicals, and implementing respiratory protection programs. Less trained industrial hygienists lead to more chemically related illnesses and less compliance among the employer community with workplace health and safety regulations. ERC safety professionals can evaluate for safety hazards, develop training programs for recognition of safety hazards, install controls, like lock out tag out, to diminish worker risk for severe injuries. Less ERC trained safety professionals means more worker injuries.

40. Similarly, the PNASH, along with 10 other Agriculture Safety and Health Centers in the US, researches and promotes best safety and health practices for workers in farming forestry and fishing, the occupational group with the highest fatal work injury rates in the country—in 2023, 24.4 workers per 100,000 FTE were killed on the job compared to the overall national average of 3.5 deaths per 100,000 FTE for all other occupations.

41. PNASH researches how to most effectively educate these vulnerable workers on safety and health topics. For example, among many education and training programs, PNASH developed Heat Education and Awareness Tools (HEAT) in collaboration with agricultural workers, tested comprehension, and evaluated the effectiveness of the health prevention efforts—and they were effective. These tools supplemented L&I's adoption of an occupational heat exposure standard in initially adopted in 2008 and updated in 2023. Simply, PNASH assists agricultural, forestry, and fishing workers decrease harmful exposures and avoid injury. Loss of PNASH will result in more injuries to this vulnerable working population and less access to social insurance programs.

Eliminating NIOSH's Research and Investigative Arm Hurts Washington Workers

42. Even beyond Washington direct reliance on NIOSH for setting its workplace safety regulations, and on NIOSH facilities (or NIOSH-funded facilities) for industry-specific workplace safety, the loss of NIOSH also means the loss of some of the world's most highly trained occupational safety and health experts. NIOSH staff are highly trained, many with advanced degrees and expertise in various occupational health and safety disciplines, such as industrial hygiene, occupational medicine, occupational health nursing, occupational safety, occupational epidemiology, and ergonomics. These expert staff positions are not easily filled or nor is the expertise easily transferred. Their thought leadership, experience and accumulated knowledge is available to Washington L&I programs, including DOSH, workers compensation, and Washington's small safety research program.

43. The termination of access to these individuals impairs future research endeavors, creating inefficiencies and the loss of many practical lessons of what does and doesn't work in occupational safety and health. While currently available, the likely loss of NIOSH's website (and its updates), loss of access to landmark studies, research reports, research articles, hazard reviews, safety recommendations, and facts sheets. With the loss of NIOSH, we lose decades of experience in reducing the harms in the workplace, such as control workplace noise exposure,[14] and evaluations of the risk for work-related musculoskeletal disorders,[15] among many other occupational safety and health hazards. With loss of NIOSH, we lose its global leadership in

[14] *NIOSH Noise and Hearing Loss, Understand Noise Exposure*, CDC (Feb. 16, 2024) https://www.cdc.gov/niosh/noise/prevent/understand.html#:~:text=The%20NIOSH%20recommended%20exposure%20limit,a%20hearing%20loss%20prevention%20program.

[15] The NIOSH Yellow Book is a summary of the epidemiologic evidence for workplace risks for work-related musculoskeletal disorders (https://www.cdc.gov/niosh/docs/97-141/default.html). NIOSH developed and updated the NIOSH Lifting Equation—a common exposure assessment tool for evaluation work risk for back disorders; (https://www.cdc.gov/niosh/ergonomics/about/RNLE.html).

ongoing study of emerging hazards, such as nanomaterials,[16] wildland fire smoke,[17] and perfluoroalkyl and polyfluoroalkyl substances (PFAS).[18] Research builds upon itself, the loss NIOSH's history stymies innovation and future research. This loss of knowledge is likely irreplaceable.

44. Overall, the loss of NIOSH would have the effect of making Washington workplaces less safe, increase the burden on the workers' compensation system, impair the quality of life of Washington workers and their families, and impose other societal costs to Washington's communities

45. I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

/s/ Margaret Leland
Margaret Leland
Policy Director/Executive Policy Manager
Washington Department of Labor & Industries

Date: May 8, 2025

[16] NIOSH has a Nanotechnology Research Center (https://www.cdc.gov/niosh/centers/nanotechnology.html)

[17] NIOSH's Wildfire Smoke on their webpage (https://www.cdc.gov/niosh/centers/nanotechnology.html). More importantly, NIOSH published a Request for Information in the Federal Register—'Draft Hazard Review: Wildland Fire Smoke Exposure Among Farmworkers and Other Outdoor Worker' (https://www.cdc.gov/niosh/docket/review/docket352a/default.html). This RFI and review is in process and would be lost with the demise of NIOSH.

[18] NIOSH started studying Per- and Polyfluoroalkyl substances more than 20 years ago. These cancer-causing agents are ubiquitous in the environment and many workplaces—(https://www.cdc.gov/niosh/pfas/about/index.html)

EXHIBIT 36

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF RHODE ISLAND

STATE OF NEW YORK, et al. Plaintiffs, v. ROBERT F. KENNEDY, JR., in his official capacity as SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., Defendants.	Case No. 1:25-cv-196

DECLARATION OF ERIC BERG

I, Eric Berg, declare under penalty of perjury, pursuant to 28 U.S.C. section 1746, that the foregoing is true and correct:

1. I am the Deputy Chief of Health for California's Division of Occupational Safety and Health (Cal-OSHA) at the Department of Industrial Relations (DIR). I have personal knowledge of the facts set forth in this declaration, and if required to testify, would and could competently do so.

2. I submit this Declaration in support of the States' Motion for a Preliminary Injunction.

3. I have been Deputy Chief of Health for Cal-OSHA since 2015, and began my career in Cal-OSHA in 1997 as an industrial hygienist. I hold a Masters of Public Health Degree in Environmental Health Engineering and Bachelor of Science Degree in Civil Engineering.

4. As Deputy Chief of Health for Cal-OSHA, I am responsible for the following offices at Cal-OSHA:

- Medical Unit,

- Research and Standards Health Unit,
- Research and Standards Safety Unit,
- Calibration and Inventory Control Laboratory,
- Asbestos and Carcinogen Unit,
- Crane Unit,
- Census of Fatal Occupational Injuries, and
- Research Data Unit.

5. One of my key roles as Deputy Chief of Health is to administer and execute the investigation, research, and development of occupational health standards for California, which are codified in Title 8 of the California Code of Regulations. Some of the recent standards I have worked on include: Workplace Violence Prevention in Healthcare; Indoor Heat Illness Prevention; Occupational Exposures to Respirable Silica; Process Safety Management in Refineries; Hotel Housekeeping Musculoskeletal Injury Prevention; Agricultural Personnel Transport Carriers; Protection from Wildfire Smoke, Lead, Airborne Contaminants; and COVID-19 Prevention.

6. Cal-OSHA's mission is to protect and improve the health and safety of workers in California, and the safety of passengers riding on elevators, amusement rides, and tramways – through the following activities:

- Setting and enforcing standards
- Providing outreach, education, and assistance
- Issuing permits, licenses, certifications, registrations, and approvals

7. Pursuant to the California Occupational Safety and Health Act of 1973 (California Labor Code section 6300 et seq.), Cal-OSHA has "the power, jurisdiction, and supervision over

every employment and place of employment in the state, which is necessary … [ ] to enforce and administer all laws and lawful standards and orders, or special orders requiring such employment and place of employment to be safe, and requiring the protection of the life, safety, and health of every employee in such employment or place of employment." (California Labor Code section 6307.)

8. Pursuant to California Labor Code section 147.1, Cal-OSHA is responsible for determining the necessity for occupational health standards, and to develop, present, and propose occupational health standards for adoption.

9. Pursuant to California Labor Code section 144.6, occupational health standards developed by Cal-OSHA, to the extent feasible, must ensure that no employee will suffer material impairment of health or functional capacity even if such employee has regular exposure to a hazard regulated by the standard for the period of their working life.

10. Pursuant to California Labor Code section 147.1, Cal-OSHA is required to maintain liaison with the National Institute for Occupational Safety and Health ("NIOSH"), which is housed in the Centers for Disease Control and Prevention ("CDC"), within the U.S. Department of Health and Human Services ("HHS") in the development of recommended federal standards.

11. It is my understanding and belief that, as a result of the massive reduction in force (RIF) across HHS, over 90% of the staff of NIOSH have been placed on administrative leave and will be permanently terminated on or after June 1, 2025.

12. Established in 1970 under the federal Occupational Safety and Health Act, NIOSH was created alongside the Occupational Safety and Health Administration ("OSHA") to protect workers across the country. While OSHA enforces workplace safety regulations, NIOSH

focuses on science, research, laboratory testing, quality assurance, and education and training to improve occupational safety and health in the United States.

13. NIOSH is the sole agency in the United States responsible for conducting studies and other comprehensive reviews of workplace physical and chemical hazards. NIOSH has issued hundreds of authoritative publications that determine the exposure limits to prevent acute and chronic work-related diseases and injuries, including cancer.

14. Losing NIOSH would be devastating for Cal-OSHA and California as a whole.

15. NIOSH is the sole agency in the United States responsible for testing and certifying respirators to protect workers against inhaling toxic chemicals, dusts, and infectious agents. Employers must use NIOSH-approved respirators when required by federal OSHA and Cal-OSHA standards to prevent acute and chronic diseases of the lung, nervous system, kidney and liver, and to prevent cancer and other serious diseases and conditions. From 2021-2023, there were 1,776 respirator models that were evaluated by NIOSH.

16. Losing NIOSH will prevent California workers from accessing high-quality respirators to protect them from toxic exposures. Per federal and state law, respirators must be certified by the National Personal Protective Technology Laboratory ("NPPTL") (https://www.cdc.gov/niosh/divisions-offices/personal-protective-tech-lab.html) of NIOSH. The elimination of the NIOSH NPPTL means that there is no way for California workers and employers to get access to improved and new respirators, as there is no method for them to be certified with the elimination of NIOSH NPPTL.

17. NIOSH NPPTL was policing the sales of imported fraudulent and counterfeit respirators (https://www.cdc.gov/niosh/ppe/counterfeit_respirators/index.html) that do not provide meaningful protection to workers. These fraudulent imports put workers at great risk and

reduce workers' access to American-made bona fide respirators. Shutting down NIOSH NPPTL rewards foreign manufacturers who have not made the same investments in quality and safety while reducing American workers' access to reliable, high-quality protective equipment that actually meet NIOSH standards.

18. Losing NIOSH is preventing Cal-OSHA from moving forward on a working model of a new respirator for firefighters in wildland and urban interface fires, which was already in motion with NIOSH prior to the RIF Directive. The development of all other new respirators and new respiratory protection technology for use in America will be halted. Also, respirator manufacturers will be unable to make any changes or improvements to existing respirators. Major American respirator manufacturers are continually making improvements to their products and are selling their newer products overseas, but not in America, as they cannot be certified here due to the shuttering of NIOSH NPPTL. California workers who will be severely impacted by this loss include the following: firefighters at risk of chronic obstructive pulmonary disease (COPD) and lung cancer caused by toxic smoke from wildland and urban interface fires; agricultural workers at risk of stroke and heart disease caused by wildland fires; construction workers at risk of pneumonia caused by Coccidioidomycosis (Valley Fever); nurses at risk of respiratory illnesses caused by infectious agents in hospitals (tuberculosis, COVID-19, measles); and dairy and poultry workers at risk from avian influenza (Bird Flu).

19. NIOSH is the sole agency in the United States that responds to outbreaks of disease and injury caused by toxic substances, excessive noise, extreme temperatures, vibration, other physical hazards, and infectious agents in the workplace. Through the NIOSH Health Hazard Evaluation (HHE) (https://www.cdc.gov/niosh/hhe/default.html) program, California employers, employees and State agencies request technical assistance from NIOSH experts in

occupational medicine, industrial hygiene, and engineering to evaluate and help control workplace injury and disease outbreaks. NIOSH has conducted 187 HHE investigations in California, including large-scale studies after an outbreak of bronchiolitis obliterans ("popcorn lung") in food flavoring workers. The NIOSH studies of food flavoring workers provided the scientific information that was needed and used by Cal-OSHA for standards to control exposure to the artificial flavor diacetyl. Cal-OSHA also depended on NIOSH's HHE Program for development of the 2024 silica, lead, and indoor heat illness prevention regulations. Such studies from NIOSH will no longer be conducted and available for future Cal-OSHA rulemaking.

20. Losing NIOSH means that funding for eighteen education and research centers (ERC Program) (https://www.cdc.gov/niosh/extramural-programs/php/about/ercs.html) will be lost. The ERC Program, established in 1977, conducts research and offers professional training in occupational safety and health in areas such as industrial/occupational hygiene, ergonomics, occupational epidemiology, toxicology, and occupational medicine. The ERC supports faculty research and student training, graduate students and post-graduate (master's and doctoral) trainees at accredited occupational health programs at UC Berkeley, UC Davis, UC San Francisco and UCLA. The University of California campuses provide the only occupational health professional degree programs in the state, including two occupational medicine residency programs, ensuring a steady supply of workforce safety and health specialists for employers, including the California Department of Public Health (CDPH), and Cal-OSHA. Research and science conducted at these UC programs help identify and find cures for chronic diseases caused by occupational exposures. The UC-based research and training programs receive $3.6 million in annual NIOSH support and have trained over 750 occupational health specialists over the past decade. There is already a deficit of occupational health specialists in California to meet the

needs of the growing workforce, and NIOSH cuts will end all these training and education programs.

21. Losing NIOSH means that it will no longer develop criteria for recommended occupational safety and health standards (https://www.cdc.gov/niosh/pubs/all_niosh_desc.html). Cal-OSHA frequently relies upon and used these NIOSH criteria as a starting point for its rulemaking proposals, such as the heat illness prevention, ergonomics, lead, silica, and many other toxic substance regulations.

22. Losing NIOSH means that it will no longer publish groundbreaking research for worker protection. For example, one of NIOSH's innovative studies produced data for OSHA and Mine Safety and Health Administration regulations, which were later adopted by California, to limit exposure to toxic chemicals and dusts such as lead, vinyl chloride, silica, coal dust and beryllium.

23. The RIF will eliminate support for state-based occupational disease surveillance (https://simpler.grants.gov/opportunity/357417), which has been vital in tracking the burden of work-related illness and injury and uncovering outbreaks. For example, Cal-OSHA relied on data tracking artificial stone silicosis among California countertop workers to support its 2024 silica rulemaking. NIOSH is the sole agency in the United States that maintained national registries of occupational illnesses and diseases and collects and releases detailed information about the causes of workplace deaths through support of State-based public health tracking and investigation programs.

24. The RIF will also shut down the Fatality Assessment and Control Evaluation (FACE) Program (https://www.cdc.gov/niosh/face/about/index.html), which is critical in identifying factors that contribute to fatal injuries at work and developing recommendations for

prevention. California has its own FACE program (https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/OHB/FACE/Pages/FACE.aspx) that is funded by NIOSH, but, as a result of Defendants' actions, it is also being defunded and shut down. Cal-OSHA used the national and California FACE reports in its rulemaking and enforcement actions.

25. Losing NIOSH means it will stop producing the wealth of educational materials (https://www.cdc.gov/niosh/pubs/default.html) related to occupational safety and health used regularly by Cal-OSHA staff, workers, unions and employers.

26. Due to the RIF, the non-profit Center for Construction Research and Training (CPWR) (https://www.cpwr.com), which provides services to the construction industry and is largely funded by NIOSH grants, has been forced to terminate its CPWR's Small Studies program (https://www.cpwr.com/research/small-studies-program/). CPWR's research-to-practice program (https://www.cpwr.com/research/research-to-practice-r2p/), which support the falls, struck-by and other national campaigns for the construction industry, will be significantly reduced or terminated.

27. Losing NIOSH means that the NIOSH National Construction Center https://www.cdc.gov/niosh/extramural-programs/php/about/construction-center.html), which is administered by CPWR, will likely be forced to shut down.

28. Losing NIOSH means that all National Occupational Research Agenda (NORA) (https://www.cdc.gov/nora/default.html) Programs will be cancelled and shut down. NORA is a partnership program of multiple stakeholders to stimulate innovative research and improved workplace practices in specific industries. NORA includes 10 industrial sector councils that develop strategic objectives for their industry to research and address.

29. Losing NIOSH means that for the California construction industry, there will be less: investigation, research and studies on construction industry risks and hazards; generation of practical solutions for protecting workers; and safety and training for the construction industry.

30. Losing NIOSH means the end of the National Firefighter Registry for Cancer (https://www.cdc.gov/niosh/firefighters/registry/index.html) to study cancer among firefighters. Firefighters are exposed to many toxic substances that can increase their risk of developing cancer. The research aimed to find answers about how cancer risk may vary across our nation's diverse fire service, but this research will be discontinued before its completion.

31. Losing NIOSH means the end of the Fire Fighter Fatality Investigation and Prevention Program (https://wwwn.cdc.gov/NIOSH-fire-fighter-face/). NIOSH conducted investigations of firefighter line-of-duty deaths to formulate recommendations for preventing future deaths and injuries and for learning from these tragic events and preventing future similar events.

32. Losing NIOSH ultimately will result in greater morbidity and mortality for California's workers.

33. I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

EXECUTED on May 8, 2025 in Oakland, California.

Eric Berg

Eric Berg
Deputy Chief of Health, Cal-OSHA
California Department of Industrial Relations

EXHIBIT 37

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF RHODE ISLAND

STATE OF NEW YORK, et al., Plaintiffs, v. ROBERT F. KENNEDY, JR., in his official capacity as SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., Defendants.	Case No. **1:25-cv-00196-MRD-PAS**

DECLARATION OF MICHELLE DAVIS

I, Michelle Davis, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the foregoing is true and correct:

1. I am the Deputy Commissioner of the Office of Public Health ("OPH"), within the New York State Department of Health ("DOH"). I am familiar with the information in the statements set forth below either through personal knowledge, in consultation with DOH staff, or from documents that have been provided to and reviewed by me.

2. I submit this Declaration in support of the States' Motion for a Preliminary Injunction.

Professional Background

3. I am the Deputy Commissioner at the OPH, within the DOH. I have served in this position since April 10, 2025. I have over thirty (30) years of public health experience serving at the local, county, state and territorial levels. I have held five (5) executive public health positions including my current position. They include: Deputy Health Commissioner for Policy and

Planning for the City of Philadelphia, Deputy Secretary for Health for Policy and Planning for the Commonwealth of Pennsylvania, Senior Executive Service within the U.S. Department of Health and Human Services ("HHS") for the Office of the Secretary (CEO), and Health Commissioner (CEO) for the U.S. Virgin Islands. I have worked in and managed across a broad portfolio of public health areas including those outlined below for the NYS Office of Public Health. Within HHS I spent ten (10) years with the Centers for Disease Control and Prevention ("CDC") as an epidemiologist and statistician developing surveys, analyzing data and training individuals how to collect and analyze data for program development and management. The CDC also assigned me to serve as the Director of Maternal and Child Health within one of our nations' health departments. As the Health Commissioner of the U.S. Virgin Islands, I oversaw most of the same programs that are conducted by the DOH. I have undergraduate training in biology, psychology and education. Utilizing this education, I have worked as a laboratory microbiologist and a science teacher. With my graduate training in Epidemiology, Statistics and Health Policy, I have conducted research, written and published journal articles, and developed policy guidance at the federal level in the areas of Sickle Cell Disease, Language Access, Performance Measures and Data utilization among other areas.

4. DOH's mission is to protect and promote health and well-being for all, building on a foundation of health equity. The OPH is responsible for a broad portfolio of essential public health activities in New York State, such as communicable disease control, immunizations, family health, chronic disease prevention, local public health practice, nutrition programs, drinking water safety, injury and violence prevention, and environmental health and food safety. The OPH oversees different centers and divisions, including the DOH's Center for Community Health ("CCH"). Within the CCH, the Division of Chronic Disease Prevention implements

evidence-based and innovative public health strategies to support New Yorkers to live healthier lives by reducing the incidence and burden of many of the leading causes of death and disability, including heart disease, stroke, cancer, obesity, diabetes, and asthma, and their associated risk factors, including tobacco use, poor nutrition, and lack of physical activity.

5. The DOH's Bureau of Tobacco Control resides within the Division of Chronic Disease Prevention and has a mission to reduce tobacco-related illness, disability and death and to alleviate the social and economic burden caused by tobacco use in New York State. Since 2000, the Bureau of Tobacco Control has administered the State's comprehensive Tobacco Control Program to prevent tobacco use initiation, reduce tobacco use among adults, eliminate exposure to secondhand smoke, and advance health equity.

6. The Bureau of Tobacco Control operates through a comprehensive, integrated, evidence-based, CDC-recommended framework of health communications, cessation-focused health systems change, local and statewide policy initiatives, and is also assessed through a state-mandated independent evaluation. The program uses health communications and mass media to conduct widespread public awareness campaigns to inform the community about the dangers of tobacco use and the benefits of quitting. The health systems change efforts aim to enhance the delivery of evidence-based tobacco cessation treatment, particularly for underserved populations, through initiatives such as integrating tobacco use screening in electronic health records, training providers, and expanding cessation benefits. Programs like the Health Systems for a Tobacco-Free NY and the New York State Smokers' Quitline provide resources and support to both individuals and healthcare providers to facilitate successful quit attempts. Through the Advancing Tobacco-Free Communities Program, the Bureau funds a network of grantees across New York State to implement community engagement and youth action strategies aimed at

creating tobacco-free environments. Their initiatives focus on policy changes to reduce tobacco marketing, promote smoke-free outdoor spaces and multiunit housing, and address tobacco use disparities among specific populations.

Office on Smoking and Health ("OSH")

7. OSH was the lead federal agency for comprehensive tobacco prevention and control and played a critical role in preventing youth tobacco use, which includes smoking, vaping, and other nicotine products, and helping adults to quit smoking. Cigarette smoking is the leading cause of preventable disease, disability, and death in the United States. OSH worked to prevent and reduce cigarette smoking by collecting, studying, and sharing information on cigarette smoking and its effects on health, as mandated by Congress. 15 U.S.C. § 1341 ("Smoking, research, education and information").

8. OSH was administered by the National Center for Chronic Disease Prevention and Health Promotion ("NCCDPHP"), within the CDC of the HHS.

9. OSH managed a tobacco use data portal which provided access to the latest tobacco prevention and control data, graphs, and maps, as well as the State Tobacco Activities Tracking and Evaluation ("STATE") System, which presented data on traditional Medicaid coverage of tobacco cessation treatments in fifty (50) U.S. States and the District of Columbia. This dataset was used by Plaintiff States to assess tobacco cessation policies and served as a national clearinghouse of information for the public.

10. OSH also managed annual submissions of cigarette and smokeless tobacco ingredient reports from manufacturers, packagers, and importers. OSH also monitored tobacco use trends and health impacts in part to inform FDA regulations and enforcement.

11. Further, staff at OSH establishes and maintains specifications for data systems needed to track measures of tobacco use for all fifty (50) states, including New York. They maintain the case definitions of measures essential to monitoring progress in tobacco control, cigarette smoking, use of other tobacco products, vaping, and quit attempts. Public health surveillance and epidemiology rely on stable data systems and these standard case definitions. The loss of experts responsible for maintaining these central data systems and technical measure specifications at HHS severely impaired New York State's tobacco control efforts; without these centralized systems; the consistency or effective collaboration amongst the fifty (50) states and US territories involved in tobacco control will be critically impacted.

12. OSH's national surveillance systems provided reliable, consistent, and cost-effective data collection that New York State used to evaluate its work and monitor progress in tobacco use prevention. OSH played an important role in surveillance and surveys, including the state-based Behavioral Risk Factor Surveillance System, National Health and Nutrition Examination Survey, and the National Youth Tobacco Survey ("NYTS"). NYTS collected data on tobacco use by high school and middle school students, including which products they were using, how often they use them, and how youth access them. The NYTS informs question development of state-level Youth Tobacco Surveys and serves as a comparison to understand state trends in context. The NYTS findings help inform the broader conversation about New York's and other states' tobacco-related outcomes among decision makers, the media and public health practitioners; and help to fill in the gaps in data for items that states do not have in their YTS. OSH additionally published state-level data on tobacco use prevention and cessation in the STATE. The STATE system helps New York State to facilitate data analysis and evaluation.

13. OSH educates the public about the harms of tobacco use, including media campaigns such as Tips from Former Smokers ("Tips Campaign") and publications derived from the Publication Catalog and Ordering System. The Tips Campaign ads, which were placed on television, radio, and billboards, encouraged people who smoke to quit by featuring real people with serious health conditions caused by smoking and secondhand smoke exposure. A CDC study of the Tips Campaign documented a significant positive impact on Americans' health. CDC estimated that during 2012-2018, over 16.4 million smokers attempted to quit and approximately one million successfully quit because of the Tips Campaign. Smokers who saw Tips Campaign videos reported greater intentions to quit smoking, and former smokers with higher exposure to the ads were associated with lower odds of relapse. The Tips Campaign was credited with helping to prevent early deaths and save precious government resources. The successful Tips Campaign continued to run from 2012 through 2024. It is estimated that a quarter of people that called quitlines in response to the Tips campaign have a disability or other chronic health condition. The loss of this campaign eliminates a critical tool that informed and assisted these groups with smoking cessation, the same groups that the DOH seeks to help through its aligned, evidence-based public awareness campaigns which were intentionally designed to complement federal efforts—coordination that is now disrupted by the loss of the Tips campaign. *See* **Exhibits A and B.**

14. OSH scientists published high-quality reports on tobacco use trends that New York and other states utilized to prioritize interventions, monitor progress, and reduce disparities. For example, OSH's Best Practices for Comprehensive Tobacco Control Program Guide advises states on how to develop, implement, and fund an evidence-based tobacco prevention and control program. OSH likewise dedicated its publications and resources to the "Publication Catalog and

Ordering System" where state agencies and other users could access campaign materials and Surgeon General's reports. Finally, CDC's OSH disseminates several fact sheets and publications which serve as foundational evidence-based guides for tobacco control programs interventions and evaluations. These publications set the stage for talking about emerging products, shifting trends and key priorities.

15. OSH maintained the national network of tobacco cessation quitlines by supporting quitline services in fifty states, two U.S. territories, and Washington, D.C. Additionally, OSH funded the New York State quitline to deliver resources such as counseling and medications.

16. OSH also supported the National Quitline Data Warehouse ("NQDW"), a large repository that serves as a continuing national resource for data on the services, utilization, and success of 54 nationwide quitlines. New York State, amongst others, has been able to conduct robust studies of its Quitline's reach and effectiveness because of the access it has to other state and national data via the NQDW. Without a primary, recognizable, and promoted program like the national quitline portal, (i.e., 1-800-QUIT-NOW), fewer people will be encouraged to quit or know where to get help. The Tips Campaign resulted in a sustained and dramatic increase of calls to quitlines. From 2012-2023, more than 2 million calls to the national tobacco quitline portal can be attributed to the Tips campaign. *See* **Exhibit C**. More than 1 million people have successfully quit because of the Tips campaign. *See* **Exhibit B**.

17. OSH also provided millions in funding to the National and State Tobacco Control Program. Participating states used OSH funds to prevent kids from using tobacco, reduce secondhand smoke exposure, help people quit smoking, and address disparities in tobacco use.

18. OSH is largely administered at the federal level by HHS employees working out of HHS Regional Offices.

19. I am providing this declaration to explain the impacts on New York State and DOH of the changes to OSH, including a reduction in staffing, since April 1, 2025. These changes have created a situation whereby the DOH must alter its practices and procedures; fill critical gaps in technical assistance, surveillance, and communications support; adapt program strategies without essential federal guidance; manage uncertainty around future grant funding; and delay implementation of key evidence-based tobacco control interventions.

Center for Tobacco Products (CTP)

20. Per 21 U.S.C. § 387a(e), the Food and Drug Administration ("FDA") of HHS was obligated to create the CTP to administer the Family Smoking Prevention and Tobacco Control Act.

21. In the past CTP has overseen the implementation of the Family Smoking Prevention and Tobacco Control Act on behalf of the FDA by setting performance standards for tobacco products, reviewing premarket applications for new and modified risk tobacco products, requiring new warning labels, and establishing and enforcing advertising and promotion restrictions.

22. Among other duties, CTP conducts compliance checks on vendors and retailers to ensure that tobacco products are not sold to those under the age of twenty-one, reviews premarket applications for new tobacco products before they can be marketed in the United States, enforces advertising and promotion restrictions, oversees warning labels on tobacco and nicotine products, and educates the public about the risks of tobacco use including the dangers of e-cigarettes and other tobacco products. A critical part of FDA's public health mission is educating youth about the dangers of e-cigarette use and since 2018, CTP has prioritized its public education efforts to further reduce e-cigarette use among youth. The CTP's "Real Cost

Campaign" is a youth-specific national e-cigarette and cigarette prevention media campaign focused on educating youth about the negative health effects and risks of vaping and smoking. The campaign was found to have prevented an estimated 444,252 American youth (aged 11 to 17 at study recruitment) from starting to use e-cigarettes between 2023 and 2024. *See* **Exhibit D**.

Changes in OSH and CTP activity since April 1, 2025

23. Prior to April 1, 2025, the DOH regularly relied on OSH staff for many aspects of the day-to-day operation of the Bureau of Tobacco Control. However, since April 1, DOH has seen significant cutbacks to the operations of OSH and CTP programs.

24. Specifically, our state's primary point of contact at OSH, for the Project Officer or Public Health Advisor, is no longer available to be contacted. We have not been able to receive answers or guidance regarding guidance, assistance, and administrative oversight regarding the federal cooperative agreement. *See* a sample CDC Cooperative Agreement attached hereto as **Exhibit E**, which describes CDC's expected "substantial programmatic involvement".

25. OSH employees assigned to the DOH have received RIF notices from HHS including the federal project officer (Public Health Advisor) assigned to New York and staff from the health communication branch, the policy team, and the epidemiology branch and evaluation team. These employees responsibilities included providing training, technical assistance, and oversight regarding: revision or submission of annual work plans; advancing program activities to achieve project outcomes; subject matter expertise and resources; development of annual evaluation plans that align with CDC evaluation activities; annual evaluation and performance measurement plan; policy, systems, and environmental strategies for tobacco control, including tobacco use and dependence treatment strategies and activities; best

practices for tobacco prevention and control; evidence-based policy, systems, and environmental strategies and activities for tobacco control through workshops, conferences, training, electronic and verbal communication; and development and maintenance of partnerships with federal and non-federal organizations to assist in tobacco control and maintain a national infrastructure that complements the state infrastructure

26. The DOH no longer has access to OSH education ads through the Media Campaign Resource Center ("MCRC"). The MCRC is a clearinghouse for tobacco use, prevention, and cessation educational campaign materials created by national and international tobacco control programs. It includes hundreds of videos, radio, print, outdoor (billboard), digital ads, and social media materials. The MCRC managed all logistics of providing the appropriate license for tobacco control programs to use its creative materials by managing licensing, talent costs, edits, and more. For over 20 years, New York has relied on the MCRC to access creative materials for its annual mass media campaigns. Presently, the MCRC's website displays a banner that says: "We are currently unable to process orders at this time." *See* **Exhibit F**.

27. Without staff at CDC's OSH, New York State has lost access to the technical advisors at CDC who provide guidance and feedback regarding state program evaluation and performance measurement plans, as well as who maintain and update key surveillance systems. Without key staff at CDC's OSH, updates to the National Youth Tobacco Survey, the STATE, and resources for NY's tobacco quitline are unlikely to occur, significantly hampering NY's efforts to effectively evaluate their tobacco prevention and control programming.

28. The Department of Health has lost access to updated OSH data and guidance on tobacco use trends, including the STATE system, the National YTS and Best Practices for Comprehensive Tobacco Control Program Guide. While these resources are still available

online, they will not be updated moving forward, hampering DOH's ability to stay current on vital information on tobacco use trends.

29. The DOH has also lost access to materials that educate on the dangers of smoking and tobacco products and means for quitting, including the Tips from Former Smokers campaign and publications derived.

30. Additionally, the DOH has lost access to the national network of tobacco cessation quitlines. OSH was responsible for providing technical assistance upon request, on the submission of data to the NQDW; it was responsible for providing technical assistance and training to states related to data collection and reporting of, aggregate data at the state-level and national level, and reporting aggregate state-level data in the STATE System and other publications, e.g., State Tobacco Control Highlights.

31. Our state tobacco laws and regulations depend on FDA review and approval of new tobacco product applications. If those applications are not properly processed, our state's ability to keep dangerous tobacco products off the shelves will be impacted.

Effect on State's Tobacco Program

32. The DOH has been significantly affected by the changes to OSH and CTP described above.

33. In the past, DOH relied on OSH and CTP for training, technical assistance, surveillance data, guidance documents, compliance checks, and other support previously provided by OSH and CTP. New York has lost access to vital technical assistance, research, and surveillance infrastructure that have supported effective tobacco control programs at both state and local levels for decades. For example, monthly National Tobacco Control Program, Media

Network, and periodic Evaluation Technical Assistance webinars to provide updates from subject matter experts about relevant tobacco-related topics and issues have been eliminated.

34. Deprecation of these two subagencies will have an effect on New York State's ability to protect its citizens, especially its youth, from the dangers of smoking and tobacco products. Inadequate or inaccurate surveillance data of tobacco use will harm DOH's ability to efficiently and effectively deploy its tobacco control tools and resources. Fewer compliance checks by the CTP will lead to more illegal sales of tobacco products, exposing the youth of New York State to a risk of becoming addicted to nicotine products and suffering known health harms. We have also seen delays in funding and slower response time, or in some cases no response, to inquiries, leaving DOH in peril.

35. These changes at OSH and CTP risk significant harm to young children and their families in New York State, reversing years of progress in public health. These reductions threaten to exacerbate the epidemic of tobacco-related chronic diseases, which significantly impact families by increasing healthcare costs and reducing quality of life. Ultimately, the consequences of these cuts could lead to higher rates of disability and premature death, disproportionately affecting vulnerable populations and children and undermining their health and well-being. New York State continues to face considerable health and economic burdens associated with smoking (28,000 smoking-attributable deaths and $7.7 billion in smoking-attributable health care expenditures in 2019).

Michelle S. Davis

MICHELLE DAVIS

Date: May 7, 2025

Exhibit A

PREVENTING CHRONIC DISEASE
PUBLIC HEALTH RESEARCH, PRACTICE, AND POLICY
Preventing Chronic Disease

Association Between the Tips From Former Smokers Campaign and Smoking Cessation Among Adults, United States, 2012–2018

CME ACTIVITY — Volume 17 — August 27, 2020 Am score 312

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Learning Objectives

Upon completion of this activity, participants will be able to:

1. Distinguish the ratio of persons who die from smoking-related illness to persons living with smoking-related illness
2. Assess the efficacy of the *Tips From Former Smokers* ® program
3. Analyze characteristics associated with higher rates of attempts to quit smoking

EDITOR

Camille Martin, RD

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Preventing Chronic Disease

Disclosure: Camille Martin, RD, has disclosed no relevant financial relationships.

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Successful completion of this CME activity, which includes participation in the evaluation component, enables the participant to earn up to 1.0 MOC points in the American Board of Internal Medicine's (ABIM) Maintenance of Certification (MOC) program. Participants will earn MOC points equivalent to the amount of CME credits claimed for the activity. It is the CME activity provider's responsibility to submit participant completion information to ACCME for the purpose of granting ABIM MOC credit.

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PEER REVIEWED

Summary

What is already known on this topic?

The Centers for Disease Control and Prevention's *Tips From Former Smokers* (*Tips*) campaign is associated with increased quit attempts among specific populations of people who smoke, including African Americans, pregnant women, people with mental health conditions, and those with lower educational attainment. The campaign increases calls to smoker quitlines and visits to the *Tips* website and other cessation resources.

What is added by this report?

During 2012–2018, the *Tips* campaign was associated with an estimated 16.4 million quit attempts and more than 1 million sustained quits among US adults.

What are the implications for public health practice?

Mass media campaigns, such as the *Tips* campaign, can increase smoking quit attempts and sustained quits as part of a comprehensive approach to reducing smoking-related disease and premature death in the United States.

Abstract

In 2012, the Centers for Disease Control and Prevention (CDC) launched the national *Tips From Former Smokers* (*Tips*) campaign to encourage people who smoke to quit by showing real-life heath consequences of tobacco use and promoting evidence-based resources for quitting. To assess the campaign's impact on quit attempts and sustained-quit estimates (ie, quits lasting ≥6 mos), CDC analyzed data from a nationally representative longitudinal survey of US adults who smoke cigarettes, aged 18 years or older in 2012–2018. The *Tips* campaign was associated with an estimated 16.4 million quit attempts and 1,005,419 sustained quits. Continued implementation of cessation campaigns, including the *Tips* campaign, could accelerate progress toward reducing rates of smoking-related diseases and death.

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Objective

Cigarette smoking remains the leading cause of preventable death in the United States (1). For every person who dies because of cigarette smoking, at least 30 people live with a serious smoking-related illness (1). Evidence-based media campaigns can increase tobacco cessation, increase use of cessation resources such as quitlines, and change tobacco-related social norms (2,3). This study aimed to determine the 7-year impact of the *Tips From Former Smokers* (*Tips*) campaign on population-level smoking cessation by measuring cumulative campaign-associated quit attempts and sustained quit estimates, accounting for smoking relapse.

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Methods

The Centers for Disease Control and Prevention (CDC) collected data from the KnowledgePanel (www.knpanel.com) (KP), an ongoing national online survey of adults in the United States. KP recruitment is conducted through random sampling of US household mailing addresses, and respondents are followed over time, allowing for participation in multiple survey waves. Current cigarette smokers are defined as people who smoked at least 100 cigarettes in their lifetime and who smoked every day or some days at the time of survey. We included data from the 2012–2018 waves of this survey (N = 35,275 observations on 9,653 unique current smokers) to assess the impact of *Tips* campaign exposure on quit attempts and sustained quit estimates.

We used a geography-based quasi-experimental design that relates variation in *Tips* campaign exposure across media markets and time to individual quit attempt behaviors across time. Quit attempts in the past 3 months among current cigarette smokers were assessed by asking, "During the past 3 months, how many times have you stopped smoking for 1 day or longer because you were trying to quit smoking cigarettes for good?" We created an indicator variable for having made at least 1 quit attempt in the past 3 months. *Tips* campaign exposure was determined by calculating past 3-month cumulative campaign television gross ratings points (GRPs, a measure of market-level campaign dose) and merging them with individual survey responses based on respondents' media market of residence and survey date. We used logistic regression to relate self-reported quit attempts in the past 3 months to GRPs (3). The model controlled for age, sex, race/ethnicity, education level, annual household income, presence of chronic physical or mental health conditions, tobacco surveys taken in the past year, presence of children in the household, presence of others who smoke cigarettes in the household, cigarette smoking prevalence in the respondent's television market, state fixed effects, and a linear time trend to control for secular trends over time. Model results were used to estimate the predicted quit attempt rate differential between observed doses of zero GRPs (ie, no campaign) and the average quarterly *Tips* campaign dose of 1,200 GRPs from 2012 to 2018 (ie, matching CDC recommendations on GRP dose) (2). The quit attempt rate differential was then multiplied by the yearly adult smoker population to create an initial estimate of total campaign-attributable quit attempts for each year during 2012–2018. Finally, the year-specific projections of campaign-attributable quit attempts were adjusted to account for the number of quarters the campaign was on the air in each year.

Sustained quit estimates were calculated using the estimated proportion of campaign-attributable quit attempters who remained abstinent from smoking at 6-month follow-up. On the basis of survey timing and resources, we were able to estimate sustained quitting during 4 of the 7 years of data in the analysis. Sustained quit rates averaged 7.2% in the available data. Because our sample was not designed to measure longer-term relapse, we used literature-based estimates (4,5) to calculate approximate relapse (15.3%) for 1 year after the initial 6 months of cigarette abstinence.

Results

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The *Tips* campaign was correlated with increased odds of a quit attempt in the past 3 months (odds ratio = 1.19; 95% confidence interval [CI], 1.11–1.27) (Table 1). An average of 1,200 GRPs per quarter translated into a 3.9 (95% CI, 3.4–4.3) percentage point increase in quit attempts per quarter during 2012–2018. Past 3-month quit attempt rates ranged from 32.5% in the absence of the campaign (0 GRPs) to 39.7% (4,000 GRPs) during the 2012–2018 campaigns (4,000 GRPs). Approximately 16.4 million quit attempts and an estimated 1,005,419 sustained quits lasting at least 1 year (95% CI, 876,519–1,108,539) were associated with *Tips* during 2012–2018 (Table 2). Sustained quit estimates ranged from 103,729 in 2012 to 188,577 in 2017.

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Discussion

During 2012–2018, the *Tips* campaign contributed to 16.4 million quit attempts and more than 1 million estimated sustained quits. These results are consistent with previous evaluations of the *Tips* campaign that have shown significant campaign effects on quit attempts and sustained quit estimates (eg, 1.6 million and 100,000 in 2012 (6); 1.83 million and 104,000 in 2014 (7); and 9 million and 522,000 in 2012–2015 (8), respectively). Additionally, the impact of *Tips* on quit attempts was recently supported with a study using data from the Behavioral Risk Factor Surveillance System (9).

Prior studies have also reported the impact of the *Tips* campaign on quit attempts among specific populations, including African Americans, pregnant women, people with mental health conditions, and those with less educational attainment (10). The campaign has also been associated with cessation-related outcomes, such as increased calls to 1–800-QUIT-NOW (6) and 1–855-DEJELO-YA (a national portal that routes Spanish-speaking callers to Spanish-language services from callers' state quitlines) (11), and visits to the *Tips* campaign website and other cessation resources (10).

These findings are subject to at least 2 limitations. The analysis used an average campaign effect estimated from 2012 to 2018. Although this effect may vary across years, research does not indicate significant variation in campaign effects over time (3). Another limitation is that we measured only television exposure and not other campaign channels such as radio, digital media, or billboards. Therefore, the estimated campaign effects may be conservative if total campaign exposure was underestimated.

In summary, the *Tips* campaign led to an estimated 16.4 million quit attempts and more than 1 million estimated sustained quits during 2012–2018, demonstrating that public health campaigns can be effective when they are based on scientific evidence and are of sufficient intensity and duration (2).

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Tables

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Table 1. Association Between Making a Quit Attempt in the Past 3 Months and Select Characteristics, *Tips From Former Smokers* Campaign, United States, 2012–2018

Model Covariate[a]	OR (95% CI)
Total campaign mass media market GRPs, past 3 months (square root functional form)	1.19 (1.11–1.27)
Age	0.98 (0.98–0.99)
Sex	
Female	1 [Reference]
Male	0.87 (0.78–0.97)
Race/ethnicity	
White	1 [Reference]
Black	1.55 (1.29–1.86)
Hispanic	1.90 (1.59–2.26)
Other	1.37 (1.08–1.75)
Education	
Less than high school	1 [Reference]
High school diploma	1.08 (0.91–1.29)
Some college	1.28 (1.08–1.52)
Bachelor's degree or higher	1.69 (1.38–2.06)
Annual household income, $	
<20,000	1 [Reference]
20,000–49,999	0.88 (0.78–1.00)
50,000–99,999	0.97 (0.84–1.12)
≥100,000	0.80 (0.67–0.97)
Chronic condition	1 [Reference]

Model Covariate[a]	OR (95% CI)
Physical	1.27 (1.14–1.42)
Mental	1.08 (0.97–1.20)
Tobacco surveys past year	0.93 (0.90–0.96)
Child in household	1.25 (1.12–1.40)
Smoker in household	0.56 (0.51–0.62)
Smoking prevalence (mass media market level)	0.99 (0.96–1.02)
Linear time	0.997 (0.99–1.00)
No. of model observations	35,275

Abbreviations: CI, confidence interval; GRPs, gross rating points; OR, odds ratio.
[a] Model includes covariates for state fixed effects (not shown).

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Table 2. Estimated Campaign Cumulative Impact on Sustained Quits, *Tips From Former Smokers* Campaign, United States, 2012–2018

Campaign Year	Dates On Air	Number of Quarters Campaign on Air	Estimated Campaign-Associated Quit Attempts (n = 16,440,928)	Estimated Campaign-Associated Sustained Quits[a] (n = 1,005,419)
2012	March 19–June 19	1.00	1,696,214	103,729
2013	March 4–June 17	1.16	1,964,772	120,152
2014	February 3–April 6; July 7–September 7	1.50	2,436,389	148,994
2015	March 30–August 16	1.49	2,198,523	134,447
2016	January 25–June 12	1.53	2,385,108	145,858
2017	January 9–July 30	2.22	3,083,677	188,577
2018	April 23–October 14	1.92	2,676,245	163,662

[a] Assuming a 15.3% relapse rate.

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Post-Test Information

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Post-Test Questions

Study Title: Association Between the *Tips From Former Smokers* Campaign and Smoking Cessation Among Adults, United States, 2012–2018

CME Questions

1. You are seeing a 35-year-old man who has smoked approximately one-half of a pack per day of cigarettes since he was 20 years old. He has no complaints or chronic illnesses and needs a physical examination to start work as a commercial truck driver. He says he is not interested in smoking cessation now because "I'm not dying anytime soon." What can you quote him regarding the ratio of number of deaths related to cigarette smoking to number of individuals living with smoking-related illness?
   A. 1:4
   B. 1:12
   C. 1:30
   D. 1:120
2. You tell this patient about the *Tips From Former Smokers* ® campaign to provide more information and motivation to quit smoking. In the current study, which of the following outcomes was associated with the *Tips From Former Smokers* campaign?
   A. Neither quit attempts nor sustained smoking cessation
   B. Quit attempts but not sustained smoking cessation
   C. Sustained smoking cessation but not quit attempts
   D. Both quit attempts and sustained smoking cessation
3. Which of the following other variables was associated with a higher rate of attempts to quit smoking in the current study?
   A. Black and Hispanic race/ethnicity
   B. Male sex
   C. Higher income
   D. Having another smoker in the household

Top

Last Reviewed: August 27, 2020

Was this page helpful?

Yes Partly No

Exhibit B

Tips Impact and Results

Tips From Former Smokers®

The *Tips From Former Smokers®* (*Tips®*) campaign shows real people living with serious long-term health effects from smoking and secondhand smoke exposure. *Tips* also features compelling stories from family members who take care of loved ones affected by a smoking-related disease or disability.

To learn more about the background of the *Tips* campaign, visit the About the Campaign web page. Campaign outcomes are listed below.

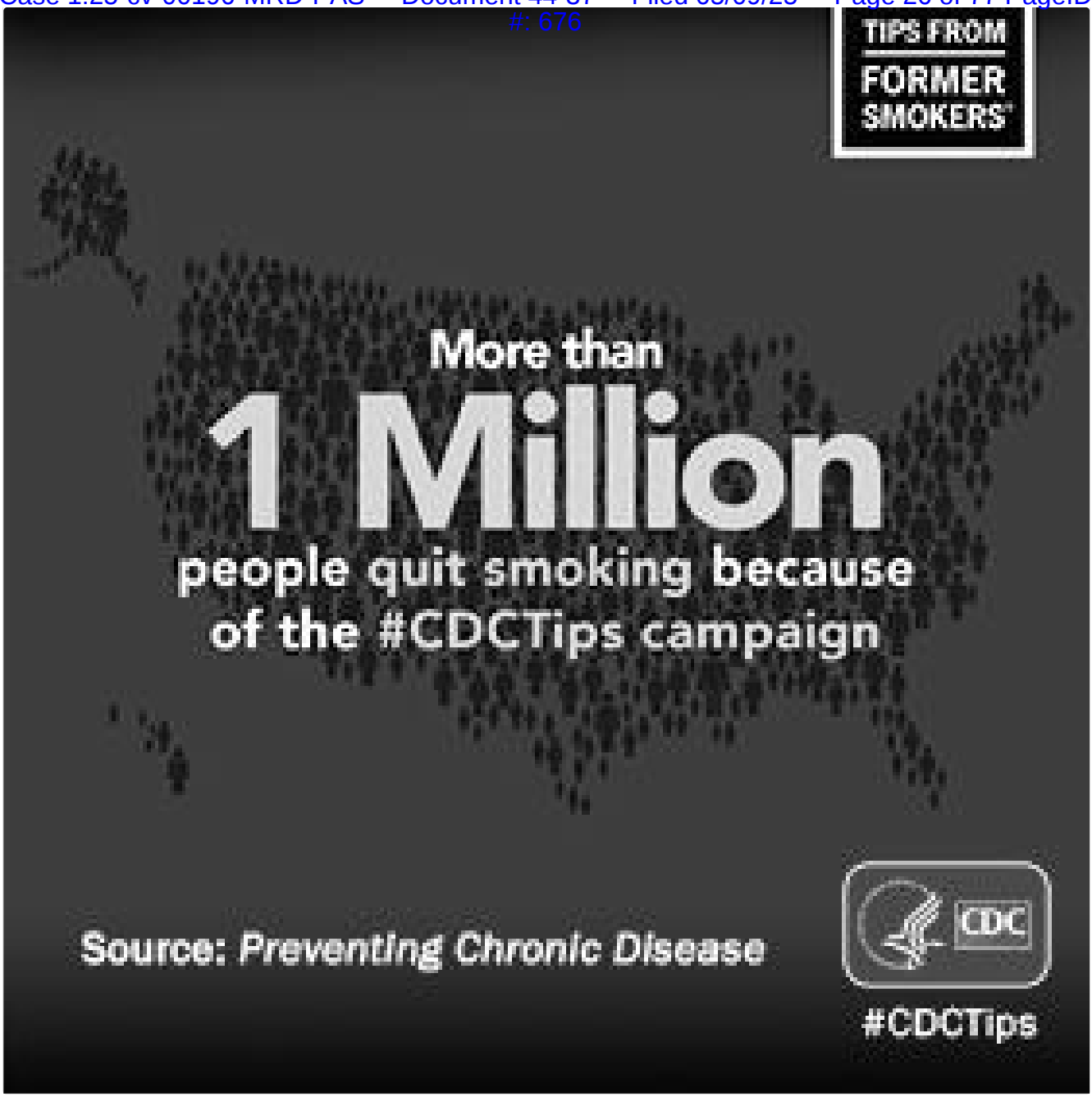
Tips Campaign Impact

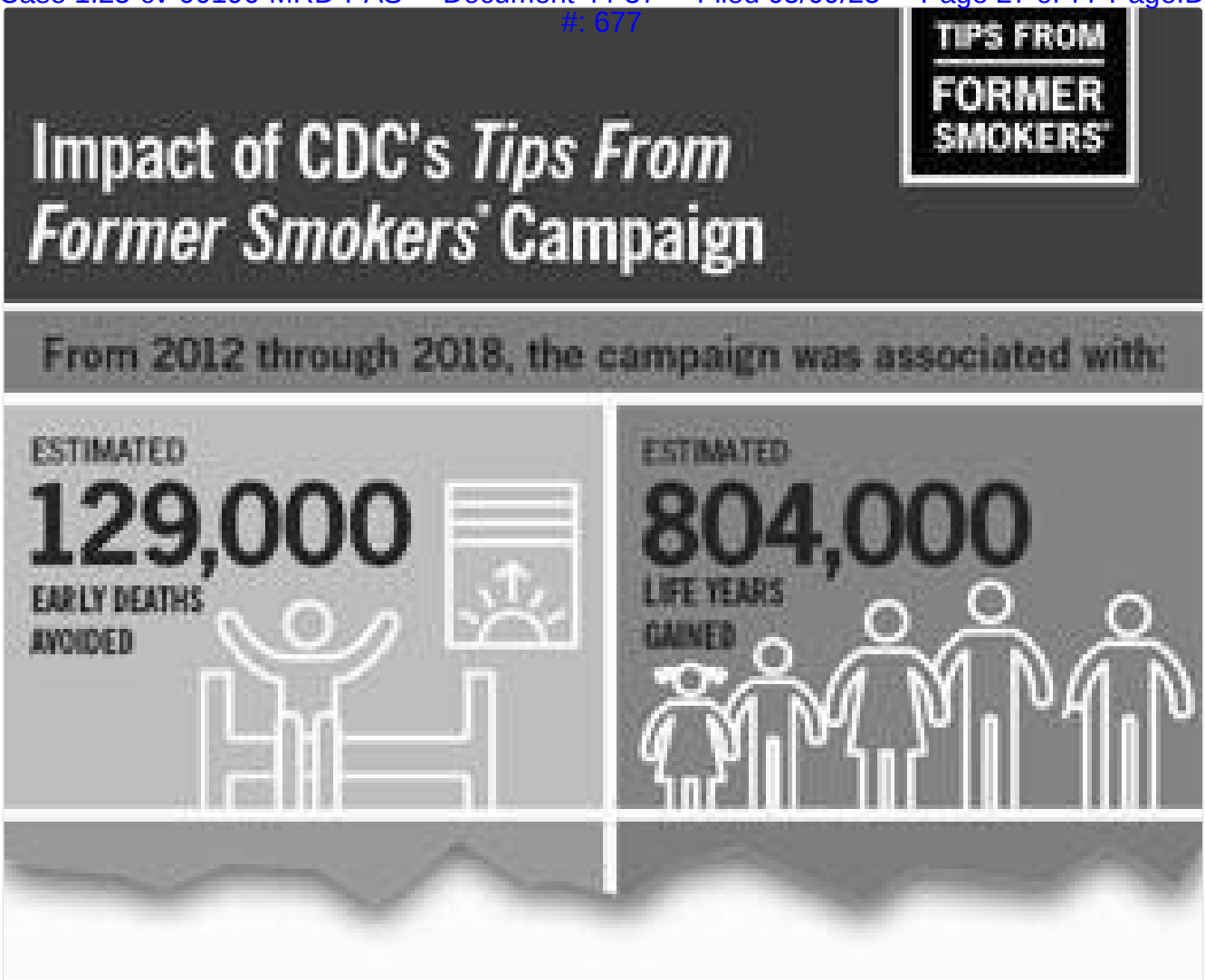
- From 2012–2018, CDC estimates that more than 16.4 million people who smoke have attempted to quit and approximately one million have successfully quit because of the *Tips* campaign.[1]
- People who smoke who have seen *Tips* ads report greater intentions to quit within the next 30 days, and people who smoke who have seen the ads multiple times have even greater intentions to quit.[2]
- Higher levels of exposure to the *Tips* campaign were associated with lower odds of relapse to cigarette smoking.[3]
- During 2012–2018, CDC's *Tips From Former Smokers* campaign helped prevent an estimated 129,000 early deaths and helped save an estimated $7.3 billion in smoking-related healthcare costs.[4]
- For every $3,800 spent on the *Tips* campaign between 2012-2018, we prevented an early death. A cost-effectiveness study on the topic factored in smoking relapse, inflation, and advertising and evaluation costs.[4]
- In each campaign, there was an immediate, sustained and dramatic spike in calls to 1-800-QUIT-NOW, and in visits to the campaign website.
- The *Tips* campaign generated over two million additional calls to 1-800-QUIT-NOW during 2012–2023.[5]

Tips Publications and Evaluation Results

Find and filter articles about the *Tips* campaign by topic, publication date, and campaign year.

Search for articles


TIPS FROM
FORMER
SMOKERS
More than
1 Million
people quit smoking because
of the #CDCTips campaign
Source: Preventing Chronic Disease
CDC
#CDCTips



Infographic [PDF – 433KB]

What People Are Saying About *Tips*

"These are the most effective antismoking PSAs I've ever seen."

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Last Reviewed: October 8, 2024

Was this page helpful?

Yes Partly No

Exhibit C

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https://doi.org/10.1093/ntr/ntae164
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Original Investigation

The Long-Term Impact of the *Tips From Former Smokers®* Campaign on Calls to 1-800-QUIT-NOW, 2012–2023

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Abstract

Introduction: There is substantial evidence that mass media campaigns increase calls to quitlines as well as smoking cessation. In 2012, the Centers for Disease Control and Prevention launched the first federally funded national tobacco education campaign, *Tips From Former Smokers®* (ie, *Tips*). From 2012 through 2023, *Tips* aired advertisements on television. To date, no studies have examined the long-term effect of a national smoking cessation campaign on quitline calls. This study examined the long-term impact of *Tips* television ads on calls to 1-800-QUIT-NOW from 2012 through 2023.

Methods: Exposure to the *Tips* campaign was measured using weekly gross rating points (GRPs) for television ads in each U.S. designated market area. We obtained data on calls to 1-800-QUIT-NOW from the National Cancer Institute and used linear regression to model calls to 1-800-QUIT-NOW, from 2012 through 2023, as a function of weekly media market-level GRPs for *Tips* television ads. Using the regression model results, we calculated predicted values of calls to 1-800-QUIT-NOW across observed GRP values to determine the total calls to 1-800-QUIT-NOW that were attributable to the *Tips* campaign during 2012–2023.

Results: *Tips* GRPs were positively and significantly associated with calls to 1-800-QUIT-NOW across all years (b = 39.94, $p < .001$). Based on this association, we estimate the *Tips* campaign generated nearly 2.1 million additional calls to 1-800-QUIT-NOW during 2012–2023.

Conclusions: Exposure to the *Tips* campaign has consistently and significantly increased calls to tobacco quitlines.

Implications: Quitlines provide evidence-based support to help people quit smoking. They have been shown to increase the likelihood of successfully quitting. Mass media campaigns have promoted quitlines, and quitline calls have increased significantly with media promotion. The long-term effect of campaigns—like the Centers for Disease Control and Prevention's *Tips From Former Smokers®* (ie, *Tips*)—on quitline calls has not been determined. From 2012 through 2023, exposure to the *Tips* campaign is estimated to have generated nearly 2.1 million additional calls to 1-800-QUIT-NOW. This study supports the continued use of mass media to promote quitlines.

Introduction

All 50 states, the District of Columbia, Guam, and Puerto Rico use telephone quitlines to provide support to people who want to quit using commercial tobacco products.[1–9] Tobacco quitlines provide free evidence-based resources such as counseling, referrals to local programs, information, and self-help materials. Many quitlines also offer free medications such as nicotine replacement therapy as well as web- and text-based support.[1–9] Substantial evidence has shown that telephone quitlines are effective at helping people who smoke make quit attempts and successfully quit.[1,3–5,7,10–13] Quitlines are used by a variety of populations and are particularly helpful for people who may face financial or logistical barriers to accessing other evidence-based cessation services (eg, health insurance and transportation are not needed to use quitline services).[1–8,11,14–22] Quitlines play an important role in addressing disparities in tobacco use cessation by reaching—and providing services to—populations disproportionately affected by tobacco use.[1–8,11,14–22]

Telephone quitlines are a key part of comprehensive efforts to increase smoking cessation and are a recommended component of state tobacco control programs.[4,5,10] The Centers for Disease Control and Prevention (CDC) provides dedicated funding for state quitlines.[2] Many states also provide additional funding to support their quitline.[3] Since 2004, people in the United States have been able to access their state quitline through the National Network of Tobacco Cessation Quitlines national portal, 1-800-QUIT-NOW, which is operated and administered by the National Cancer Institute (NCI).[1,2,4,5] During its first 15 years, from 2004 through 2019, 1-800-QUIT-NOW received more than 10 million calls.[1,2]

A number of studies in the United States and elsewhere have demonstrated that mass media campaigns are effective at promoting calls to quitlines.[4,11,12,15,20,23–28] In 2012, CDC launched the first federally funded national tobacco education campaign—*Tips From Former Smokers®* (ie, *Tips*)—to raise awareness of the negative health effects caused by smoking cigarettes, motivate people who smoke to quit, and encourage those who do not smoke to protect themselves and

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their families from exposure to secondhand smoke. The *Tips* campaign tells the personal stories of real people from many different backgrounds who are living with serious long-term health consequences from smoking and secondhand smoke exposure.[29,30] Campaign advertisements are placed on television and radio, in print, and on digital platforms. Since 2012, the campaign has run multiple weeks every year, typically during spring and summer. The largest portion of the *Tips* media budget goes toward TV ads, which have aired nationally on both broadcast and cable channels. To encourage adults who smoke to seek assistance with quitting, *Tips* TV advertisements are typically tagged with a call to action directing people to 1-800-QUIT-NOW, which appears at the end of the ads. Early research showed that the initial *Tips* campaign in 2012 generated over 150 000 additional calls to 1-800-QUIT-NOW nationwide[23–25] and significantly increased calls to 1-800-QUIT-NOW in almost every state.[26]

Although these prior studies showed a positive impact of the *Tips* campaign on quitline calls, there has not been an assessment of the long-term effect of the campaign on quitline calls over multiple years. In this study, we estimate the long-term dose–response relationship between the *Tips* campaign and calls to 1-800-QUIT-NOW. To assess the effect of the campaign on quitline calls over time, we calculated the impact of *Tips* media on total calls to 1-800-QUIT-NOW from 2012 through 2023. To the best of our knowledge, this is the first study to examine the impact of a long-termnational anti-smoking media campaign occuring over more than a decade on calls to telephone quitlines.

Materials and Methods

Data and Measures

The outcome variable was the weekly number of calls to 1-800-QUIT-NOW by media market. Data for all incoming calls to 1-800-QUIT-NOW from January 2, 2012, through December 31, 2023, for all 50 U.S. states and Washington, DC, were obtained from NCI. These data comprise records for each individual call received, not unique callers. Some state quitlines use numbers other than 1-800-QUIT-NOW as their primary or secondary number. Calls to these other quitline numbers are not included in this analysis, since those numbers were not promoted by *Tips* TV ads. Furthermore, calls to those numbers are not included in the NCI call volume data for

1-800-QUIT-NOW. The primary independent variable was *Tips* campaign exposure, measured by weekly gross rating points (GRPs) for television ads in each media market. GRPs measure the relative "dose" of advertising delivered to a given audience (eg, adults who smoke) in a given media market and time period. GRPs are defined as the product of reach (ie, the proportion of the audience exposed to a given ad) and frequency (ie, the number of times the audience is exposed to an ad) during a given time period.[4]

Weekly GRPs for *Tips* television ads in each media market were matched with weekly counts of calls to 1-800-QUIT-NOW from that media market. There are 210 Nielsen designated market areas (DMAs) that geographically define each U.S. television media market. Calls to 1-800-QUIT-NOW were matched to corresponding Nielsen DMAs by area code. For area codes geographically located entirely within a single DMA, all calls were assigned to that specific DMA. For area codes geographically located in multiple DMAs, the total number of calls from that area code were distributed across those DMAs based on the proportion of the area code's population located in each DMA. The final data used for this analysis included 8 617 439 total calls to 1-800-QUIT-NOW (100%) received from 2012 through 2023 in all 210 Nielsen DMAs.

Analysis

We began our analysis by plotting total calls to 1-800-QUIT-NOW and average population-weighted GRPs for *Tips* television ads by week. This plot provides an initial visual representation of the basic relationship between *Tips* advertising and calls to 1-800-QUIT-NOW. We then used multivariable linear regression to model weekly DMA-level calls to 1-800-QUIT-NOW as a function of weekly DMA-level GRPs for *Tips* television ads. In this model, GRPs were scaled such that the GRP coefficient represents the increase in weekly calls to 1-800-QUIT-NOW per DMA per increase of 100 weekly GRPs in a given DMA. We chose this scaling factor because 100 GRPs per week in a DMA represents the approximate average size of the weekly *Tips* TV ad buys from 2012 through 2023.

Our model also controlled for several potential confounders that could be associated with calls to 1-800-QUIT-NOW. These included the number of homes with a TV in the DMA (in the hundreds of thousands) as well as the adult smoking prevalence for each DMA. We estimated DMA-level smoking prevalence using state-level adult smoking prevalence from the CDC's Behavioral Risk Factor Surveillance System for the years 2012 through 2022. DMAs completely contained within a single state were assigned that state's adult smoking prevalence. For DMAs located in multiple states, we generated a weighted average adult smoking prevalence based on the percentage of the DMA's population located in each state. At the time of this analysis, Behavioral Risk Factor Surveillance System data for 2023 were not yet available. We assumed adult smoking prevalence in 2023 was equal to the 2022 values. To account for trends in call volume over time that may have been independent of the *Tips* campaign, we included a linear weekly time trend variable. To account for fixed state-level differences that might be correlated with calls to 1-800-QUIT-NOW, we also included separate indicator variables for the primary state where each DMA is located (ie, primary state fixed effects). The primary state represents the state in which each market is completely located or the state containing the largest proportion of the DMA's total population. There are 48 primary states, which each received their own indicator variable. Three states (Delaware, New Hampshire, and New Jersey) and the District of Columbia did not get primary state indicators. Although those areas are covered by Nielsen DMAs, there are no DMAs for which those areas represent the largest proportion of the DMA's total population.

Using the regression results, we calculated the predicted values of calls to 1-800-QUIT-NOW at zero GRPs (ie, "no campaign") to estimate what the number of calls would have been in the absence of the campaign. This "no campaign" predicted value was then compared to the actual number of calls received by 1-800-QUIT-NOW to estimate the total campaign-attributable additional calls during 2012–2023. We also assessed the impact of *Tips* TV ads on calls to 1-800-QUIT-NOW by calculating the percentage difference between actual calls received by 1-800-QUIT-NOW and the estimate of how many calls 1-800-QUIT-NOW would have received if there had not been any *Tips* TV ads (eg, *Tips* TV GRPs = 0).

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Sensitivity Analyses

We conducted sensitivity analyses to further investigate two aspects of our study. First, we examined whether, and to what degree, the potential misassignment of some calls to 1-800-QUIT-NOW from cell phones to Nielsen DMAs affected our results. Because calls to 1-800-QUIT-NOW are matched with Nielsen DMAs based on the area code of the call, callers with cell phones may have area codes that do not correspond to the DMA where they resided when they called the quitline. Since landlines are not subject to this limitation, we ran alternative versions of our model that were separately limited to only landline calls and then to only cell phone calls. These models provide estimated effects of *Tips* TV ads on calls among landline and cell phone callers, respectively. We also estimated a simple, aggregate national model wherein we did not match calls to 1-800-QUIT-NOW with a Nielsen DMA. In this model, *Tips* GRPs varied by time but not by DMA, eliminating any potential for bias arising from area code to DMA misassignments. Using this model, we examined the relationship between weekly total calls to 1-800-QUIT-NOW in the United States and total weekly GRPs for all *Tips* TV ads aired in the United States.

We conducted a second sensitivity analysis to examine whether the magnitude of the *Tips* campaign effects on calls to 1-800-QUIT-NOW varied significantly in the period from 2012 through 2023 and the extent to which our estimate of the cumulative campaign effect is consistent with the average of annual campaign effects. Additionally, the period covered by our data includes 2020, when the global COVID-19 pandemic began. As a result of the pandemic, a national emergency was declared in the United States on March 13, 2020, just prior to the launch of the 2020 *Tips* campaign on March 23, 2020. During this unprecedented emergency, there was nearly universal media and news coverage related to COVID-19. We were interested to see whether the COVID-19 pandemic altered or affected the relationship between *Tips* TV ads and calls to 1-800-QUIT-NOW, particularly as pandemic-related news coverage may have distracted from preplanned health education campaigns such as *Tips*.

To address these questions, our second sensitivity analysis estimated separate year-specific models for the years 2012 through 2023 using the same analysis data and model specifications as our main multiyear model. These annual models produced year-specific estimates of the impact of *Tips* TV ads on calls to 1-800-QUIT-NOW. We compared the total model-predicted campaign-attributable increases in calls from the annual models for the years 2012 through 2023 to the model-predicted campaign-attributable increases in calls from our main multiyear model for the years 2012 through 2023. To address the question of whether the COVID-19 pandemic might have affected the relationship between *Tips* TV ads and calls to 1-800-QUIT-NOW, we then compared year-specific model results for 2020 to the annual model results for the 3 years prior to and after 2020.

Results

Figure 1 shows the variation in weekly calls to 1-800-QUIT-NOW and GRPs for *Tips* TV ads from 2012 through

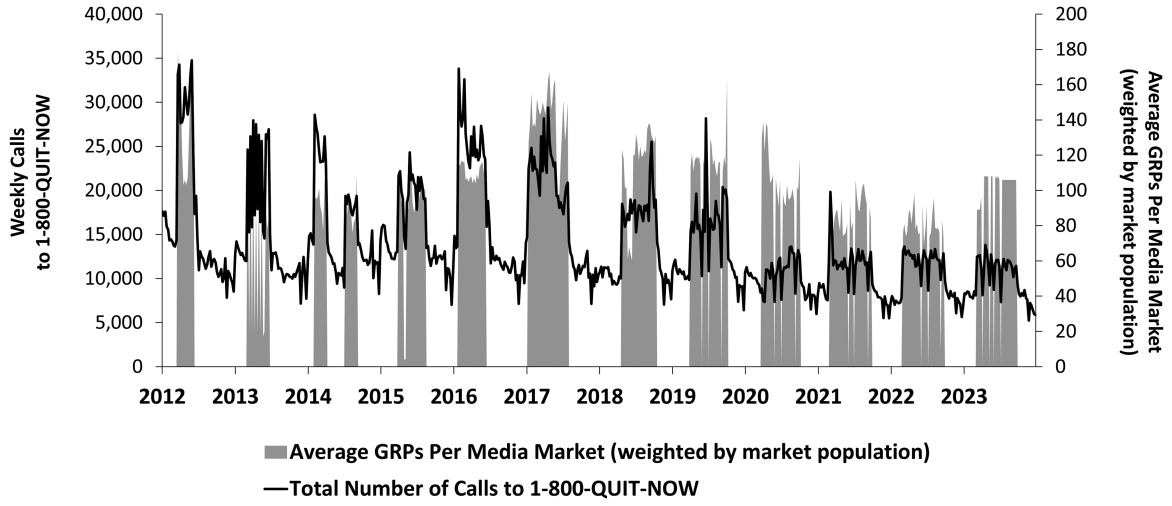

Figure 1. Total national calls to 1-800-QUIT-NOW and average market-level GRPs for *Tips* television ads by week, January 2012–December 2023. GRPs = Gross rating points. Defined as the product of reach (ie, the proportion of the audience that is exposed to a given advertisement) and frequency (ie, the number of times the audience is exposed to an advertisement) during a given period. In 2012, *Tips* aired March 19–June 10, for a 12-week campaign. In 2023, *Tips* aired March 4–June 23, for a 16-week campaign. The campaign employed a pulsing strategy during the first 12 weeks where national television ads alternated between being on air in 1 week and off air during the following week. Television ads were on air for a total of 10 weeks during the campaign. In 2014, *Tips* aired February 3–September 7, for an 18-week campaign. The campaign was implemented in two separate 9-week phases (February 3–April 6 and July 7–September 7), with a 13-week period between each phase. In 2015, *Tips* aired March 30–August 16, for a 20-week campaign. In 2016, *Tips* aired January 25–June 12, for a 20-week campaign. In 2017, *Tips* aired January 9–July 30, for a 29-week campaign. In 2018, *Tips* aired April 23–October 14, for a 25-week campaign. In 2019, *Tips* aired April 1–October 6, for a 27-week campaign. *Tips* television ads were off air for three holiday weeks during the campaign: May 27–June 2 (Memorial Day); July 1–July 7 (Independence Day); September 2–September 9 (Labor Day). In 2020, *Tips* aired March 23–October 4, for a 28-week campaign. *Tips* television ads were off air for three holiday weeks during the campaign: May 25–May 31 (Memorial Day); June 29–July 5 (Independence Day); September 7–September 13 (Labor Day). In 2021, *Tips* aired March 1–September 26, for a 30-week campaign. *Tips* television ads were off air for three holiday weeks during the campaign: May 31–June 6 (Memorial Day); June 28–July 4 (Independence Day); September 6–September 12 (Labor Day). In 2022, *Tips* aired February 28–September 25, for a 30-week campaign. *Tips* television ads were off air for two holiday weeks during the campaign: May 30–June 5 (Memorial Day); July 4–July 10 (Independence Day). In 2023, *Tips* aired March 6–September 24, for a 29-week campaign. *Tips* television ads were off air for 4 weeks during the campaign, two of which were holiday weeks: April 3–April 9; May 8–May 14; May 29–June 4 (Memorial Day); July 3–July 9 (Independence Day).

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Table 1. Multivariable Linear Regression Model of the Relationship Between Exposure to Weekly *Tips* Television Ads and Weekly Calls to 1-800-QUIT-NOW, January 2, 2012–December 31, 2023

Model variables	*ß* coefficient (*P*-value[a]) [95% CI]
Independent variable	
Weekly GRPs for *Tips* Television Ads (in 100s)	39.94 (.000) [39.11 to 40.78]
Control variables[b]	
DMA-level number of homes with a TV (in 100 000s)	6.11 (.000) [5.99 to 6.23]
DMA-level adult smoking prevalence	1.28 (.000) [0.92 to 1.65]
Weekly time trend	−0.06 (.000) [−0.07 to −0.06]

CI = confidence interval; GRP = gross rating points.
Model includes data for 8 617 439 calls to 1-800-QUIT-NOW for 2012 through 2023. Observations in the model consist of weekly calls for 626 weeks from 2012 through 2023 from 210 Nielsen Designated Market Areas (DMAs). The sample size for the model is 131 460, which is based on call volume counts for 626 weeks in 210 DMAs (626 × 210 = 131 460). $R^2 = 0.551$.
[a]Calculated from standard ordinary least squares regression *t* tests for regression coefficient.
[b]The model also includes primary state fixed effects which represent the state where each DMA is located (if the DMA is contained completely within a single state) or the state containing the largest proportion of the DMA's total population (if the DMA is located in multiple states). There are 48 primary states, which each receive their own indicator variable. Three states (Delaware, New Hampshire, and New Jersey) as well as the District of Columbia do not have primary state indicators since no DMAs have the largest proportion of their total population located within those areas. All primary state fixed effects were statistically significant ($p < .05$), except for two primary states.

2023. Over the entire period, there were 8 617 439 calls to 1-800-QUIT-NOW, with an average of 13 766 calls per week. During the 269 weeks when *Tips* TV ads were on air, there were a total of 4 806 934 calls, with an average of 17 870 calls per week and an average of 104 GRPs for *Tips* TV ads per week and per Nielsen DMA, weighted by market population. During the remaining 357 weeks when *Tips* TV ads were off the air, there were a total of 3 810 505 calls, with an average of 10 674 calls per week and zero GRPs for *Tips* TV ads.

Table 1 presents results from our regression model of weekly DMA-level calls to 1-800-QUIT-NOW as a function of weekly DMA-level GRPs for *Tips* television ads. GRPs for *Tips* TV ads were positively and significantly associated with increases in calls to 1-800-QUIT-NOW ($b = 39.94$, $p < .001$). Our model results indicated that DMAs that had more homes with a television and higher adult smoking prevalence tended to have more calls to 1-800-QUIT-NOW per week, regardless of whether *Tips* TV ads were on air ($p < .001$). The linear weekly time trend was negative and statistically significant ($p < .001$). This indicates that there was a small downward trend in weekly calls to 1-800-QUIT-NOW over the 12-year period of 2012 through 2023, independent of the *Tips* campaign or *Tips* TV ads. The slight linear decrease in average weekly calls to 1-800-QUIT-NOW is consistent with observed decreases in DMA-level average adult smoking prevalence, which declined by approximately 31% over the same period.

Using the model-predicted value of calls at zero TV GRPs, we estimated that during the 269 weeks when *Tips* TV ads were airing, there would have been 2 724 648 (confidence interval [CI]: 2 590 910–2 858 382) calls if *Tips* TV ads had not aired (ie, if GRPs for all *Tips* TV ads equaled zero; Figure 2, Table 2). During this period, actual calls totaled 4 806 934. Therefore, we estimate there were 2 082 286 (CI: 1 948 552 to 2 216 024) calls attributable to *Tips* TV ads from 2012 through 2023. This represents a 76% increase in calls during weeks when *Tips* TV ads were on air, compared to the estimated 2 724 648 calls that would have been received during those weeks if *Tips* TV ads had not aired.

For the 626 weeks from 2012 through 2023, including the 269 weeks when *Tips* TV ads were on air as well as the 357 weeks when *Tips* TV ads were off air, the 2 082 286 estimated additional calls associated with *Tips* TV ads represent a 32% increase in calls to 1-800-QUIT-NOW, compared to the estimated 6 535 153 calls that would have been received if *Tips* TV ads had not aired.

Sensitivity Analyses

In total, there were 3.23 million call records from landline phones (37%) and 5.36 million from cell phones (63%) in our analytic data. GRPs for *Tips* TV ads were positively and significantly associated with increases in calls to 1-800-QUIT-NOW for both landline and cell phone calls ($p < .001$). Our simplified, aggregate national model analyzed total weekly calls to 1-800-QUIT-NOW from all valid U.S. area codes as a function of total GRPs delivered nationally and did not consider variation in either calls or GRPs by DMA. Results from this model also showed that weekly GRPs for *Tips* TV ads were positively and significantly associated with increases in calls to 1-800-QUIT-NOW ($b = 40.39$, $p < .001$). The simplified model estimated 2 099 456 (95% CI: 2 005 015 to 2 193 902) additional calls associated with *Tips* TV ads, which represents a 78% increase in calls above what calls would have been if the *Tips* campaign had not occurred. These results are very similar to the primary market-level model results showing an estimated 76% increase in calls above the estimated number of calls that would have been received if the *Tips* campaign had not occurred.

Tips GRPs were positively and significantly associated with increases in calls to 1-800-QUIT-NOW ($p < .001$) for each of the year-specific annual models. Summing the number of calls attributable to *Tips* TV ads estimated by each of the 12 year-specific models yielded a total of 1 920 410 calls attributable to *Tips* TV ads from 2012 through 2023, which is 161 876 calls fewer (7.8% lower) than the 2 082 286 campaign-attributable calls estimated by our single multiyear model. Looking across the year-specific models, the annual campaign-attributable percentage increase in calls averaged 68%, with a median annual percentage increase of 62%.

Although *Tips* GRPs were positively associated with increases in calls to 1-800-QUIT-NOW in all 12 years from 2012 through 2023, the magnitude of the campaign effect was the smallest during 2020. We estimated the percentage increase in calls during weeks when *Tips* TV ads were on air was 25% in 2020 compared to annual percentage increases of at least 50% for all other years from 2012 through 2023. During the 3-year period before the onset of the COVID-19 pandemic (2017–2019), the estimated annual campaign-attributable percentage increase in calls to 1-800-QUIT-NOW ranged from 54% to 65%, with an average of 60%. By comparison, after the initial stages of the pandemic in 2020, during the 3-year period from 2021 through 2023, the annual percentage increase in calls to 1-800-QUIT-NOW associated

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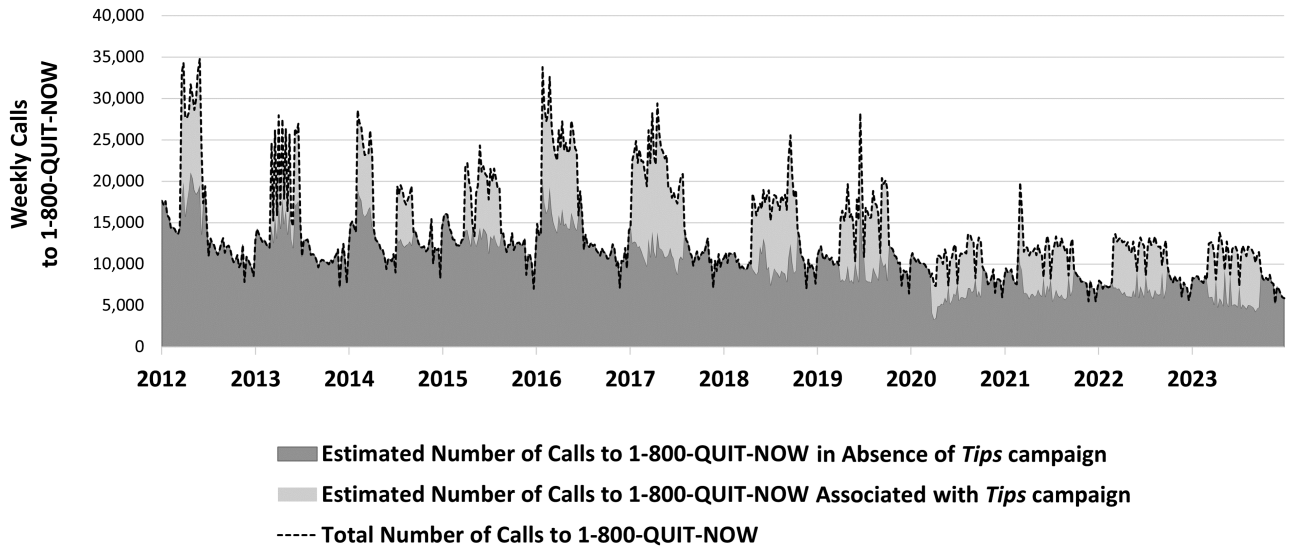

Figure 2. Impact of CDC *Tips* campaign on calls to 1-800-QUIT-NOW: 2012–2023. *Notes*: The area shaded in dark gray represents the estimated number of calls to 1-800-QUIT-NOW in absence of the *Tips* campaign. During weeks when *Tips* television ads were not on air, this area is equal to the actual total number of calls received by 1-800-QUIT-NOW. During weeks when *Tips* television ads were on air, this is the estimated number of calls that 1-800-QUIT-NOW would have received if no *Tips* television ads had aired. This estimate is based on predictions from our multivariable linear regression model. The area shaded in light gray represents the estimated calls to 1-800-QUIT-NOW that were associated with *Tips* television ads. During weeks when *Tips* television ads were not on air, no light gray areas appear on the chart. During weeks when *Tips* television ads were on air, this represents the difference between actual calls received by 1-800-QUIT-NOW and estimated calls to 1-800-QUIT-NOW in absence of *Tips* television ads.

Table 2. Estimate of Calls to 1-800-QUIT-NOW Associated with *Tips* Television Advertisements: 2012–2023

Measure	*Tips* TV Ads		Total
	Off air	On air	
Number of weeks	357	269	626
Actual calls to 1-800-QUIT-NOW	3 810 505	4 806 934	8 617 439
Estimated calls to 1-800-QUIT-NOW: in absence of *Tips* TV ads	3 810 505	2 724 648 [2 509 910–2 858 382]	6 535 153 [6 401 415–6 668 887]
Estimated calls to 1-800-QUIT-NOW: associated with *Tips* TV ads	0	2 082 286 [1 948 552–2 216 024]	2 082 286 [1 948 552–2 216 024]

with *Tips* TV ads ranged from 50% to 60%, with an average of 55%.

Discussion

Over the first 12 years of the *Tips* campaign, from 2012 through 2023, *Tips* TV ads were associated with nearly 2.1 million additional calls to 1-800-QUIT-NOW (Table 2). Based on our analysis, actual calls received by 1-800-QUIT-NOW during the 269 weeks when *Tips* TV ads were on air were 76% higher than the estimated number of calls that would have been received during those weeks if the *Tips* campaign had not occurred. Our results demonstrate that *Tips* was associated with statistically significant increases in calls to 1-800-QUIT-NOW during each of the first 12 years of the campaign, including during the onset of the COVID-19 pandemic and related emergency declarations in 2020. Although the effects of the campaign were smaller in 2020, *Tips* still generated significant increases in calls despite widespread press coverage of COVID-19 and saturation of the broader media landscape with pandemic-related topics and content. Furthermore, our results suggest the *Tips* campaign's effects on calls to 1-800-QUIT-NOW rebounded to prepandemic magnitudes in the years following 2020. These findings point to the continued robust impact of *Tips* and mass media campaigns promoting evidence-based quitlines.

This study has some limitations to consider. First, calls to 1-800-QUIT-NOW were matched to media markets based on the caller's area code. However, some people, particularly people with cell phones, might have called 1-800-QUIT-NOW from an area code that did not correspond with the area where they resided when they called 1-800-QUIT-NOW. Results from our sensitivity analysis indicated that *Tips* TV GRPs were positively and significantly associated with increases in both landline and cell phone calls. In addition, total weekly GRPs for all *Tips* TV ads aired in the U.S. were associated with total weekly calls in a simpler aggregated analysis that was not subject to market-level GRP variation. This simplified model produced nearly identical results to the main model that used market-level variation in GRPs and calls to 1-800-QUIT-NOW. Based on the sensitivity analysis, we do not believe that our results are affected by potential mismatching of calls to media markets.

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A second limitation of our study is that our analysis was based on paid *Tips* TV media that aired from 2012 through 2023. We were not able to control for other *Tips*-related paid media (such as digital media), public service announcements, earned media, or state-purchased media that also used *Tips* ads. Such additional media could have prompted additional calls to 1-800-QUIT-NOW. However, most of the *Tips* campaign's media buy has been devoted to TV advertising. We are not aware of any state-based campaigns that have invested advertising resources at a scale similar to the *Tips* campaign and that promote calls to 1-800-QUIT-NOW. In addition, *Tips* digital ads predominantly drive users to the *Tips* campaign website via the URL in the ads. Although ad viewers can find information about 1-800-QUIT-NOW on the campaign website, calling the quitline is not an explicit call to action in the campaign's digital ads. Given the timing of *Tips* media buys, the 1-800-QUIT-NOW call to action in all *Tips* TV ads, and the association between GRPs for *Tips* TV ads and calls to 1-800-QUIT-NOW shown in Figure 1, we do not believe any of the factors noted here could significantly confound our results.

Our study shows that during the first 12 years of the *Tips* campaign, from 2012 through 2023, *Tips* TV ads were associated with significant increases in calls to 1-800-QUIT-NOW, which connects callers with state-based telephone quitlines that provide free, evidence-based assistance to help people quit using commercial tobacco products. Our findings are consistent with previous studies showing that *Tips* had immediate effects on information-seeking behavior, such as calling a quitline.[23–26] These substantial increases in calls to 1-800-QUIT-NOW associated with exposure to *Tips* TV ads also translate to a higher likelihood that a greater number of people received evidence-based cessation services that have been shown to be effective at helping people successfully quit smoking. The results presented in this paper add to a growing body of research on the *Tips* campaign, which has demonstrated effectiveness in: generating calls to 1-800-QUIT-NOW[23–26]; increasing cessation-related attitudes and beliefs, quit intentions, quit attempts,[30–35] and sustained quits[32,34,35]; preventing smoking relapse[36]; and offering a cost-effective public health intervention.[37] Collectively, this research suggests the *Tips* campaign remains poised to continue having long-term effects on smoking cessation-related health outcomes.

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Declaration of Interest

The authors declare that they have no conflicts of interest, financial or otherwise.

Author Contributions

Nathan Mann (Conceptualization [lead], Data curation [equal], Formal analysis [lead], Methodology [lead], Project administration [equal], Supervision [lead], Visualization [equal], Writing—original draft [lead], Writing—review & editing [lead]), Rebecca Murphy (Conceptualization [equal], Project administration [equal], Writing—original draft [equal], Writing—review & editing [equal]), Kevin Davis (Conceptualization [equal], Formal analysis [supporting], Methodology [equal], Project administration [supporting], Writing—original draft [equal], Writing—review & editing [equal]), Annette Von Jaglinsky (Data curation [equal], Formal analysis [equal], Methodology [supporting], Visualization [equal], Writing—original draft [supporting], Writing—review & editing [supporting]), Robert Rodes (Conceptualization [supporting], Project administration [supporting], Writing—original draft [supporting], Writing—review & editing [supporting]), and Diane Beistle (Conceptualization [supporting], Project administration [supporting], Writing—original draft [supporting], Writing—review & editing [supporting])

Data Availability

The data underlying this article were provided by the National Cancer Institute (NCI) and PlowShare by permission and by Nielsen Media under license. Data will be shared on reasonable request to the corresponding author with permission of NCI, PlowShare, and Nielsen Media.

Disclaimer

The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

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Exhibit D

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The Impact of “The Real Cost” on E-cigarette Initiation among U.S. Youth

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TITLE: The Impact of "The Real Cost" on E-cigarette Initiation among U.S. Youth

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ABSTRACT: 250/250 WORDS

Introduction

E-cigarette use among U.S. youth has declined in recent years. This study examined the effect of exposure to "The Real Cost" Youth E-cigarette Prevention Campaign on e-cigarette initiation among U.S. youth aged 11–18.

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Methods

Data were analyzed from the first two waves of a longitudinal evaluation of the campaign (baseline: August–December 2023; follow-up: June–September 2024; analyses: 2025). The analysis included youth who reported never having tried an e-cigarette at baseline and completed the follow-up survey (n = 3,408). An exposure index (range: 0–16) was generated using respondents' self-reported frequency of exposure to each of four campaign advertisements (0 = never; 4 = very often). The impact of exposure on e-cigarette initiation was examined at follow-up using a discrete-time survival analysis logistic regression model, controlling for potential confounding variables. The estimated number of youth prevented from initiating e-cigarette use was extrapolated to the national youth population.

Results

The odds of reporting e-cigarette initiation at follow-up decreased as exposure to campaign advertisements increased. For every unit increase in the exposure index, there was a 6% reduction in the probability of initiation. The campaign prevented an estimated 444,252 (95% CI: 73,639–814,866) U.S. youth aged 11–18 from initiating e-cigarettes between 2023 and 2024.

Conclusions

Youth with higher exposure to "The Real Cost" E-cigarette Prevention Campaign ads were less likely to initiate e-cigarettes during the study period. These findings indicate that the campaign has contributed to recent declines in e-cigarette use among U.S. youth.

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INTRODUCTION

E-cigarettes are currently the most commonly used tobacco product by U.S. youth, with 1.63 million youth reporting use of e-cigarettes in 2024.[1] E-cigarette use exposes youth to harmful chemicals, including nicotine, which is highly addictive and poses dangers to adolescent brain development.[2] E-cigarette use has declined considerably since its peak in 2019, including a significant drop in the number of students who reported current e-cigarette use between 2023 and 2024—2.13 million youth reported use in 2023, compared to 1.63 million in 2024.[3]

Tobacco prevention public education campaigns are a critical component of comprehensive tobacco control efforts with decades of research highlighting their success at changing tobacco risk perceptions, intentions to use tobacco products in the future, and tobacco product use initiation.[4-6] For more than a decade, the U.S. Food and Drug Administration (FDA) Center for Tobacco Products (CTP) has utilized an evidence-based health communication and campaign framework to plan, develop, implement, and evaluate its youth tobacco prevention public education campaigns, starting with "The Real Cost" Youth Cigarette Prevention Campaign[7] which first aired in 2014. This health communication and campaign framework encompasses foundational research (e.g., conducting tobacco product surveillance, media landscaping, subject matter expert consultations, audience analysis),[8] formative research (e.g., testing strategic and creative concepts with intended teen audiences to assess message comprehension and message performance),[9,10] and evaluation research (e.g., conducting process, implementation, and outcome evaluation).[11-13] Additionally, campaign implementation is informed by a data-driven media strategy that identifies effective channels and messengers for the intended audience.[14]

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To address the rapid increase in e-cigarette use among youth observed between 2013 to 2017, FDA expanded its messaging in 2018 to educate youth about the harms of e-cigarette use. FDA created and launched "The Real Cost" Youth E-cigarette Prevention Campaign under "The Real Cost" umbrella.[15] To help maximize impact and best reach youth through the media channels they use most frequently, the campaign also moved away from traditional broadcast and cable TV in favor of a broader and deeper presence on digital and social media platforms.

Prior studies have found that "The Real Cost" e-cigarette prevention messages shifted tobacco- and cigarette-related beliefs among U.S. youth.[13,16-18] However, to date, no study has assessed the potential effects of the campaign on youth e-cigarette use behaviors. The current paper addresses this gap by presenting findings from the evaluation of "The Real Cost" Youth E-cigarette Prevention Campaign and its impact on e-cigarette use initiation among a nationally representative longitudinal sample of U.S. youth.

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METHODS

Sample

The sample consisted of a nationally representative longitudinal cohort of U.S. youth developed to evaluate "The Real Cost" Youth E-cigarette Prevention Campaign. The study used address-based sampling to identify households for inclusion in the study. Households were mailed invitations for an adult to complete an online screener designed to identify the presence of one or more eligible youth between 11 and 17 years of age. Parents of eligible youth were asked to provide permission for their child to participate. After obtaining parental permission, eligible youth were invited to provide consent/assent and take an online survey. Youth participants

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received a $25 incentive for completing each survey, with a $5 bonus for completing in the first 30 days of data collection.

Baseline data were collected from August 2023 through December 2023, and follow-up data were collected from June 2024 through September 2024. All respondents who completed the baseline survey were invited to take the follow-up survey. At baseline, 5,347 youth completed the survey, with 77% returning to complete the follow-up survey (N = 4,125). The analytic sample for this study was restricted to respondents who reported never having used an e-cigarette at baseline, completed the follow-up survey, and passed data quality checks (these included assessing responses to survey attention checks, survey speeding, and item straightlining) at each wave, for a final sample size of 3,408. Oversight for this study was provided by the Advarra Institutional Review Board (Protocol number 00065019).

Measures

The primary outcome of interest was e-cigarette initiation among youth who had never used an e-cigarette at baseline. E-cigarette initiation was defined as a respondent transitioning from never having used an e-cigarette that contains nicotine at baseline to having ever used an e-cigarette that contains nicotine at follow-up. Ever use of an e-cigarette that contains nicotine was assessed with the question, “Have you ever tried vaping nicotine, even one time?” Respondents were asked to not consider e-cigarettes containing THC/CBD/Delta-8 when responding to survey questions about e-cigarettes.

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The study examined individual-level variability in recall of the media campaign, a standard exposure measure employed in evaluations of mass media for over two decades.[12,19-21] The main predictor variable was a linear index representing the frequency of exposure for each of four "The Real Cost" E-cigarette Prevention Campaign advertisements (ads) that were on air between baseline and follow-up. In the follow-up survey, respondents were shown 6- or 15-second clips of each video ad and asked, "Apart from this survey, how frequently have you seen this ad in the past 3 months?" More details on the ads ("Addiction Isn't Pretty: Toilet," "Don't Pollute Yourself," "Toxic Taxidermy," and "Scary Enough") can be found in Appendix Table A-1. Response options were 0 = "Never," 1 = "Rarely," 2 = "Sometimes," 3 = "Often," and 4 = "Very often." Responses were summed across the four ads to generate a numeric linear awareness index representing total exposure ranging from 0 (never saw any ads) to 16 (saw all four ads very often). The larger values indicating greater frequency of exposure to the advertisements may reflect either seeing more ads or seeing any number of the ads more frequently.

Models controlled for demographic and environmental variables previously shown to be associated with e-cigarette use.[22-25] The variables identified as potential covariates were then selected for inclusion based on a backward elimination approach, with a significance threshold of $p < 0.10$. The variables included in the final mode were age (indicators for each age); living with someone who uses tobacco (0 = no, 1 = yes); household income (1 = less than $30,000; 2 = $30,000 to less than $70,000; 3 = $70,000 to less than $110,000, 4 = $110,000+); parent communication (mean of two items: "Thinking about the adult or adults you live with, how satisfied are you with the way you communicate with each other?" [5-point scale ranging from 1 – "Not at all satisfied" to 5 – "Very satisfied"] and "How close do you feel to the adult or adults

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you live with?" [5-point scale ranging from 1 – "Not at all close" to 5 – "Very close"]); sensation seeking using the Brief Sensation Seeking Scale[26]; self-reported social media frequency of use, based on 7-item response scales that indicate how often respondents reported use of Instagram, Snapchat, Facebook, TikTok, and Reddit (for each platform: 0 = never, 6 = several times a day) (tertiles of use averaged across social media platforms; mean values were categorized as 0–1.4 = Low [1], 1.5–3.4 = Medium [2] and 3.56 = High [3]); and frequency of exposure to e-cigarette promotional content on social media (0 = never; 1 = more than a week ago; 2 = sometime in the past week; 3 = sometime in the past day).

Analyses also adjusted for the number of months between a respondent's participation in the baseline and follow-up surveys, as well as an indicator for self-reported awareness to other national tobacco prevention campaigns (i.e., Truth Initiative's *truth* campaign and the Centers for Disease Control and Prevention's *Tips From Former Smokers* [*Tips*] campaign) (0 = Not aware of ads from either campaign, 1 = Aware of ads from at least one other campaign).

Statistical Analysis

A discrete-time survival analysis was performed to examine the impact of the exposure index on e-cigarette initiation at follow-up by using logistic regression models that controlled for the above-mentioned demographic and environmental variables. The hazards at each age (i.e., the probability of initiating at that age given one has not yet initiated) were calculated using Stata's post-estimation "margins" command.

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The estimated number of youth prevented from initiating e-cigarette use was calculated using the difference between (a) the predicted probability for initiation by age as observed in this sample and (b) the predicted probability for initiation by age in a hypothetical scenario where exposure to the campaign was zero for all respondents. The difference in these two estimates (b-a) was calculated for each age and confidence intervals reflecting the uncertainty in the difference of the predicted probabilities of initiation were produced. These estimates (the lower bound, difference, and upper bound) were extrapolated to the national youth population for each age using estimates from the U.S. Census Bureau's 2023 American Community Survey[27] to estimate the number of youth who did not initiate e-cigarette use as a result of exposure to the campaign and a confidence interval around each estimate. The estimates were summed across ages to calculate the total number of youth who were prevented from initiating as a result of exposure to the campaign (see Table A-4 in the appendix for more details on the calculations).

Sensitivity analyses included discrete-time survival models for three additional exposure variations: a square root transformation (to capture diminishing returns), a quadratic transformation, and a dichotomous threshold exposure indicator (awareness index score of 0–6 vs. 7+) to capture the fact that the relationship between exposure and the outcome may not be linear. Model fit was assessed for the alternative models using AIC/BIC criterion; results indicated the primary model using the linear frequency index was the best fit, though this conclusion may be specific to the range of exposures examined. Additionally, a model was run to assess potential confounds related to respondents' prior campaign exposure by adjusting for the frequency of exposure index from respondents' baseline surveys (which captured exposure to ads

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on air prior to baseline). All analyses (main analysis and sensitivity) were conducted in 2025 using unweighted data with Stata, version 16.0.

RESULTS

This analysis included 3,804 observations. Table 1 presents unweighted descriptive statistics for the analytic sample. Among respondents who had never used an e-cigarette at baseline, 232 (6.8%) reported initiating e-cigarette use at follow-up. The analytic sample was predominantly composed of 12- to 17-year-olds at follow-up, with fewer 11-year-olds (2.4%) and 18-year-olds (9.5%). 23.1% of the analytic sample reported living with a person who used tobacco at follow-up and 36.8% of respondents reported prior exposure to promotional content for e-cigarettes on social media.

[Table 1]

Figure 1 shows the distribution of the frequency of exposure index on a scale of zero to 16. The mean exposure index for the analytic sample was 3.7, and 77.4% of the sample reported at least some exposure to one or more of the campaign advertisements (value of 1 or more on the index). Individual ad awareness descriptives are in Appendix Table A-2.

[Figure 1]

Table 2 provides the adjusted model results for the discrete-time survival analysis on the probability of initiation in relation to campaign exposure. Higher awareness of the campaign was

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significantly associated with a reduction in the odds of initiating e-cigarettes at follow-up (adjusted OR = 0.94; 95% CI: 0.90–0.99). The effect was linear; with each unit increase in the exposure index, the risk of initiating e-cigarettes decreased by 6%. The negative, significant relationship between campaign advertisements exposure and e-cigarette initiation was consistent across all sensitivity analyses, indicating the findings are robust to different specifications of exposure (Appendix Table A-3).

[Table 2]

Models also controlled for time between waves (in months) and awareness of another tobacco prevention/cessation campaign (*Tips, truth*).

Figure 2 shows the effect of the campaign on e-cigarette initiation by age. The figure shows the hazard, or probability, of e-cigarette initiation by age (a) as observed in the study with actual exposure levels and (b) in the hypothetical scenario of no exposure to the campaign, with the frequency of exposure index equaling zero for all observations. Extrapolating the difference in the initiation rates (b-a) for each age to the U.S. population of youth at each age across the range of respondents (11 to 18), the campaign was associated with preventing 444,252 (95% CI: 73,639–814,866) U.S. youth from initiating e-cigarette use during the study period (Appendix Table A-4).

[Figure 2]

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DISCUSSION

The current study found that exposure to "The Real Cost*"* Youth E-cigarette Prevention Campaign is associated with lower odds of initiating e-cigarette use at follow-up among a nationally representative longitudinal cohort of youth. Specifically, the campaign prevented an estimated 444,252 (95% CI: 73,639–814,866) youth 11 to 18 years of age from initiating e-cigarette use nationwide between 2023 and 2024.[1] These findings are consistent with prior evaluations of "The Real Cost" campaigns, which have shown that campaign exposure is related to increased tobacco product harm perceptions[13,16-18] and decreased tobacco product use among U.S. youth.[11,12]

Data from the 2024 National Youth Tobacco Survey (NYTS) data indicate that e-cigarette use among U.S. middle and high school students declined by nearly 500,000 youth between 2023 and 2024.[28] The current study's findings suggest that "The Real Cost" Youth E-cigarette Campaign was an important contributor to this decline. However, it is important to acknowledge that the observed decreases to prevalence of youth e-cigarette use in the U.S. should be considered in the context of comprehensive tobacco control strategies implemented during the same time period—including those at the national level. For example, legislation signed in December 2019 immediately raised the federal minimum age of sale of tobacco products in the United States from 18 to 21 years of age,[29] leading to promulgation of the FDA final rule that went into effect in August 2024 [30]; FDA review of premarket applications for new tobacco products resulted in marketing denial orders of e-cigarettes with youth-appealing designs and flavors, including candy and fruit; and FDA enforcement actions such as warning letters, civil money penalties, injunctions, and seizures ensure those across the supply chain obey laws that prevent youth tobacco product use[31] as well as obey laws at the state, local, and tribal levels (e.g.,

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state e-cigarette taxes; smoke-free indoor air laws prohibiting the use of e-cigarettes in indoor areas of private worksites, restaurants, and bars; restrictions on flavored e-cigarettes).[32]

The success of "The Real Cost" Youth E-cigarette Prevention Campaign in preventing youth e-cigarette use reinforces that public education initiatives, such as mass media campaigns that communicate the harms and risks of tobacco product use, are a key component of the comprehensive regulatory approach required to prevent and reduce youth tobacco product use. An iterative, science-based campaign framework remains critical to sustain the campaign's prevention of youth tobacco use and continually refresh its understanding of teen audiences, factors that place them at risk for tobacco initiation and use, and effective message delivery channels. FDA's campaign framework uses evidence-based strategies that will enable "The Real Cost*"* to evolve to address public health needs, including the rise of new and emerging tobacco products. The agency's tobacco campaign framework, rooted in rigorous, science-based, public health and communications best practices, will continue to guide development of effective youth prevention messaging that is tailored to the intended teen audiences and responsive to the dynamic tobacco and media landscapes.

In addition to demonstrating the success of "The Real Cost" campaign, the findings also highlighted factors associated with increased youth e-cigarette initiation—namely, greater levels of social media use and tendency toward sensation seeking, lower levels of household income and satisfaction with parental communication, and household tobacco use. These findings are congruent with prior literature suggesting that sensation seeking,[33] along with increased normalization of e-cigarette–related content[34] and behaviors are associated with greater

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susceptibility to e-cigarette use, while parental communication[25] may serve as a protective factor due to increased messaging surrounding risky behavior. Future public health campaigns could benefit from exploring how these social and behavioral factors might inform effective e-cigarette prevention messages.

Study limitations include the inability to control for the effects of state- or local-level public education campaigns, though the model did control for respondents' exposure to other national tobacco prevention campaigns. In addition, models only examined the effect of campaign exposure on e-cigarette initiation. Follow-up analyses assessing the campaign's potential impact on disrupting the progression of experimentation to regular or daily e-cigarette use would broaden understanding of the campaign's impact on youth tobacco prevention. Relatedly, this campaign examines initiation over a 1-year period, but longer studies are required to determine whether the campaign effectively led to sustained abstinence among this cohort. The exposure index measure in this study is based on recall of the ads airing at the highest levels between the survey waves and does not capture all potential exposure to the full range of campaign advertising materials (e.g., audio spots, social media reels, other custom placements), potentially rendering a smaller effect size for campaign exposure in the modeling. Despite use of a potentially narrow measure of campaign exposure, this study found robust evidence of campaign effect on youth e-cigarette use. As noted above, the exposure index is assessed using self-reported data, which is subject to recall bias. However, prior studies have demonstrated that findings using self-reported measures of exposure align with findings for exogenous measures of exposure not subject to recall bias.[11,12] The present study is unable to control for policies or regulations at the national, state, or local level enacted during the study period (August 2023 to

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October 2024). This study examines differences in the probability of youth e-cigarette initiation by different exposure levels to the campaign in a longitudinal cohort. Therefore, other national policies or regulations should affect youth equally within the study and not impact the study findings; however, to the extent that state or local policies might be related to exposure and initiation, their omission could bias the findings. The campaign is implemented at a national level, therefore the impact to study findings are expected to be minimal and not a threat to the study validity. Despite these limitations, the study findings collectively support the causal role of the campaign on preventing youth e-cigarette initiation.

CONCLUSIONS

This is the first longitudinal study demonstrating the behavioral effects of a national tobacco education campaign about e-cigarettes on U.S. youth. This study and other effective tobacco-focused campaigns are similar in their conclusions[35,36]—because media effects on behavior occur in cluttered, real-world environments, substantially resourced campaigns with high advertising levels over extended periods of time are crucial to achieve sustainable population changes in tobacco use behaviors. In demonstrating the effects of public health messages on population-level behaviors, evaluation studies such as this one provide strong support for continued implementation of science-based public education campaigns to reduce the future harms of tobacco use and improve the health of U.S. youth.

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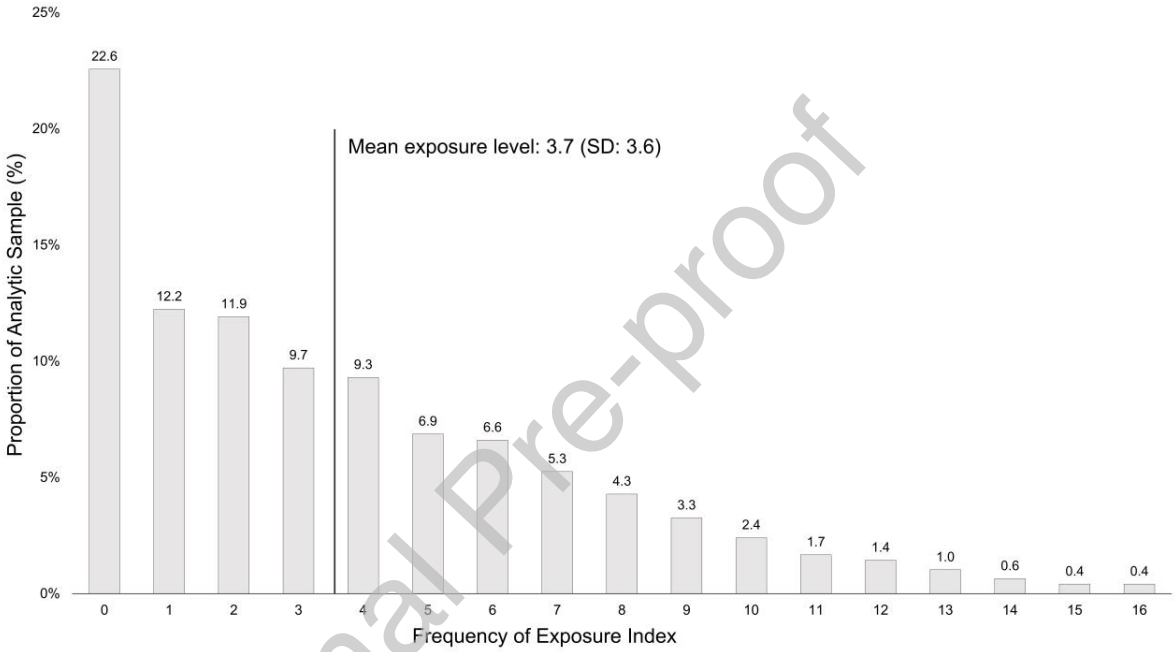

Figure 1. Distribution of the Self-Reported Frequency Index for Exposure to E-cigarette Campaign Advertisements at Follow-Up 1

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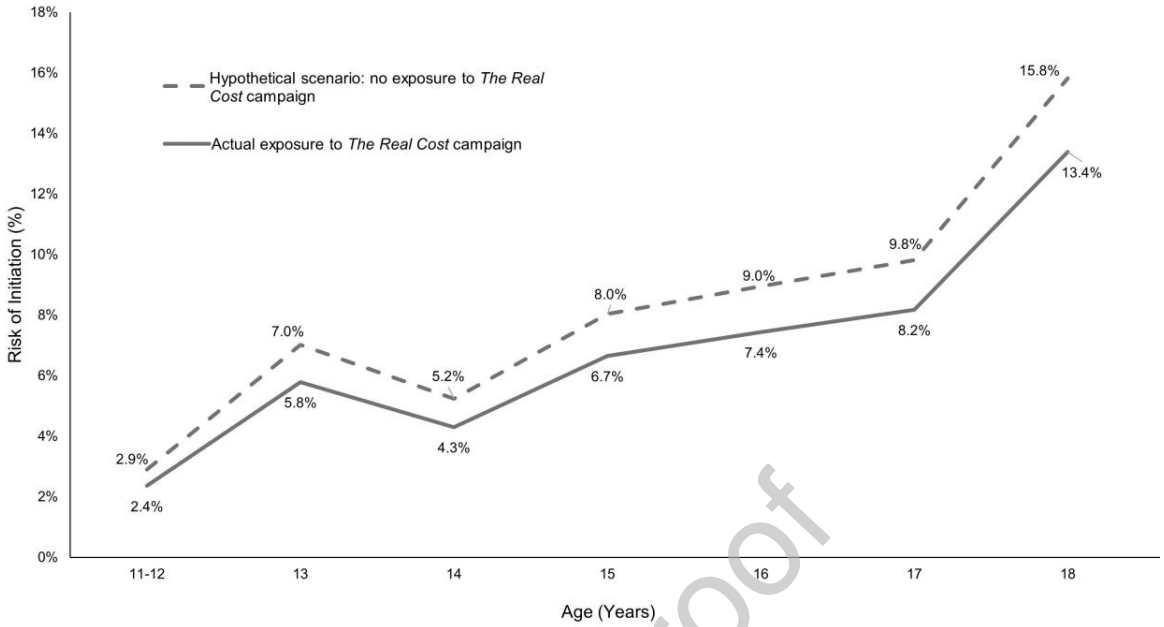

Figure 2. Estimated Youth E-cigarette Initiation Risk: Actual Exposure to "The Real Cost" Versus Hypothetical No-Exposure Scenario

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Table 1. Demographic Characteristics: Analytic Sample of "The Real Cost" Youth E-cigarette Prevention Campaign Longitudinal Evaluation Measures	**N (%) or Mean (SD)**
E-cigarette initiation between baseline and follow-up	
No	3,176 (93.2)
Yes	232 (6.8)
Age in years[a]	
11	82 (2.4)
12	424 (12.4)
13	518 (15.2)
14	548 (16.1)
15	517 (15.2)
16	533 (15.6)
17	462 (13.6)
18	324 (9.5)
Household income[b]	
Less than $30,000	335 (9.9)
$30,000 to under $70,000	689 (20.3)
$70,000 to under $110,000	752 (22.2)
$110,000 or more	1,612 (47.6)
Lives with someone who uses tobacco products	
No	2,612 (76.9)
Yes	786 (23.1)
Parent communication scale	4.4 (0.8)
Sensation-seeking scale	2.9 (0.9)

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Aware of another tobacco prevention/cessation campaign (*Tips, truth*)	
No	1,273 (37.4)
Yes	2,135 (62.6)
Time between waves (months)	9.7 (1.2)
Tertiles of social media platform use index (1 – Low, 2 – Medium, 3 – High)	1.8 (0.8)
Self-reported exposure to vaping promotional content on social media	
Never	2,156 (63.3)
More than a week ago	619 (18.2)
Sometime in the past week	472 (13.9)
Sometime in the past day	160 (4.7)

[a] Due to sample sizes, 11- and 12-year-old respondents were combined into a single group in the analysis.

[b] Analyses were conducted using baseline responses for household income.

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Table 2. Discrete-Time Survival Model: Relationship between Self-Reported Exposure to "The Real Cost" and Youth E-cigarette Initiation[a]

Explanatory Variables	OR (95% CI)
Self-reported exposure to "The Real Cost" ads	**0.94*** (0.90,0.99)
Age in years	
11–12	Ref
13	**2.68*** (1.17,6.14)
14	1.92 (0.83,4.43)
15	**3.14**** (1.41,7.01)
16	**3.58**** (1.62,7.92)
17	**4.00***** (1.80,8.89)
18	**7.41***** (3.36,16.34)
Household income	
Less than $30,000	Ref
$30,000 to under $70,000	**0.41***** (0.26, 0.65)
$70,000 to under $110,000	**0.51**** (0.33, 0.79)
$110,000 or more	**0.35***** (0.23, 0.53)
Lives with someone who uses tobacco products	**2.37***** (1.77,3.18)
Parent communication scale	**0.74***** (0.63,0.86)
Sensation-seeking scale	**1.36***** (1.15,1.60)
Tertiles of social media platform use index (1-Low, 2-Medium, 3-High)	**1.70***** (1.39,2.07)
Self-reported exposure to vaping promotional content on social media	
Never	Ref
More than a week ago	1.19 (0.81,1.73)

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Explanatory Variables	OR (95% CI)
Sometime in the past week	**1.55*** (1.08,2.24)
Sometime in the past day	1.62 (0.94,2.80)

CI = Confidence interval; OR = Odds ratio; TRC = *The Real Cost*

Note: Boldface indicates statistical significance (*p < 0.05, **p<0.01, ***p<0.001).

[a] United States, 2023–2024

CRediT author statement

Anna MacMonegle: Conceptualization, Methodology, Validation, Writing - Original Draft, Supervision, Project administration, Funding acquisition
Anh Nguyen Zarndt: Conceptualization, Writing - Review & Editing, Supervision
Yifan Wang: Software, Formal analysis, Writing - Original Draft, Visualization
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Leeann Siegel: Methodology, Writing - Original Draft
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James Nonnemaker: Methodology, Validation, Writing - Review & Editing
Nathaniel Taylor: Resources, Writing - Original Draft, Project administration
Jennifer Duke: Conceptualization, Writing - Review & Editing, Funding acquisition

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Exhibit E

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Notice of Award

Award# 5 NU58DP006802-05-00
FAIN# NU58DP006802
Federal Award Date: 04/18/2024

Recipient Information

1. Recipient Name
HEALTH RESEARCH, INC.
150 Broadway STE 280
Riverview Center
Health Research, Inc.
Menands, NY 12204-2732
[NO DATA]

2. Congressional District of Recipient
20

3. Payment System Identifier (ID)
1141402155A1

4. Employer Identification Number (EIN)
141402155

5. Data Universal Numbering System (DUNS)
153695809

6. Recipient's Unique Entity Identifier (UEI)
WJ37AD42G8A5

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Federal Award Information

11. Award Number
5 NU58DP006802-05-00

12. Unique Federal Award Identification Number (FAIN)
NU58DP006802

13. Statutory Authority
301(a) and 317(k)(2) of the Public Health Service Act, [42 U.S.C. Section 241(a) and 247b(k)(2)], as amended.

14. Federal Award Project Title
New York State Tobacco Control Program

15. Assistance Listing Number
93.387

16. Assistance Listing Program Title
National and State Tobacco Control Program

17. Award Action Type
Non-Competing Continuation

18. Is the Award R&D?
No

Summary Federal Award Financial Information

19.	**Budget Period Start Date** 04/29/2024 **- End Date** 04/28/2025	
20.	**Total Amount of Federal Funds Obligated by this Action**	$2,905,769.00
	20a. Direct Cost Amount	$2,579,293.00
	20b. Indirect Cost Amount	$326,476.00
21.	Authorized Carryover	$0.00
22.	Offset	$0.00
23.	Total Amount of Federal Funds Obligated this budget period	$0.00
24.	**Total Approved Cost Sharing or Matching, where applicable**	$325,000.00
25.	**Total Federal and Non-Federal Approved this Budget Period**	$3,230,769.00
26.	**Period of Performance Start Date** 06/29/2020 **- End Date** 04/28/2025	
27.	Total Amount of the Federal Award including Approved Cost Sharing or Matching this Period of Performance	$14,694,550.00

28. Authorized Treatment of Program Income
ADDITIONAL COSTS

29. Grants Management Officer – Signature
Darryl Mitchell

30. Remarks

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Notice of Award

Award# 5 NU58DP006802-05-00
FAIN# NU58DP006802
Federal Award Date: 04/18/2024

Recipient Information

Recipient Name
HEALTH RESEARCH, INC.
150 Broadway STE 280
Riverview Center
Health Research, Inc.
Menands, NY 12204-2732
[NO DATA]

Congressional District of Recipient
20

Payment Account Number and Type
1141402155A1

Employer Identification Number (EIN) Data
141402155

Universal Numbering System (DUNS)
153695809

Recipient's Unique Entity Identifier (UEI)
WJ37AD42G8A5

31. Assistance Type
Cooperative Agreement

32. Type of Award
Other

33. Approved Budget
(Excludes Direct Assistance)

I. Financial Assistance from the Federal Awarding Agency Only
II. Total project costs including grant funds and all other financial participation

a. Salaries and Wages	$1,348,926.00
b. Fringe Benefits	$538,221.00
c. Total Personnel Costs	$1,887,147.00
d. Equipment	$0.00
e. Supplies	$300,360.00
f. Travel	$12,810.00
g. Construction	$0.00
h. Other	$22,150.00
i. Contractual	$356,826.00
j. TOTAL DIRECT COSTS	$2,579,293.00
k. INDIRECT COSTS	$326,476.00
l. TOTAL APPROVED BUDGET	$2,905,769.00
m. Federal Share	$2,905,769.00
n. Non-Federal Share	$325,000.00

34. Accounting Classification Codes

FY-ACCOUNT NO.	DOCUMENT NO.	ADMINISTRATIVE CODE	OBJECT CLASS	CFDA NO.	AMT ACTION FINANCIAL ASSISTANCE	APPROPRIATION
3-9390L46	20NU58DP006802	DP	41.51	93.387	$0.00	75-X-0948
4-939ZREN	20NU58DP006802	DP	41.51	93.387	$2,905,769.00	75-24-0948

DEPARTMENT OF HEALTH AND HUMAN SERVICES Notice of Award

Centers for Disease Control and Prevention

Award# 5 NU58DP006802-05-00
FAIN# NU58DP006802
Federal Award Date: 04/18/2024

Direct Assistance

BUDGET CATEGORIES	PREVIOUS AMOUNT (A)	AMOUNT THIS ACTION (B)	TOTAL (A + B)
Personnel	$0.00	$0.00	$0.00
Fringe Benefits	$0.00	$0.00	$0.00
Travel	$0.00	$0.00	$0.00
Equipment	$0.00	$0.00	$0.00
Supplies	$0.00	$0.00	$0.00
Contractual	$0.00	$0.00	$0.00
Construction	$0.00	$0.00	$0.00
Other	$0.00	$0.00	$0.00
Total	$0.00	$0.00	$0.00

AWARD ATTACHMENTS

HEALTH RESEARCH, INC. 5 NU58DP006802-05-00

1. Terms and Conditions

AWARD INFORMATION

Incorporation: In addition to the federal laws, regulations, policies, and CDC General Terms and Conditions for Non-research awards at https://www.cdc.gov/grants/federal-regulations-policies/index.html, the Centers for Disease Control and Prevention (CDC) hereby incorporates Notice of Funding Opportunity (NOFO) number DP20-2001, entitled National and State Tobacco Control Program, and application dated January 31, 2024, as may be amended, which are hereby made a part of this Non-research award, hereinafter referred to as the Notice of Award (NOA).

Total Approved Funding is included in Summary Federal Award Financial Information on page 1 of the NOA. All future year funding will be based on satisfactory programmatic progress and the availability of funds.

The federal award amount is subject to adjustment based on total allowable costs incurred and/or the value of any third-party in-kind contribution when applicable.

Note: Refer to the Payment Information section for Payment Management System (PMS) subaccount information.

***Approved* Component Funding:** The NOFO provides for the funding of multiple components under this award. For this NOA, the approved funding level for each component is shown below:

NOFO Component	Amount
Component I	$2,036,862
Component II	$868,907

Financial Assistance Mechanism: Cooperative Agreement

Technical Review: Within 5 days of this Notice of Award's (NOA) issue date, the Technical Review will be accessible to the recipient in GrantSolutions Grant Notes. Contact the assigned Program Officer indicated in the NOA with any questions regarding this document or any follow up requirements and timelines set forth therein.

Substantial Involvement by CDC: This is a cooperative agreement and CDC will have substantial programmatic involvement after the award is made. Substantial involvement is in addition to all post-award monitoring, technical assistance, and performance reviews undertaken in the normal course of stewardship of federal funds.

CDC program staff will assist, coordinate, or participate in carrying out effort under the award, and recipients agree to the responsibilities as detailed in the NOFO and included below.

- Providing technical assistance to revise annual work plans.
- Assisting in advancing program activities to achieve project outcomes.
- Providing scientific subject matter expertise and resources.
- Collaborating with recipients to develop evaluation plans that align with CDC evaluation

activities.

- Providing technical assistance on recipient's evaluation and performance measurement plan.
- Providing ongoing training, technical assistance, and consultation on policy, systems, and environmental strategies and activities for tobacco control, including tobacco use and dependence treatment strategies and activities.
- Providing up-to-date information that includes dissemination of best practices for tobacco prevention and control.
- Informing and educating recipients and other partners about evidence-based policy, systems, and environmental strategies and activities for tobacco control through workshops, conferences, training, electronic and verbal communication, including the National Conference on Tobacco or Health.
- Identifying, developing, and disseminating education media campaign materials for use by programs; facilitating coordination of education media ads between programs; providing technical assistance on design, implementation, and evaluation of media.
- Providing monthly National Tobacco Control Program, Media Network, and periodic Evaluation Technical Assistance webinars to provide updates from subject matter experts about relevant tobacco-related topics and issues.
- Maintaining electronic mechanisms for information sharing, program planning, and progress reporting.
- Developing and maintaining partnerships with federal and non-federal organizations to assist in tobacco control and maintain a national infrastructure that complements the state infrastructure.
- Serving as a resource to recipients in identifying and eliminating tobacco-related disparities among population groups.
- Maintaining a website with access to a data warehouse containing comparable measures of tobacco use and dependence prevention and control from different data sources.
- Helping identify gaps in the evidence-base of tobacco control and prioritizing efforts to fill those gaps; providing training and technical assistance on publications and opportunities for dissemination of program evaluation findings.
- Serving as a convener and resource for the continued expansion of the evidence-base of tobacco control.
- Providing technical assistance, as requested, for developing impact statements and publishing selected statements on the CDC/OSH website as appropriate.
- Providing technical assistance, as requested, on the submission of data to the National Quitline Data Warehouse (NQDW).
- Facilitating development of the evidence base especially in areas of innovative strategies in reaching populations disproportionately impacted by tobacco use and dependence and associated disease, disability, and death through tobacco use and dependence treatment initiatives.
- Collecting and analyzing data that can be used to monitor and evaluate tobacco use and dependence treatment initiatives.
- Disseminating the Weekly Dose newsletter containing pertinent information regarding tobacco-related topics and NOFO-related information.
- Providing access to CDC's Office on Smoking and Health Media Campaign Resource Center.
- Collaborating with the Food and Drug Administration to provide information related to regulatory action.
- Providing data visualization training and technical assistance.

- Providing a Tobacco Control Network, Communities of Practice, and tailored webinars that include lessons learned from peers, and opportunities for tailored technical assistance and sustainability planning.
- Providing 12-month on-boarding support for new tobacco control program managers.
- Providing leadership development through the OSH Leadership and Sustainability School for program managers.

Expanded Authority: The recipient is permitted the following expanded authority in the administration of the award.

☒ Carryover of unobligated balances from one budget period to a subsequent budget period. Unobligated funds may be used for purposes within the scope of the project as originally approved. Recipients will report use, or intended use, of carried over unobligated funds in Section 12 "Remarks" of the annual Federal Financial Report. If the GMO determines that some or all of the unobligated funds are not necessary to complete the project, the GMO may restrict the recipient's authority to automatically carry over unobligated balances in the future, use the balance to reduce or offset CDC funding for a subsequent budget period, or use a combination of these actions.

FUNDING RESTRICTIONS AND LIMITATIONS

Indirect Costs:
Indirect costs are approved based on the negotiated indirect cost rate agreement dated August 14, 2023, which calculates indirect costs as follows, a Provisional is approved at a rate of 17.3% of the base, which includes, direct salaries and wages including all fringe benefits in Albany (b). The effective dates of this indirect cost rate are from 04/01/2023 - 03/31/2026.

Missing Contractual Elements - The TBD contractor cost noted in the budget narrative are not approved and the recipient may not begin the contract until the six elements in accordance with the CDC Budget Preparation Guidance, are provided via GrantSolutions as a Notice of Contractor Amendment and GMO approval is provided via Notice of Award.

- BTC facilitation contractor (Comp 1 contractor# 4 - $30,000)

PAYMENT INFORMATION

Payment Management System Subaccount: Funds awarded in support of approved activities have been obligated in a subaccount in the PMS, herein identified as the "P Account". Funds must be used in support of approved activities in the NOFO and the approved application.

The grant document number identified beginning on the bottom of Page 2 of the Notice of Award must be known in order to draw down funds.

CLOSEOUT REQUIREMENTS

Standard closeout reporting requirements are identified in the General Terms and Conditions, which are published on the CDC website at https://www.cdc.gov/grants/federal-regulations-policies/index.html.

Final Performance Progress and Evaluation Report: This report should include the information specified in the NOFO and is submitted 120 days following the end of the period of

performance via www.grantsolutions.gov . At a minimum, the report will include the following:

- Statement of progress made toward the achievement of originally stated aims.
- Description of results (positive or negative) considered significant.
- List of publications resulting from the project, with plans, if any, for further publication.

Additional guidance may be provided by the GMS and found at: https://www.cdc.gov/grants/already-have-grant/index.html.

Exhibit F

Centers for Disease Control and Prevention

Media Campaign Resource Center (MCRC)

We are currently unable to process orders at this time.

MCRC | MEDIA CAMPAIGN RESOURCE CENTER

OR BROWSE THE COLLECTION

SAVE TIME, MONEY, AND LIVES

SEARCH MCRC

About MCRC

Educate audiences about the harmful effects of commercial tobacco use with the MCRC, your source for free and low-cost tobacco education campaign materials. This collection is available to the tobacco control community and partners to support your communications efforts. You can type in a keyword to start your search or use the section links to find ads for your campaign.

Featured Ads & Campaigns

Fred W. Fishing Tip

You Are the Target

Felicita R., Déjelo Tip

Tammy W., Everyone Can See It Tip

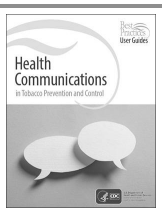
Take the First Step

Additional Featured Content

EMPOWER Vape-Free YOUTH™

Empower Vape-Free Youth

State & Community Health Media Ctr



Health Communications User Guide

Visit the Tips From Former Smokers Website

Common Searches

Ads in Cycle Big savings! Check out our collection of advertisements in cycle (initial fees are paid). Learn more

Free Ads Take a look at campaign materials which are free to use

New Ads Browse the newest submissions to the MCRC!

EXHIBIT 38

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF RHODE ISLAND

DECLARATION OF STEPHEN PROPHETER

Professional Background

The Head Start Program

OHS Funding for EHS-CCP

Reliance on HHS Head Start Staff Prior to April 1, 2025

Changes in HHS Head Start Operations Since April 1, 2025

Effect on California's Head Start Program

Stephen Propheter

Digitally signed by Stephen Propheter
Date: 2025.05.06 15:51:20 -07'00'

EXHIBIT 39

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF RHODE ISLAND

STATE OF NEW YORK, et al., Plaintiffs, v. ROBERT F. KENNEDY, JR., in his official capacity as SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., Defendants.	C.A. No. 1:25-cv-00196-MRD-PAS

DECLARATION OF ELANA MARTON

1. I, Elana Marton, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the foregoing is true and correct:

2. I am the Deputy Director and Counsel of the New York State Council on Children and Families (CCF). I am familiar with the information in the statements set forth below either through personal knowledge, in consultation with CCF staff, or from documents that have been provided to and reviewed by me.

3. I submit this Declaration in support of the Plaintiff States' Motion for a Preliminary Injunction.

Professional Background

4. CCF is a small executive state agency responsible for supporting cross-system coordination and collaboration among New York State's health, education, and human service systems to improve outcomes for all of New York's children and families.

5. I have worked at CCF for nearly 18 years, providing legal counsel and programmatic support and oversight of agency operations, including federal grant administration.

6. Since 1991, CCF has administered the Head Start Collaboration Project, a grant staffed by the New York State Head Start Collaboration Director housed at CCF, and funded by the Office of Head Start (OHS) under the Administration for Children and Families (ACF) within the U.S. Department of Health and Human Services (HHS). The Head Start Collaboration Project provides a structure and a process for OHS to work with state agencies and local entities to leverage common efforts and resolve challenges to formulate, implement, and improve state and local policies and practices to best support young children and their families.

7. The New York State Head Start Collaboration Project conducts community needs assessments to assess significant changes in New York communities that may affect stakeholders. Such assessments help programs evaluate how major shifts may impact operations, services, and families. Additionally, the Head Start Collaboration Project Director monitors and responds to common challenges, like those resulting from the rapid change in directives and operations by HHS to the administration of Head Start grants since late January 2025.

The Head Start Program

8. Head Start provides vital services at no cost to eligible families with young children, birth to age 5. Eligible families include those with low-incomes, children in foster care, or children living in temporary housing. In addition to providing high quality child care and early childhood education, Head Start programs connect children and families to social services and supports. Head Start programs integrate state benefit programs to provide children with meals and snacks during the day, as well as diapers for young children, enrollment assistance in health insurance plans, and supports for parents including connections to career services and adult education. Many Head Start

families live paycheck to paycheck, making them susceptible to homelessness if they face job loss. The same is true of many Head Start staff whose wages are so low that they struggle to make ends meet.

9. The day-to-day operations of the Head Start program historically have been administered at the federal level by OHS employees working out of HHS Regional Offices. Regional office staff, including program specialists, fiscal specialists, and other program leadership, play an integral role in ensuring that the services to enrolled children and families are reliable, high-quality, and fiscally sound. They help interpret federal regulations and provide essential support to Head Start grant recipients. Prior to reconfiguring the Regional Offices of OHS in April 2025, the Region 2 office (located in New York City) supported the grant recipients in New York, New Jersey, the Virgin Islands, and Puerto Rico.

10. Head Start grant recipients typically are awarded a competitive grant for a five-year time frame. Grant recipients usually submit a refunding application once a year (with grant funding renewal dates staggered over the course of the year) to enable them to continue seamlessly providing services to enrolled children and families in their community. After the refunding application is approved by OHS, grant recipients receive a Notice of Award and have access to the Payment Management System (PMS) where they can draw down funds in small increments and with a lead time of just a few days, to pay operating expenses (payroll, rent food, etc.). Currently, however, because the federal government is operating under a Continuing Resolution until September 30, 2025, funding renewals by OHS are for shorter periods, six months (not annual) periods. This increased frequency of grant renewals places an additional burden on OHS, amplified by the elimination and reconfiguration of Regional Offices and significantly fewer OHS staff to support Head Start grantees, funding delays and disruptions now are common.

11. There are 147 Head Start Programs (administering 274 Head Start grants) in New York State, serving approximately 43,327 children from birth to school entry and 900 pregnant women. 14,400 staff serve these young children and families in 927 sites across the state.

12. I am providing this declaration to explain the impact of recent federal actions and directives, HHS and OHS reorganization, and other changes to OHS operations on Head Start programs in New York State. These changes have placed thousands of our state's most vulnerable children and families in limbo. Significant stress and hardship have been experienced due to the possible and actual disruptions to children's care, education, support services, food security, health, and well-being, and the possibility and actuality of parents having to miss work, risk losing their jobs, and/or drop out of education and vocational programs. Like Head Start children and families, many Head Start staff also live in or near poverty levels, and experience financial and mental health stressors when a paycheck is anticipated to be missed or delayed.

Recent Changes in Head Start Operations

13. On January 27, 2025, the Office of Management and Budget froze all funds for federal funding recipients in the HHS Payment Management System (PMS), including Head Start grant recipients. Following multiple legal challenges and injunctions, the freeze was reportedly lifted. Nevertheless, Head Start programs in New York continued to face challenges drawing down approved grant funds and experienced looming uncertainty about the availability of future funds. Approximately 20 Head Start programs[1] expecting a Notice of Award for refunding starting in

[1] Bedford-Stuyvesant Early Childhood Development Center, Inc. CEO Empowers, Inc., Columbia Opportunities, Inc., Committee for Early Childhood Development Day Care Center, Inc., Community Action Planning Council of Jefferson County, Inc., East Side House, Family Enrichment Network, Inc., Head Start Of Eastern Orange County, Opportunities for Otsego, Inc., The Community Program Centers of Long Island, LEAP (formerly Washington County Economic Opportunity Council), Lifeworks Community Action Agency, Inc., Long Island Child and Family Development Centers, Inc., Promesa Head Start, Tompkins Community Action, Ulster County Community Action Committee, Inc.,. United Talmudical Academy of Borough Park Head Start, Warren County Head Start, Inc., and West Harlem Community Organization, Inc.

April or May received no updates on the status of their applications. Similarly, grantees attempting to draw down funds received messages of 'pending' or 'in process' when they requested funds in PMS. As Head Start programs rely on steady, predictable access to maintain program operations to pay staff, rent, food vendors, and other essential expenses, these 20 programs had to make difficult choices with limited information about whether to remain open or suspend operations.

14. In early February 2025, the Cattaraugus-Wyoming County Head Start program was forced to temporarily close when approved funds could not be accessed. Approximately 200 children had no care, and their parents were not able to work or go to school, and 87 program staff were furloughed. After the Head Start center re-opened, the agency's chief executive officer reported that parents and staff remained very concerned. She said parents were starting to look at other placements and staff were asking whether they should start looking for a new job.

15. In early February 2025, the Great Neck-Manhasset Head Start, one of the smallest Head Start programs in the state, with an annual grant of $577,859 to serve 46 families and employ 11 staff, was on the brink of closure. The program notified families that it would have to suspend programming if they could not access their funding. While funding was received at the last minute, the program and the families faced an existential threat.

16. On April 1, 2025, the OHS regional office serving New York State (Region 2) was abruptly closed. Regional Offices have provided long-standing and essential operational assistance to Head Start grantees, ensuring the delivery of high-quality early childhood care, education, health, nutrition, and other supports. Before the closure of the Region 2 OHS, staff in this office administered approximately $706.5 million in annual funding directly to Head Start programs in New York. Region 2 staff were consistently available to promptly respond to programmatic questions and needs. With the closure of the Region 2 OHS, New York Head Start grantees had no

designated federal staff to help them, with training and technical assistance questions, receiving/ filing of required reports (e.g., of child injuries or accidents), providing updates on the status of grant applications or pending requests for payments, or answering questions on compliance arising with the rapidly changing federal landscape. With the enormous void left by the abrupt elimination of regional OHS staff on whom the state's Head Start grantees had long relied, the New York State Head Start Collaboration Director was inundated with frantic calls and questions. Concerns from Head Start programs on the brink of closing were heard, monitored, and shared, but in the absence of any guidance or assistance from OHS, no further aid could be offered.

17. Following the closure of the Region 2 OHS, and "reductions in force" eliminating more than half of the OHS staff in Washington D.C. (out of 230 staff, only 95 staff remained), Head Start grantees who attempted to contact OHS about their anticipated Notice of Award were directed to use the Correspondence feature within the Head Start Enterprise System (HSES) as their primary means of communication. Grantees reported receiving either a basic answer (e.g., OHS is working on your funding request) or no response. For general questions, grantees were directed to a centralized OHS email mailbox. As with questions submitted in HSES, grantees received limited or no answers to their questions. Desperate for help, some grantees then contacted the New York State Head Start Collaboration Director, who shared a federal contact she had learned about from the National Head Start Association and Head Start Collaboration Directors from other states. The OHS contact was Heather Wanderski, Program Operations Director, responsible for supporting grant recipient operations. No responses to these direct messages were reportedly received either.

18. On April 3, 2025, the chief financial officer from one Head Start program (Community Action Planning Council of Jefferson County) awaiting its Notice of Award,

anticipated to be received during the prior month of March, expressed how critical Head Start is to their community and the agency's determination to operate as long as possible to avoid an interruption in services. Yet, without access to the remainder of their funds, their resources would be stretched too thin if the renewal award was not received within a few days. The New York State Head Start Collaboration Director received similar messages from other Head Start grantees while they waited for their grant awards or access to funding requested through PMS.

19. Further delaying and exacerbating delays and uncertainties about funding, on April 7, 2025, the Department of Government Efficiency began intercepting Head Start grantees' requests to draw down their money for routines requests (such as payroll) through PMS by directing them to justify "what the award is for, what the funds will be used for, and why it is necessary." Programs were directed to send an email to defendthespend@hhs.gov, adding another step in the payment request process, largely duplicative of the grantee's Notice of Award. Programs were surprised by this new requirement and unclear about what was expected and whether they needed to answer the questions. In addition to concerns about payments being further delayed, questions about whether the new requirement violated the Paperwork Reduction Act (cited in the Notice of Award) were raised by the president of the New York State Head Start Association during an April 8th phone call with the New York State Head Start Collaboration Director.

20. On April 16, 2025, HHS amended its Grants Policy Statement[2] to add a certification requirement stating that agencies that accept grant awards "are certifying that … they do not and will not during the term of this financial assistance operate any programs that advance or promote DEI, DEIA, or discriminatory equity ideology in violation of Federal anti-discrimination laws." In the event that a funding recipient engages in impermissible "DEIA," consequences might include

[2] https://www.hhs.gov/sites/default/files/hhs-grants-policy-statement-april-2025.pdf

a claw back of grant funds and civil and criminal liability for misrepresentation under the False Claims Act. No guidance was provided about what was considered a "diversity, equity, and inclusion (DEI) initiative, an activity "advancing" or "promoting" "DEIA," or "discriminatory equity ideology." In addition, no guidance was provided on how to reconcile these limitations on Head Start programming content with the conflicting obligations under the Head Start Act to serve the "diverse needs" of communities. Head Start grantees expressed confusion about applying this new Certification requirement (e.g., would specialized services for children with disabilities, food that meets cultural or religious dietary needs, or interpretation services violate the new requirements?). Grantees also reported their fear of the extreme consequences of non-compliance (losing their funding, having funds clawed back, or being subject to investigation).

21. Since March 2025, the New York State Head Start Collaboration Project Director conducted ongoing surveys to Head Start grantees identified as being at immediate risk of closure due to delays in receiving federal funds, specifically asking the programs to estimate how long they could operate if there was a disruption in funding. As many programs operate with razor thin margins, responses ranged from one week to a maximum of two months. Numerous messages of distress from Head Start programs in fear of closing were received, too. Programs shared that they were grappling with the difficult choice of whether to remain open while waiting for funds to become available, and facing the possibility of being unable to cover payroll, pay food vendors, rent, and other program expenses.

22. Programs also reported being unable to fill open staff positions due to funding uncertainty, threatening their ability to maintain sufficient staffing and continue operating.

23. Head Start grantees in New York continued to report funding issues. On April 14, 2025, the Warren County Head Start executive director was poised to suspend programming for

183 children and families and lay off 78 staff. Following multiple communications with elected officials, including U.S. Senators Schumer and Gillibrand and Congresswoman Stefanik, and the local media outlets, funding was received at the last possible moment. While closure was ultimately avoided, Head Start families experienced significant fear of the possible temporary and/or permanent disruption in services, as did program staff, some of whom reported looking for another job in anticipation of the program closing.

24. Even for programs that did not have to close, the anticipated delays and disruption in accessing funding threatened the continued operation and long-term viability of their programs and caused significant distress and harm. Head Start program directors repeatedly shared that the chaos and uncertainty were negatively impacting their Head Start parents and staff. Parents asked if they would have care so they could keep working, concerned that they would lose their jobs. Similarly, Head Start staff expressed concerns about the stability of their jobs. Program directors were heavily burdened by the additional work and troubled by the lack of certainty about the future to remain open and provide critical services to Head Start children and families in their communities.

Conclusion

25. The blitz of changes to the Head Start Program by HHS have been deeply concerning and harmful to New York State children and families and the dedicated staff who serve them. These changes have been marked by chaos, a lack of clarity, uncertainty, and panic. With the closure of the OHS Region 2 office, Head Start programs have been left without essential guidance and support, and their ability to deliver Head Start's high-quality early care and education, health, nutrition, and other supports significantly impeded, posing a substantial risk of irreparable and

ongoing harm to the thousands of children and families who depend on these critical services and the providers who care for them.

Elana Hart

[NAME]

Date: 5/7/2025

EXHIBIT 40

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF RHODE ISLAND

STATE OF NEW YORK, et al. Plaintiffs, v. ROBERT F. KENNEDY, JR., in his official capacity as SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., Defendants.	Case No. 1:25-cv-00196 (MRD)

DECLARATION OF CONNECTICUT OFFICE OF EARLY CHILDHOOD

I, Karen Pascale, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the foregoing is true and correct:

1. I am the Head Start Collaboration Office Director for the Connecticut Office of Early Childhood (CT OEC). I have personal knowledge of the facts set forth in this declaration, and if required to testify, would and could competently do so.

2. I submit this Declaration in support of the States' Motion for a Preliminary Injunction.

Professional Background

3. I am a Director at the CT OEC; I have served as the Head Start Collaboration Office Director since April of 2023. I previously served as the Senior Director of Early Childhood at the United Way, and I also served as an Early Head Start Director for the United Way. Other notable professional experience includes serving as an Education and Disabilities Coordinator and Program Manager at a Head Start program in Connecticut. I have a master's

degree in education and have devoted my entire professional career to working in early care and education and often serving the most vulnerable children in Connecticut.

4. The CT OEC's mission is embodied in its enabling statute, Connecticut General Statutes (C.G.S.) section 10-500. Among other salient provisions included within C.G.S. § 10-500, CT OEC's mission includes, but is not limited to: ". . . Delivering services to young children and their families to ensure optimal health, safety and learning for each young child . . . developing a state-wide developmentally appropriate kindergarten entrance inventory that measures a child's preparedness for kindergarten . . . continually monitoring and evaluating all early care and education and child care development programs and services, focusing on program outcomes in satisfying the health, safety, developmental and educational needs of all children . . . providing information and technical assistance to persons seeking early care and education and child development programs and services . . . integrating early childhood care and education and special education services . . . performing any other activities that will assist in the provision of early care and education and child development programs and services . . ."

5. CT OEC has one office location at 450 Columbus Boulevard in the state's capitol, Hartford, Connecticut. The vast scope of the agency's work includes, but is not limited to facilitating and coordinating Head Start services to best meet the needs of the children and families served; in short, to ensure the efficient administration of the Head Start Program. Other noteworthy programs that the CT OEC administers are the state's child-care subsidy program, Care For Kids, and the state's early intervention, Birth To Three, program.

The Head Start Program

6. The federal Head Start program, founded in 1965, promotes school readiness for children of low-income families from birth to 5 years old. Head Start services support early learning and development, health, and family wellbeing.

7. Head Start is administered by the Office of Head Start (OHS) within the Administration for Children and Families (ACF) of the U.S. Department of Health and Human Services (HHS).

8. Head Start programs include Early Head Start (EHS) programs for infants, toddlers, and expectant families and Head Start preschool programs for primarily 3- and 4-year-old children. In addition, Head Start includes American Indian and Alaska Native (AIAN) Head Start programs and Migrant and Seasonal Head Start (MSHS) programs serving farmworker families.

9. Head Start provides vital services to low-income children and families. In addition to providing high quality childcare and early childhood education, Head Start programs connect children and families to wrap around social services and supports. Head Start programs integrate state benefit programs to provide children with meals and snacks during the school day, as well as diapers for young children, enrollment assistance in health insurance plans, and supports for parents including connections to career services and adult education.

10. The Head Start program is largely administered at the federal level by HHS employees working out of HHS Regional Offices.

11. In Connecticut, the Head Start program serves over five thousand children and their families; there are twenty-two (22) Head Start programs throughout the state, including grant recipients and delegate agencies. Programs receive almost $84 million dollars

($83,584,000.) in federal Head Start funding annually. There is a Head Start and/or Early Head Start program in every county in Connecticut.

12. I am providing this declaration to explain the impacts on Connecticut and the Office of Early Childhood regarding the changes to Head Start, including a reduction in staffing, since April 1, 2025. These changes have created a situation whereby, *inter alia*, it is unclear who (if anyone) has been designated as Connecticut's Program Specialist and liaison. For example, the Head Start Enterprise System still shows the Agency's Program Specialist as an individual who was terminated on April 1, 2025. Recently, during an Office of Head Start webinar entitled "Office of Head Start Operations Update," although the undersigned was registered to attend, when attempting to launch the link to attend the videoconference, a message was received indicating the webinar had reached capacity. It is the undersigned's understanding that the webinar's purpose was to share information about the regional realignment and how to reach the Office of Head Start, but the webinar lasted less than ten (10) minutes.

13. The workplace demands placed on the undersigned since the massive April 1 reduction in force and closing of the Region 1 office has increased exponentially, particularly among communications with programs that are awaiting Notice of Awards, Balance of Funds, and those awaiting news of the status and disposition of competitive grant applications. A one-person operation, the undersigned has spent additional and increased time attending in-person, onsite Head Start meetings, events, press conferences and preparing *ad hoc* Head Start reports and Fact Sheets. In addition, the undersigned is being sought out by various programs seeking support regarding the recently communicated (but unclear) new justification process to drawdown previously approved budgetary expenditures. In addition, CT OEC submitted a "carry-over" request application in the amount of $65,564.00 on April 1, 2025, and while a

federal fiscal contact acknowledged receipt and exchanged some preliminary communications; given the agency's Program Specialist was terminated on April 1, 2025, the CT OEC has not yet received any final communication regarding the status of the "carry-over" request. In the past, such requests were routinely processed promptly.

Reliance on HHS Head Start Staff Prior to April 1, 2025

14. Prior to April 1, 2025, the CT OEC Head Start Collaboration Office regularly relied on HHS Head Start staff (and typically communicated weekly or bi-weekly) for many aspects of the routine operation of the CT OEC Head Start Collaboration Office.

15. The HHS Head Start staff with whom we communicated and relied upon were primarily located in the Regional Office of Region 1, in Boston.

Changes in HHS Head Start Operations Since April 1, 2025

16. Since April 1, 2025, CT OEC and various Head Start programs have seen significant changes to the operations of HHS's Head Start Program. For example, it was unprecedented in the past for programs to receive their Notice of Awards mere days before the scheduled annual funding was to commence. In addition, many programs are jointly funded by the federal and state governments; if the federal funding is eliminated or reduced it impacts the programs' ability to sustain the classrooms since both funding streams are relied upon to support the programs.

17. Specifically, we have been told that as of April 1, 2025, the Regional Office for Region 1, located in Boston has been closed.

18. On April 3, 2025, CT OEC received an email from Laurie Todd-Smith, Ph.D., Deputy Assistant Secretary for Early Childhood Development of ACF confirming the closure of

5 HHS Regional Offices effective April 1, 2025, and requesting that communications to HHS about Head Start be directed to the following email address: ohsrecipientsupport@acf.hhs.gov

Effect on State's Head Start Program

19. The CT OEC has been significantly affected by the changes to the HHS Head Start Program described above primarily due to the lack of communication with any Program Specialist.

20. We have also seen delays in communication regarding funding for the "carry-over" requested and it has been represented to the CT OEC Head Start Collaboration Office that programs are receiving slower response time to inquiries. The changes to the HHS Head Start Program have placed a burden on the CT OEC because staff at the HHS Head Start Program are no longer available to field questions and inquiries from Head Start Programs. Those Programs are now contacting CT OEC frequently, placing a burden and strain on CT OEC's sole Head Start Collaboration Office staff member.

21. There is imminent risk that funding to Head Start programs in Connecticut will be delayed because the HHS Head Start staffing cuts may have impacts on HHS's ability to make payments to Head Start Programs. This will in turn harm Connecticut directly as described above and because there were 1,611 Head Start staff reported in the 2023-2024 Program Information Report; these taxpaying employees contribute to the state's economy.

22. These changes risk significant harm to young children and their families in Connecticut because families may not have a safe place to bring their children for affordable child care or parents may be unable to work; parents may potentially place their children in unlicensed child care. In addition, if children do not have access to high-quality learning environments, among other detriments, they would lose the ability to socialize with other

children. These high-quality learning environments also provide students with breakfast, lunch and snacks. And many early HS programs provide diapers (reducing a costly expenditure for families) and monitor regular pediatric and dental visits including ensuring preventative care.

Conclusion

23. The changes to the HHS Head Start Program described above and the uncertainty created regarding the receipt of future awards--coupled with additional justifications required for previously authorized expenditures--creates an untenable, unstable and unsustainable environment.

Karen Pascale

Karen Pascale

Date: May 7, 2025

EXHIBIT 41

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF RHODE ISLAND

STATE OF NEW YORK, et al. Plaintiffs, v. ROBERT F. KENNEDY, JR., in his official capacity as SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., Defendants.	Case No. 1:25-cv-00196

DECLARATION OF ANGELA RODGERS

I, Angela Rodgers, declare under the penalty of perjury pursuant to 28 U.S.C. §1746 that the foregoing is true and correct:

1. I am a Deputy Director of Programs for the Arizona Department of Economic Security (ADES). I am familiar with the information in the statements set forth below either through personal knowledge, in consultation with the ADES staff, and/or from documents that have been provided to and reviewed by me.

Professional Background

2. As a Deputy Director, I oversee three divisions within ADES: Benefits and Medical Eligibility, Employment and Rehabilitation Services, and Child and Community Services.

3. Before becoming a Deputy Director at ADES, I served as the ADES Director for two (2) years and over a decade as President and Chief Executive Officer of the Arizona Food Bank Network. Collectively, I have over 25 years of experience in human services operations, policy analysis, resource management and cross sector collaboration. I hold a master's degree in

social work from Arizona State University and a bachelor's degree in criminology and sociology from the University of Kansas.

4. The ADES is Arizona's comprehensive social services agency. Its mission is strengthening individuals, families, and communities for a better quality of life. ADES carries out its mission through work with families, community and advocacy organizations, and state and federal partners to facilitate the safety and economic security of persons who qualify for ADES benefits and services in the State of Arizona.

5. ADES has 61 client facing offices statewide with approximately 8,500 full time equivalent employees. ADES provides services to individuals in person, on the phone, through numerous local and statewide call centers and virtually through a number of portals and self-service opportunities. DES administers approximately 60 programs focused on delivering specialized services to align with the needs of the community and ADES' programmatic areas.

The Federal Poverty Guidelines

6. The federal poverty guidelines were originally developed in 1964 by the Social Security Administration.

7. The federal poverty guidelines are used by federal, state, local, and tribal agencies in numerous ways, including to assess eligibility for certain means tested programs.

8. HHS maintains the federal poverty guidelines and updates them annually.

9. ADES relies on the federal poverty guidelines to determine eligibility for means-tested benefits, including but not limited to the Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance to Needy Families (TANF) cash assistance, the Low Income Home Energy Assistance Program (LIHEAP), the Community Services Block Grant (CSBG), the

National Farmworker Jobs Program, and the Workforce Investment and Opportunity Act. The aforementioned programs collectively serve millions of Arizona residents.

Harm from Delay or Failure to Maintain the Federal Poverty Guidelines

10. An extended delay in HHS' ability to calculate and publish future federal poverty guidelines or if done inaccurately or not at all could have consequences for ADES as it serves eligible clients.

11. For example, ADES would no longer have timely and accurate guidelines for the calculation of the aforementioned programs. This could cause harm in the form of uncertainty for state officials and program recipients regarding eligibility. It could also harm ADES by placing a burden on state officials, who may have to expend resources fielding questions regarding the lack or accuracy of applicable guidelines. It could also harm ADES by increasing the administrative burden that would arise if different states use different guideline thresholds. Federally funded but state administered benefits could have different eligibility criteria and the result could be inconsistently administered benefits.

Executed this 6th day of May 2025.

Angela Rodgers
Deputy Director of Programs
Arizona Department of Economic Security

EXHIBIT 42

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF RHODE ISLAND

STATE OF NEW YORK, et al. Plaintiffs, v. ROBERT F. KENNEDY, JR., in his official capacity as SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., Defendants.	Case No. 1:25-cv-00196-MRD

DECLARATION OF PETER HADLER

I, Peter Hadler, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the foregoing is true and correct:

1. I am a Deputy Commissioner of the Connecticut Department of Social Services. I have personal knowledge of the facts set forth in this declaration, and if required to testify, would and could competently do so.

2. I submit this Declaration in support of the States' Motion for a Preliminary Injunction.

Professional Background

3. I am the Deputy Commissioner for the Connecticut Department of Social Services (DSS). I have been employed in this position since April 2023 and have been employed by DSS since January 2012. I am responsible for executive level program and policy oversight including administration of the Low Income Home Energy Assistance Program (LIHEAP). In my capacity as Deputy Commissioner, I also oversee the state's program and policy administration for the Supplemental Nutrition Assistance Program (SNAP), the Temporary Assistance for Needy

Families (TANF) block grant, the Community Services Block Grant (CSBG), the Social Services Block Grant (SSBG) and numerous other public assistance programs. I also oversee eligibility policy and enrollment determinations for the Medicaid program and the Children's Health Insurance Program (CHIP).

4. I am an attorney with a juris doctor degree from Boston University and am admitted to the bar in both Connecticut and New York.

5. The Connecticut Department of Social Services is statutorily designated in Connecticut General Statutes section 17b-2 as the state agency responsible for "the administration of (1) the Connecticut energy assistance program pursuant to the Low Income Home Energy Assistance Act of 1981; (2) the state plan for vocational rehabilitation services for the fiscal year ending June 30, 1994; (3) the refugee assistance program pursuant to the Refugee Act of 1980; (4) the legalization impact assistance grant program pursuant to the Immigration Reform and Control Act of 1986; (5) the temporary assistance for needy families program pursuant to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996; (6) the Medicaid program pursuant to Title XIX of the Social Security Act; (7) the supplemental nutrition assistance program pursuant to the Food and Nutrition Act of 2008; (8) the state supplement to the Supplemental Security Income Program pursuant to the Social Security Act; (9) the state child support enforcement plan pursuant to Title IV-D of the Social Security Act; (10) the state social services plan for the implementation of the social services block grants and community services block grants pursuant to the Social Security Act; and (11) services for persons with autism spectrum disorder."

6. Among other statutory duties, pursuant to section 17b-3 of the Connecticut General Statutes, the Department has the power and duty to "(1) Administer, coordinate and direct the

operation of the department; . . . (4) establish and develop programs and administer services to achieve the purposes of the department as established by statute; . . . (9) promote economic self-sufficiency where appropriate in the department's programs, policies, practices and staff interactions with recipients; (10) act as advocate for the need of more comprehensive and coordinated programs for persons served by the department; (11) plan services and programs for persons served by the department; . . . (15) encourage and facilitate effective communication and coordination among federal, state, municipal and private agencies; (16) inquire into the utilization of state and federal government resources which offer solutions to problems of the delivery of social services; (17) conduct, encourage and maintain research and studies relating to social services development; (18) prepare, review and encourage model comprehensive social service programs; (19) maintain an inventory of data and information and act as a clearing house and referral agency for information on state and federal programs and services; . . . The Commissioner of Social Services is authorized to do all things necessary to apply for, qualify for and accept any federal funds made available or allotted under any federal act for social service development, or any other projects, programs or activities which may be established by federal law, for any of the purposes or activities related thereto, and said commissioner shall administer any such funds allotted to the department in accordance with federal law."

7. In Connecticut, Medicaid, CHIP and other medical assistance programs are collectively called "HUSKY Health" or simply "HUSKY." HUSKY provides comprehensive health care coverage to State residents, including preventative care, inpatient and outpatient services, behavioral health services and many other health care services. DSS is Connecticut's Medicaid authority and functions as one of the largest providers of health coverage in Connecticut. It is a leader in ensuring Connecticut residents have access to high-quality, affordable health care,

and it is committed to whole-person care, integrating physical and behavioral health services for better results and healthier communities in Connecticut. DSS provides health care for over one million state residents annually through HUSKY.

8. For example, as of 2024, DSS administered Medicaid-funded coverage for more than 380,000 children annually in Connecticut, and CHIP-funded coverage for approximately 39,000 children in Connecticut. DSS estimates that coverage on a per-child basis costs approximately $3,850 per year on average. For this coverage, Connecticut expended approximately $1,450,000,000 and received $744,000,000 in reimbursement from the federal government under Medicaid and CHIP.

The Federal Poverty Guidelines

9. The federal poverty guidelines are used by federal, state, local, and tribal agencies in numerous ways, including to assess eligibility for certain means tested programs.

10. HHS maintains the federal poverty guidelines and updates them annually.

11. Connecticut relies on the federal poverty guidelines to determine eligibility for a multitude of means-tested benefits, including: (i) HUSKY Health and CHIP; (ii) the Covered Connecticut program established pursuant to section 19a-754c of the Connecticut General Statutes; (iii) TANF; (iv) SNAP; (v) LIHEAP; (vi) CSBG; (vii) SSBG; and (viii) the Medicare Savings Programs (MSP), which collectively serve over one million Connecticut residents annually.

12. Connecticut further relies on the federal poverty guidelines to establish benefit amounts and duration within programs, including for SNAP, LIHEAP, MSP, and certain TANF-funded programs.

Harm from Delay or Failure to Maintain the Federal Poverty Guidelines

13. Any delay in issuing, failure to issue, or inaccuracy in the federal poverty guidelines would have immediate harmful consequences for Connecticut.

14. For example, Connecticut would no longer have timely and accurate guidelines for the calculation of eligibility for or level of the benefits referred to in paragraphs 11 and 12, above. This would cause harm in the form of uncertainty for state officials and benefits recipients regarding eligibility. It would also harm Connecticut by placing a burden on state officials, who would have to expend resources fielding questions regarding the applicable guidelines and/or calculating their own replacement guidelines. It would also harm Connecticut by increasing the administrative burden that would arise if different states were to use different applicable guidelines levels, as well as increased costs to modify computer system functions that are currently linked to routinely and timely updated federal poverty guidelines.

15. Connecticut residents would be at risk of receiving less federal benefits than they are entitled to if overall program eligibility level and client-specific benefit amounts cannot be promptly ascertained due to outdated federal poverty guideline data. Connecticut residents would suffer from the calculation of public assistance benefits under data points that have not properly been updated to reflect the actual cost of living, therefore leaving them with reduced benefits despite a higher cost of living. Connecticut residents with incomes close to eligibility thresholds could lose benefits entirely if an increase in income, such as a routine annual increase in Social Security benefits, puts them over program income thresholds based on federal poverty guidelines that are no longer updated at regular and predictable intervals that are parallel to other cost-of-living and inflationary adjustments, such as those used to update Social Security benefit amounts.

Peter Hadler

Digitally signed by Peter Hadler
DN: cn=Peter Hadler, o=DSS, ou=Deputy Commissioner, email=peter.hadler@ct.gov, c=US
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PETER HADLER
DEPUTY COMMISSIONER
CONNECTICUT DEPARTMENT OF SOCIAL SERVICES

Date: May 7, 2025

EXHIBIT 43

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF RHODE ISLAND

STATE OF NEW YORK, et al.

Plaintiffs,

v.

ROBERT F. KENNEDY, JR., in his official capacity as SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,

Defendants.

Case No. _____

DECLARATION OF LISA A. SCHIEFFERT

I, Lisa A. Schieffert, declare:

1. I am the Deputy Cabinet Secretary of Delaware Department of Health and Social Services (DHSS). I am familiar with the information in the statements set forth below either through personal knowledge, in consultation with the Division of Social Services (DSS) staff, or from documents that have been provided to and reviewed by me.

2. I submit this Declaration in support of the States' Motion for a Preliminary Injunction.

3. As DHSS' Deputy Cabinet Secretary, I am responsible for managing and overseeing the Division of Social Services, Division for the Visually Impaired, and Division of Child Support Services as well as supporting the Cabinet Secretary in implementing the Governor's polies and priorities. DHSS has over 4,000 full-time employees and total budget/spending authority for over $5 billion

4. DHSS' statutory mission is to improve the quality of life for Delaware's citizens by promoting health and well-being, fostering self-sufficiency, and protecting vulnerable populations, including administering certain means tested programs.

5. DHSS administers certain means tested programs at nineteen (19) State Service Centers, located throughout Delaware, to provide food, medical care, subsidized childcare, cash assistance and emergency housing services. Collectively, these programs serve as the safety net for individuals and families who need supportive assistance as they move from crisis toward self-sufficiency.

The Federal Poverty Guidelines

6. The federal poverty guidelines are used by federal, state, local, and tribal agencies in numerous ways, including to assess eligibility for certain means tested programs.

7. The U.S. Department of Health and Human Services (HHS) maintains the federal poverty guidelines and updates them annually.

8. Delaware relies on the federal poverty guidelines to determine eligibility for means-tested benefits, including the Supplemental Nutrition Assistance Program (SNAP), Medicaid, Subsidized Child Care, Emergency Housing Assistance, Temporary Assistance for Needy Families (TANF), Community Services Block Grant services (CSBG), the Women, Infant and Children's Program (WIC), Refugee Cash Assistance, and Refugee Medical Assistance, which collectively serve 368,393 Delawareans.

Harm from Delay or Failure to Maintain the Federal Poverty Guidelines

9. Any delay in issuing the federal poverty guidelines or inaccuracy in or failure to do so would have catastrophic consequences for Delaware.

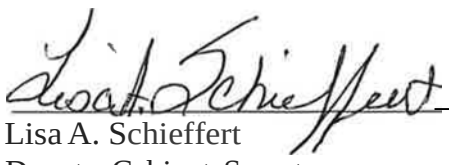
10. For example, Delaware would no longer have timely and accurate guidelines for the calculation of the following means-tested programs: SNAP, Medicaid, Subsidized Child Care, Emergency Housing Assistance, TANF, CSBG, WIC, Refugee Cash Assistance, and Refugee Medical Assistance. This causes harm in the form of uncertainty for state officials and benefits recipients regarding eligibility. It would also harm Delaware by placing a burden on state officials, who would have to expend resources fielding questions regarding the applicable guidelines and/or calculating their own replacement guidelines. It would also harm Delaware by increasing the administrative burden that would arise if different states were to use different applicable guidelines levels.

11. Furthermore, inequities in benefit determinations could be created if state and federal government agencies set their own federal poverty guidelines.

12. Without revising the 2025 federal poverty guidelines standard next year, thousands of low-income Delawareans could be at risk of losing benefits that are critical to obtaining and maintaining self-sufficiency.

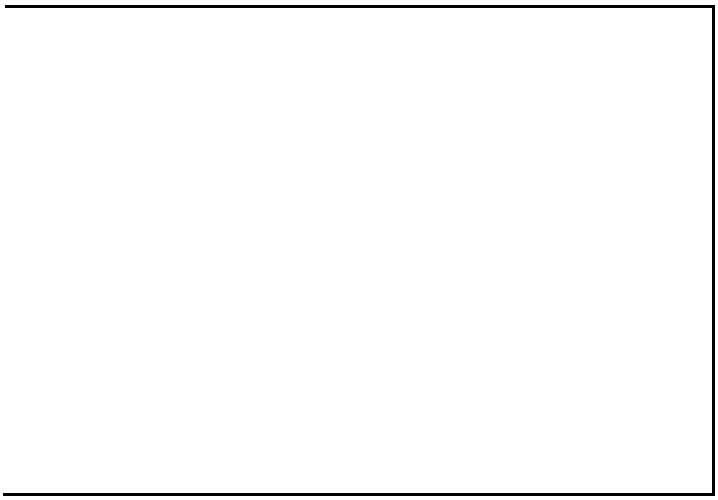
13. I declare under penalty of perjury that, to the best of my knowledge, the foregoing is true and correct.

Executed on May 6, 2025, at New Castle, DE.



Lisa A. Schieffert
Deputy Cabinet Secretary
Delaware Department of Health and Social Services

EXHIBIT 44



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Sarah Adelman

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April 7, 2025

EXHIBIT 45

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF RHODE ISLAND

STATE OF NEW YORK, et al. Plaintiffs, v. ROBERT F. KENNEDY, JR., in his official capacity as SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., Defendants.	Case No. 1:25-cv-00196

DECLARATION OF BRICE MONTGOMERY

I, Brice Montgomery, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the foregoing is true and correct:

1. I am the Director of the Community Services Division of the Washington State Department of Social and Health Services, an agency of the state of Washington. I am familiar with the information in the statements set forth below either through personal knowledge, in consultation with Community Services Division staff, or from documents that have been provided to and reviewed by me.

2. I submit this Declaration in support of the States' Motion for a Preliminary Injunction.

Professional Background

3. I am the Director of the Community Services Division, having served in this capacity for approximately one year. For the prior two years I was the Senior Policy and Government Affairs Advisor for the Economic Services Administration, the parent organization to the Community Services Division. I was a Special Assistant with the Economic Services

Administration from October 2018 through April 2022. I am proud to have served in various capacities with the Economic Services Administration for more than thirty-one years. I earned a Master of Public Administration from the University of Southern California in 1992 and a Bachelor of Arts from the University of Washington in 1988.

4. The Community Services Division mission: We partner with people to access support, care, and resources.

5. The Community Services Division provides direct client services to the public through a network of forty-eight local Community Services Offices. Services are also provided through a variety of out-stationed staff in different communities, eight fully self-contained and equipped mobile offices which consist of two 40-foot trucks and six smaller 28-foot trucks, and a single statewide Customer Service Contact Center. The Community Services Division helps low-income people meet their basic needs and achieve economic independence through cash grants, food and medical assistance as well as employment-focused services. Major programs include Temporary Assistance for Needy Families cash assistance and WorkFirst (Washington's Welfare to Work program); Basic Food assistance (Washington's Supplemental Nutrition Assistance Program); Aged, Blind or Disabled cash assistance; Pregnant Women's Assistance; Refugee Cash Assistance; and medical assistance.

The Federal Poverty Guidelines

6. The federal poverty guidelines are used by federal, state, local, and tribal agencies in numerous ways, including to assess eligibility for certain means tested programs.

7. The U.S. Department of Health and Human Services (HHS) maintains the federal poverty guidelines and updates them annually.

8. Washington relies on the federal poverty guidelines to determine eligibility for means-tested benefits, including Basic Food, Washington's name for the combination of federally-funded Supplemental Nutrition Assistance Program and the state-funded Food Assistance Program for legal immigrants, which collectively serve over 1.2 million residents each year.

9. All of the Medicare Savings Programs the Community Services Division administers have a federal poverty level based income limit. Any delay, inaccuracy or failure to implement issuance of updated federal poverty guidelines would impact the Community Services Division's ability to make timely and accurate eligibility determinations. Medicare Savings Programs served nearly 246,000 individuals in state fiscal year 2024.

Harm from Delay or Failure to Maintain the Federal Poverty Guidelines

10. Any delay in issuing the federal poverty guidelines or inaccuracy in or failure to do so would have catastrophic consequences for Washington. The Community Services Division relies on accurate and timely availability of the federal poverty level to make eligibility determinations for low-income customers.

11. For example, Washington would no longer have timely and accurate guidelines to determine eligibility for Basic Food. This causes harm in the form of uncertainty for state officials and benefits recipients regarding eligibility. It would also harm Washington by placing a burden on state officials, who would have to expend resources fielding questions regarding the applicable guidelines and/or calculating their own replacement guidelines. It would further harm Washington by increasing the administrative burden that would arise if different states were to use different applicable guidelines levels. If federal regulators disagree with the State's calculations resulting in

financial penalties or the disallowance of funds, it would be harmful to the State and benefit recipients subject to over or underpayments.

12. Medicare Saving Programs: Low-income Washingtonians who are entitled to Medicare may have their ability to pay Medicare premiums, co-payments, and deductibles. This could result in a financial burden for households who are already struggling to make ends meet.

13. In addition, the Division of Child Support prosecuting attorneys' offices, individuals, attorneys, administrative law judges, and superior court commissioners and judges use the federal poverty guidelines as a basis for a low-income limitation when calculating support using the child support guidelines in RCW 26.19. Under RCW 26.19.065(2), the self-support reserve is based on 125% of the federal poverty guideline for one person. As of January 16, 2025, the self-support reserve is $1,630 per month, which is 125% of the one-person federal poverty guideline published by HHS on that date. The basic support obligation of the paying parent shall not reduce their net income below that amount.

14. If HHS does not adjust the federal poverty guidelines, the self-support reserve will remain static. As wages and prices increase over time due to inflation, fewer individuals will have income below the federal poverty guidelines meaning fewer child support obligations will be adjusted because of the self-support reserve. Those that are adjusted will see a smaller reduction. The longer we go without an adjustment to the self-support reserve, the more misaligned Division of Child Support predicts it will become in comparison to the actual needs of families near poverty.

15. I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Brice Montgomery

Date: May 7, 2025

EXHIBIT 46

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF RHODE ISLAND

STATE OF NEW YORK, et al. Plaintiffs, v. ROBERT F. KENNEDY, JR., in his official capacity as SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., Defendants.	Case No. 1:25-cv-00196

DECLARATION OF JOHN DOE 1

I, John Doe, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the foregoing is true and correct:

1. I was employed by the Division of Environmental Health Science and Practice (DEHSP), part of the National Center for Environmental Health (NCEH) within the Centers for Disease Control and Prevention (CDC). I have personal knowledge of the facts set forth in this declaration, and if required to testify, would and could competently do so.

2. I am submitting this declaration pseudonymously because I fear retaliation. But if the Court would like to know my name or job position, I would be willing to provide it ex parte and under seal.

3. I submit this Declaration in support of the States' Motion for a Preliminary Injunction.

Professional Background

4. I have worked in public health for over two decades. I understand how environmental health is done in public health departments at the local, state, and federal levels.

In brief, when an environmental health professional needs assistance or support for any of their work at the local level then they rely on their state to support them. When a very large city or the state environmental health program in their public health department needs assistance and support then they rely on us at the CDC to support them. That federal support stopped on April 1, 2025. All of the environmental health programs in public health departments across the country are on their own now without any support from their former key partners within DEHSP in the National Center for Environmental Health at the CDC.

5. I am providing this declaration to explain the impacts of the reductions in force (RIFs) of April 1, 2025, on the operations of DEHSP. The April 1 RIFs have brought DEHSP's work to a halt and interrupted the deployment of DEHSP staff to jurisdictions facing acute environmental health crises. All of our programs and all of our work focused on supporting environmental health programs in health departments across the country are gone. These are listed on our website here: About Division of Environmental Health Science and Practice | NCEH | CDC (available here: https://perma.cc/9GSH-8X47). Again, none of these activities, programs, or branches listed on our website are active because DEHSP was effectively abolished on April1, 2025. These impacts will continue to be felt by the states as well as by their residents, as DEHSP will no longer be able to support state, territorial, local, and tribal (STLT) partners in responding to events that threaten public health from hazards in the environment including lead contamination, water pollution, hurricanes, heat waves, wildfires, and more.

DEHSP's Mission and Work Prior to April 1, 2025

6. Environmental health professionals are the second most common profession in public health at the local levels. They are the foundation to our public health infrastructure ensuring that our local food, water, air, and places where we live, learn, work, and play are safe

and healthy. They are the reason why Americans don't fear drinking from a water fountain in a county park, swimming in a city pool, eating at a restaurant or at a farmers' market. They are the reason why we don't fear for the health of our families when we send our children off to school or daycare, our parents into nursing homes, or ourselves when we exercise in the gym, go to the spa, or get a tattoo. Environmental health professionals across the country use primary prevention to protect the public from health hazards in these environments and enable the freedoms that we have in America to live, work and play freely. This public health infrastructure, which is empowered by the inspections and permitting of local environmental public health officials across the country, enables our economy to thrive because our people are healthy and safe from the public health hazards which plagued our nation prior to the public health and sanitation movements of the early and mid-1900s. These freedoms from disease hazards in our environment still don't exist in some other countries around the world. That is why we remain vigilant regarding the reintroduction of such disease hazards in our environment from others coming into America. DEHSP is established to support this entire environmental public health infrastructure through their dedicated support of environmental health programs at all levels of government. DEHSP has stood at the ready to provide the needed environmental health expertise required for outbreaks of disease, natural disasters, and other public health crises from hazards in the environment. In doing so, DEHSP prevents exposures to environmental health hazards to improve health in all communities through applied environmental public health science and practice. No other public health unit at CDC or HHS has this focus on supporting environmental health programs across the country; our work is not duplicated anywhere else, and our experts and expertise are unique. DEHSP's mission is supported by surveillance, epidemiology, technical assistance, training, and preparedness activities. The Division provides critical environmental

health support and funding for environmental health departments and other partners with similar missions. Our nation's environmental health programs at all levels of government rely on the premier expertise and experience of the staff in DEHSP. These experts in DEHSP are called upon by our environmental health programs across the country when no one else can help them with the challenges that they face. All of that support, expertise, and experience is now gone because DEHSP was abolished on April 1, 2025, when all of the civilian staff were subjected to the RIF. Our environmental health professionals across the country do not have any premier environmental public health professionals to call now at the CDC to help them. Our states, territories and tribes are on their own now to manage all of their environmental public health challenges and crises.

7. NCEH contains two divisions: DEHSP and the Division of Laboratory Sciences. DEHSP handles the non-laboratory work of the NCEH with a focus on supporting state, territorial, local, and tribal environmental public health programs and departments. There is no overlap with the Division of Laboratory Sciences.

DEHSP Core functions and structure

8. DEHSP is organized into five branches and one activity. These include all of the national public health programs supporting the environmental health work in STLT health departments and other allied partners: childhood asthma, childhood lead poisoning prevention, public health impacts from our changing climate, environmental health data tracking, safe food, safe water, general environmental public health services, natural hazards and public health, cancer clusters, disaster epidemiology, environmental epidemiology, public health impacts of radiation, chemical weapons demilitarization, medical toxicology and poisoning surveillance, and more. Our cruise ship program supports public health in port communities across the

country. These are the core functions of DEHSP. Most states and large cities lack the resources to support complementary specialized environmental public health expertise locally within their jurisdictions. That is why the nation depends on the expertise and experts in DEHSP.

9. DEHSP Disaster Epidemiology teams deploy to the sites of environmental health crises to assist state, territorial, local, and tribal health departments in their response. For example, in recent years Disaster Epidemiology teams have been deployed to Los Angeles, California and Maui, Hawai‘i to respond to the public health effects of wildfires, and Maricopa County, Arizona to assist with ongoing heat waves and cooling center efforts. We also supported communities responding to disaster remotely in other ways.

10. DEHSP’s Lead Poisoning Prevention and Surveillance Branch provides support for managing ongoing lead crises, including through the congressionally mandated Childhood Lead Poisoning Prevention Program. The program strengthens blood lead testing, reporting, and surveillance. DEHSP also supports state and local health departments in population-based interventions and connecting lead-exposed children to services. Moreover, DEHSP manages the poison control center reporting exposure to lead contaminated products.

11. DEHSP’s Radiation Studies Section sets guidelines for preventing and responding to radiological threats to public health. These guidelines help make nuclear and radiological resources safe for consumers.

12. DEHSP is also responsible for the congressionally mandated Asthma Control Program, which focuses of reducing the number of deaths, hospitalizations, emergency department visits, school or workdays missed, and limitations on activity due to asthma. The Asthma Control Program funds state and local health departments to ensure access to asthma treatment for individuals and has led to improvements in disease outcomes and quality of care,

and fostered policies to reduce exposure to environmental facts contributing to asthma, including air pollution.

13. DEHSP's Environmental Public Health Tracking Network collects, analyzes, and disseminates data on threats to public health from non-infectious disease, environmental risk factors, and socio-economic factors. This data is collected and shared with state, territorial, local, and tribal partners.

14. DEHSP's Vessel Sanitation Programs helps the cruise ship industry prevent and control the spread of illness on cruises, protecting both passengers and cruise ship workers. Through this program, DEHSP inspects cruise ships, monitors illness data, reviews ship design, and trains cruise ship leaders and staff on public health practices.

15. DEHSP also provides support for state, territorial, local, and tribal health departments conducting investigations into unusual patterns of cancers potentially caused by environmental health factors.

16. DEHSP's work is authorized by Congress. Its work regarding lead contamination, asthma, emerging environmental hazards and health effects, climate and health, food safety, data tracking, public health concerns from radiation, and environmental public health disasters are authorized primarily under the Public Health Service Act. There is special legislation empowering the work of the vessel sanitation, cancer clusters, and chemical weapons demilitarization programs.

17. Much of DEHSP's work is conducted through cooperative agreements with STLT partners. Unlike grants, under a cooperative agreement CDC is required to make staff available to work cooperatively with partner entities, including by answering questions, providing technical assistance, and actively managing the funds. DEHSP manages the Environmental

Health Capacity funding mechanism for CDC, the only funding mechanism specifically dedicated to supporting the broadly required capabilities in environmental health programs within health departments nationwide. The focused funding opportunities for childhood asthma, lead poisoning prevention, environmental public health data tracking, and climate and health are unique and not replicated elsewhere in CDC or HHS.

18. DEHSP works closely with the Agency for Toxic Substances and Disease Registry (ATSDR), a separate operating division of the Department of Health and Human Services (HHS). ATSDR is not mandated to provide comprehensive environmental health support to state, territorial, local, and tribal health departments as DEHSP does. ATSDR's mission is complementary to DEHSP but very different with a specific focus on supporting communities exposed to toxic contamination in their local environment. ATSDR is empowered through the CERCLA legislation. That legislation is not designed to support the core functions of environmental health departments in public health agencies across the USA unlike the core funding and mission of DEHSP. Although jointly administered with the NCEH in the CDC, there is no programmatic overlap between DEHSP and ATSDR.

DEHSP emergency preparedness and response functions

19. CDC is the lead agency within HHS for any public health emergency, crisis, outbreak, epidemic, or disaster of national significance. Within the CDC, different Centers are delegated specific preparedness and response functions. NCEH has been designated to lead the response to any natural disaster, chemical terrorist event (e.g. sarin attack in Tokyo), radiological or nuclear event (e.g. Three Mile Island or Fukushima), or explosion (e.g. Beirut or Iran port explosions). Within NCEH, the bulk of the expertise needed to lead and staff a public health response for CDC is in DEHSP. All of the programs supporting this required expertise in DEHSP

is now gone and the expertise lost. Therefore, NCEH will be unable to support a national public health response to any of these types of events right now. Going into the summer season, the lead programs and experts to support a public health response to natural disasters in DEHSP are gone. These are experts in disasters like catastrophic flooding, tornadoes, heat waves, wildfires and associate smoke events, hurricanes, and algal blooms. High consequence but lower probability events like chemical, nuclear, radiological, or explosive events will have insufficient specialized experts to support them. Due to the low probability for these events at the local level, STLT partners rarely staff their health departments with expertise like that within DEHSP. They rely on the expertise of DEHSP in events like these. Any nuclear event anywhere in the world would require a national public health response at CDC like we led during the Fukushima disaster. If there were an event at one of the nuclear power plants in Ukraine right now, like what was narrowly averted with the Zaporizhzhia nuclear power plant during the current war in Ukraine, then the US would be unable to support a public health response due to the loss of the expertise in DEHSP. The abolishment of DEHSP has put the public health of the USA at risk and vulnerable to natural and technological disasters.

The April 1, 2025, RIFs and Effects on DEHSP

20. On April 1, 2025, the remainder of our roughly 200 DEHSP employees—myself included—received RIF notices. We were placed on administrative leave until our expected termination on June 2. We have not been permitted to continue our work during this time.

21. The RIFs effectively shut down DEHSP. All but one civilian employee of DEHSP received a RIF notice. Only commissioned members of the Public Health Service remain employed in the Division and a few fellows employed through non-HHS mechanisms.

22. Prior to the April 1 RIFs, all of the Division's probationary employees were let go on February 14th. Since then some staff voluntarily chose to retire early due to the political uncertainty, accepted the deferred resignation program, or accepted the VERA/VSIP retirement option.

23. The contractors working with DEHSP have not been terminated yet. Their contracts run through the end of the fiscal year, but they are unable to adequately and efficiently carry out their work functions without DEHSP staff in place directing them.

The April 1 RIFs Have Eviscerated DEHSP's Work

24. The RIFs have effectively halted all of DEHSP's Congressionally funded work because there is insufficient PHS staff left in the Division to carry it out. This includes the Division's statutorily mandated functions. The Vessel Sanitation Program is funded by fees collected from the cruise industry and has sufficient PHS and NCEH support staff now assigned to support them to maintain the program currently.

25. A DEHSP Disaster Epidemiology team was traveling to North Carolina to support authorities there in responding to hurricane-related health threats when the RIF notices came through. The team was forced to turn around and was unable to provide support.

26. Milwaukee, Wisconsin is in the midst of a lead contamination crisis in its public schools. DEHSP had begun providing support to the state and local health departments for lead contamination response but was forced to withdraw that desperately needed support after the RIFs. Without DEHSP, public health officials responding to the crisis have been denied the expertise and experience of the federal government. That has placed public health at risk.

27. Moreover, without staff DEHSP does not stand ready to respond to the public health crises and challenges that will emerge in the coming months and years. For example,

extreme heat routinely leads to catastrophic harmful algae blooms requiring DEHSP's response (a concern in Florida in years past). Or, if a chemical emergency such as a Sarin attack, nuclear meltdown, or chemical explosion should occur in the near future, CDC would be unable to provide support to state, territorial, local, or tribal public health authorities without DEHSP staff in place.

Conclusion

28. The April 1, 2025 RIFs have incapacitated DEHSP. Thus, the Division's standard programmatic work to address lead contamination, asthma, safe water, emerging environmental hazards and health effects, food safety, data tracking, chemical demilitarization, and other environmental health threats, is not being completed. Nor can DEHSP respond to acute environmental health crises including natural and man-made disasters. Moreover, without DEHSP, no other agency within CDC or HHS will carry out DEHSP's function providing guidance and support to state, territorial, local, and tribal public health authorities in important matters of public health.

John Doe

John Doe

Date: May 7, 2025

EXHIBIT 47

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF RHODE ISLAND

DECLARATION OF OHN DOE 2

THROUGH: Wilma M. Robinson, Ph.D., Deputy Executive Secretary

FROM: Dorothy A. Fink, MD, Acting Secretary

DATE: January 21, 2025

SUBJECT: Immediate Pause on Issuing Documents and Public Communications – ACTION

As the new Administration considers its plan for managing the federal policy and public communications processes, it is important that the President's appointees and designees have the opportunity to review and approve any regulations, guidance documents, and other public documents and communications (including social media). Therefore, at the direction of the new Administration and consistent with precedent, I am directing that you immediately take the following steps through February 1, 2025:

1. Refrain from sending any document intended for publication to the Office of the Federal Register until it has been reviewed and approved by a Presidential appointee. Please note that the Office of the Executive Secretary (Exec Sec) withdrew from OFR all documents that had not been published in the Federal Register to allow for such review and approval.
2. Refrain from publicly issuing any document (e.g., regulation, guidance, notice, grant announcement) or communication (e.g., social media, websites, press releases, and communication using listservs) until it has been reviewed and approved by a Presidential appointee.
3. Refrain from participating in any public speaking engagement until the event and material have been reviewed and approved by a Presidential appointee.
4. Coordinate with Presidential appointees prior to issuing official correspondence to public officials (e.g., members of Congress, governors) or containing interpretations or statements of Department regulations or policy. Nothing in this guidance is intended to limit an employee's personal correspondence with members of Congress or other third parties, including an employee's whistleblower protected communications.
5. Notify Exec Sec promptly of any documents or communications that you believe should not be subject to the directives in paragraphs 1-4 because they are required by statute or litigation; affect critical health, safety, environmental, financial, or national security functions of the Department; or for some other reason. Please provide the title, a brief summary, the target release date, and the rationale for expedited release to your Exec Sec Policy Coordinator.

The President's appointees intend to review documents and communications expeditiously and return to a more regular process as soon as possible.

FROM: Tom Nagy, Chief Human Capital Officer

SUBJECT: Specific Notice of Reduction in Force

In accordance with President Donald Trump's Executive Order 14210, dated February 11, 2025, and the Department of Health and Human Services' (HHS) broader reorganization strategy to improve its efficiency and effectiveness to make America healthier, HHS is executing a Reduction in Force (RIF). This memorandum constitutes a specific notice of a RIF.

I regret to inform you that you are being affected by a RIF action. This RIF is necessary to reshape the workforce of HHS.

Colleagues:

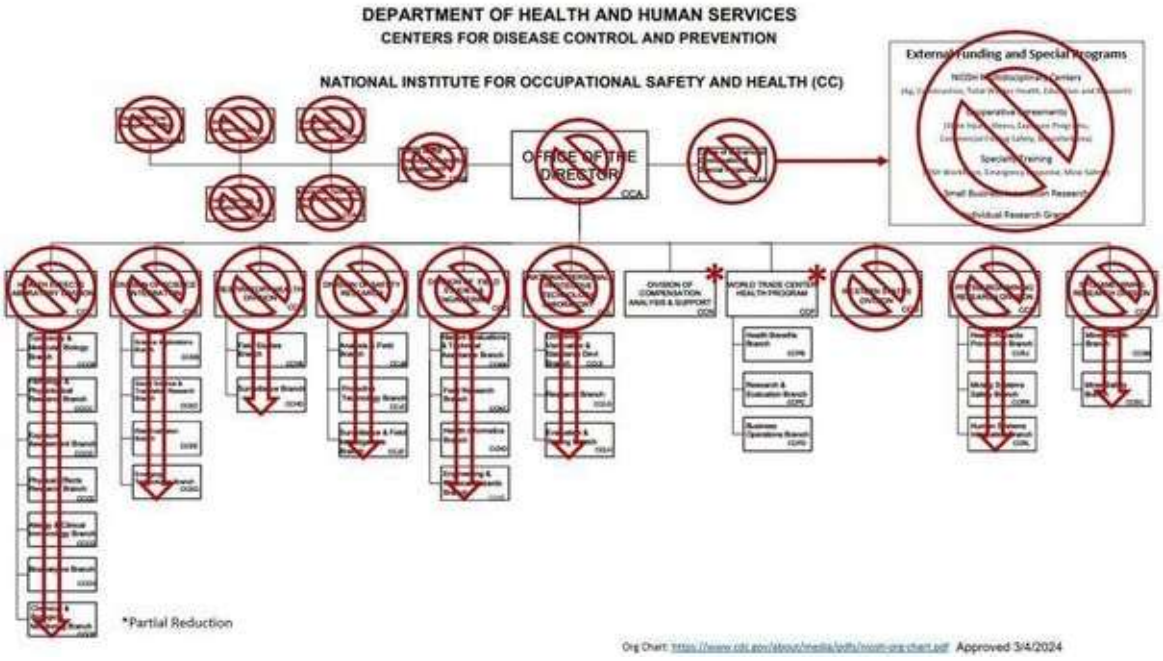
I want each of you to know that your work is valued, not only within our Institute, but across the Nation. I also want to acknowledge that the past few months have been challenging and frustrating as we have seen a significant amount of NIOSH's work be impacted by reductions in our staff and recent Reduction in Force (RIF) notices sent out on April 1st. The significant number of RIF notices sent to staff, including myself, across NIOSH and CDC has created confusion and gaps in information that we are continuing to try to fill. These challenges have resulted in limited communication during a time when I know many are seeking guidance and answers.

In the last four weeks, we have seen a significant number of our partners speak up about the impact NIOSH research and service programs has had in improving and protecting the health and safety of all workers. The work you have done throughout your time at NIOSH has had lasting and meaningful impact in the lives of everyday workers.

We are still uncertain about what the future holds. This week we saw some NIOSH staff be brought back from administrative leave to continue their work. Currently, this is a temporary arrangement to help complete our obligations within these programs. Additionally, we are continuing to work with CDC to understand how to transfer and archive NIOSH's significant body of work so that it continues to be available to other researchers and our partners in the occupational safety and health community. For those programs who will be moving to the Administration for a Healthy America (AHA), we are also working with HHS to understand how that transition will occur.

While I cannot say what the future will be, I can say that it is my honor and privilege to work beside so many talented and dedicated individuals. You are each shining examples of what it means to be public servants.

JH


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION
NATIONAL INSTITUTE FOR OCCUPATIONAL SAFETY AND HEALTH (CC)
OFFICE OF THE DIRECTOR
CCA
External Funding and Special Programs
*Partial Reduction
Org Chart: https://www.cdc.gov/about/media/pdfs/niosh-org-chart.pdf Approved 3/4/2024

JOHN DOE 2

EXHIBIT 48

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF RHODE ISLAND

STATE OF NEW YORK, et al. Plaintiffs, v. ROBERT F. KENNEDY, JR., in his official capacity as SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., Defendants.	Case No. 1:25-cv-00196

DECLARATION OF SARA GAGNÉ-HOLMES

I, Sara Gagné-Holmes, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the foregoing is true and correct:

1. I am currently employed by the State of Maine Department of Health and Human Services "Maine DHHS" as its Commissioner. I am familiar with the information in the statements set forth below either through personal knowledge, in consultation with Maine DHHS staff, or from documents that have been provided to and reviewed by me.

2. I submit this Declaration in support of the States' Motion for a Preliminary Injunction.

Professional Background

3. I am the Commissioner of Maine DHHS and have maintained this role since October 15, 2024. I served in an acting Commissioner capacity for Maine DHHS since June 1, 2024. Before this role, I served as the Deputy Commissioner for Maine DHHS for five years from 2019 to 2024.

4. Maine DHHS's mission, as articulated by statute in Title 22-A M.R.S. § 202(1), is to provide health and human services to the people of Maine so that all persons may achieve and maintain their optimal level of health and their full potential for economic independence and personal development. Within available funds, Maine DHHS is charged with endeavoring to assist Maine individuals in meeting their needs and families in providing for the developmental, health and safety needs of their children, while respecting the rights and preferences of the individual or family. Maine statute directs Maine DHHS, in the performance of its mission, to use relevant, meaningful data and objective analyses of population-based needs in program planning, decision making and quality assurance, as a guiding principle under Maine statute at 22-A M.R.S. § 202 (2)(F).

5. Maine DHHS is located at its central office in Augusta, Maine, with other offices throughout Maine in Biddeford, Calais, Caribou, Ellsworth, Farmington, Fort Kent, Houlton, Machias, Presque Isle, Rockland, South Paris, Lewiston, Sanford, Portland, and Bangor.

6. I am providing this declaration to explain the impacts on Maine of the cuts to U.S. Health and Human Services (HHS), including cuts to U.S. Centers for Disease Control and Prevention (CDC), the Federal Drug Administration (FDA), and Substance Abuse and Mental Health Services Administration (SAMHSA).

Reliance on HHS Data and Technical Expertise

7. Prior to April 1, 2025, Maine DHHS relied on HHS to provide accurate and up-to-date data that is critical to the operation of numerous programs supporting the health and wellness of people of the State of Maine. Additionally, Maine DHHS relied upon HHS technical expertise to access data systems, as well as to provide educational materials, guidance, and assistance in health prevention and control efforts.

8. Maine DHHS relied on CDC for its assistance in maternal mortality review committees and other efforts to eliminate maternal mortality with funding from the Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE-MM) grant.

9. Maine DHHS relied on CDC for data relating to the health and well-being of pregnant people and babies, including the Pregnancy Risk Assessment Monitoring System (PRAMS). As our only population-based surveillance survey of maternal experiences around the time of pregnancy, PRAMS is an essential component of the public health system, both nationally and in Maine. Almost all states participate in PRAMS, which covers about 81% of births in the United States. Maine was one of the first states in the country to participate in PRAMS when it started to collect data in 1987. Data collected by PRAMS is used by public health officials, researchers, and community organizations to help identify health disparities, identify public health priorities, monitor population health and changes in health status, and measure progress towards improving the health of birthing people and infants. As an example, from 2015-2017, Maine's infant mortality rate was the highest of all New England states and Sudden Infant Death Syndrome/Sudden Unexplained Infant Death (SIDS/SUID) was the third leading cause of infant death in Maine. SIDS/SUID is largely preventable with safe sleep practices. PRAMS data on infant sleep practices was used to initiate a multi-tiered Safe Sleep Campaign that resulted in all of Maine's birthing hospitals becoming Safe-Sleep Certified and more Maine parents reporting safe sleep practices. As the primary source of safe sleep data, PRAMS is essential to monitoring ongoing progress towards reducing sleep-related infant deaths in Maine. Without CDC staff, since April of 2025, Maine DHHS has been unable to access 2024 PRAMS data it submitted to the CDC or the associated data management system, and is,

therefore, unable to continue data collection efforts for 2025 due to the lack of a validated data collection instrument.

10. Maine DHHS relied on CDC and FDA for their assistance in tobacco prevention and control, including funding for the State Tobacco Activities Tracking and Evaluation Maine System, and provision of resources for Maine's tobacco quitline. These agencies provided Maine with access to tailored subject matter expertise and consultation, the opportunity to collaborate and consult with other professionals, a clearinghouse of cost-effective media assets in the Media Campaign Resources Center (MCRC), evaluation and surveillance guidance, access to free or low-cost trainings, pertinent information, best practices, emerging trends, quitline data, and funding opportunities. Maine DHHS relied on the access to partners and contacts who could provide specific guidance and knowledge in various areas of tobacco prevention control including policy and legislation, surveillance and evaluation, tobacco use trends, tobacco treatment (cessation) resources, nicotine replacement therapies, subject matter experts, and who provided Maine DHHS with updates in evidence and data.

11. Maine DHHS relied on CDC for its assistance in preventing HIV/AIDS, viral hepatitis, sexually transmitted infections (STIs), and tuberculosis, as well as assistance with viral hepatitis surveillance and analysis, outbreak detection and response, and in developing strategies to increase impact in prevention, care, and treatment. Maine DHHS relied on Federal CDC for Tuberculosis education and clinical support.

12. Maine DHHS relied on CDC for its assistance in obtaining nationally consistent guidance on best practices for childhood lead poisoning and prevention practices, case management practices, blood lead testing and poisoning surveillance measures, education and outreach materials and tools, the derivation of blood lead reference values, and program funding

support. Maine DHHS also relied on CDC for its assistance in investigating lead poisoning associated with novel emerging exposure sources, such as the recent applesauce contamination situation, and with blood testing device recalls.

13. Maine DHHS relied on SAMHSA for regularly updated data about drug use. Maine DHHS relied on national data collected, analyzed, and reported by SAMHSA, which has now been removed. The National Survey on Drug Use and Health (NSDUH) provided Maine DHHS with data in critical areas, including substance use disorders, substance use treatment, recovery, and suicidality. Maine DHHS uses this data for several reporting obligations, including, but not limited to, reporting associated with its Mental Health Block Grant, Substance Abuse Prevention and Treatment Block Grant, State Opioid Response Grant, and Certified Community Behavioral Health Centers Grant. In addition to federal reporting, Maine DHHS also uses data from the NSDUH survey to contextualize its analyses. Substance use prevalence data from NSDUH is a critical data point in Maine DHHS' evaluation of overdose death, substance use disorder programming, and gaps in substance use disorder treatment access. Without this information, Maine DHHS can no longer calibrate its performance measures, compare its progress to other states or jurisdictions, nor can it complete key modeling required for analyses such as naloxone saturation estimation.

Changes in HHS Data and Technical Assistance Since April 1, 2025

14. Since April 1, 2025, Maine DHHS experienced several, significant changes to its data landscape and partnerships with HHS as a result of HHS terminations and reorganizations.

15. Since April 1, 2025, Maine DHHS has experienced harm relating to CDC's role in maternal mortality review committees and other efforts to eliminate maternal mortality related to reduction in force for technical assistance and paused national activities. Maine DHHS has

submitted plans for the second year of the five-year ERASE-MM grant. The second year of the grant is scheduled to begin September 30, 2025, and includes funding for the continuation of the work of three contracted staff and the operations of the maternal mortality review committees. Terminations of CDC staff jeopardizes Maine DHHS' ability to receive approval for a continuation of this grant funding, which is critical to supporting Maine DHHS' efforts to eliminate maternal mortality. Moreover, a lack of funding as outlined in the proposed federal budget, essential to the continuation of CDC's work, would amount to a cessation of this program and, by virtue, harming Maine DHHS' ability to continue this critical work.

16. Since April 1, 2025, Maine DHHS has experienced harm relating to CDC data regarding the health and well-being of pregnant people and babies, including the PRAMS. Without CDC staff, Maine DHHS is unable to access 2024 PRAMS data it submitted to the CDC. Additionally, Maine DHHS is unable to continue data collection efforts for 2025 due to a lack of CDC staff support, including access to their data management system which is used to carry out survey operations.

17. Since April 1, 2025, Maine DHHS has experienced harm relating to CDC and FDA's role in tobacco prevention and control. With a loss of CDC and FDA staff and technical expertise, Maine DHHS has lost resources and educational material to support the State of Maine's tobacco quitline, and critical grant funding including funding to support Maine's Tobacco Activities Tracking and Evaluation System quitline. The typical annual Notice of Award for a multi-year grant to support this work, which should have occurred in April, did not. This lack of funding, alongside federal efforts to defund programs supporting this work, jeopardizes Maine DHHS' ability to continue its tobacco prevention and control efforts. Without CDC and

FDA staff, Maine DHHS is not able to gain insight on next steps for these programs, harming Maine DHHS' ability to effectively plan for future work.

18. Since April 1, 2025, Maine has experienced harm relating to CDC's role in preventing HIV/AIDS, viral hepatitis, STIs, and tuberculosis, including limited access to technical guidance; loss of federal laboratory capacity related to STIs and viral hepatitis; and missed opportunities to apply expertise in prevention, care, and treatment due to reductions in force. Additionally, changes to data reporting requirements will inhibit the State's ability to make national comparisons for disease prevention, care, and treatment. Viral hepatitis had a fifty percent reduction in funding for special projects that Maine DHHS allocates for harm reduction services, such as testing and navigation services at syringe service programs. HHS support for Tuberculosis education has been cut which inhibits our ability to provide updates and complete information to providers and the public. The CDC's elimination of Tuberculosis education limits Maine DHHS' opportunities for training, its ability to get current information for staff, and its ability to support a clinical response.

19. Since April 1, 2025, Maine DHHS has experienced harm relating to the elimination of the Office of the Assistant Secretary for Planning and Evaluation. The Ryan White Program utilizes the Federal Poverty Level to determine Program Eligibility. Without the federal role within the Office of the Assistant Secretary for Planning and Evaluation to determine the federal poverty levels on an annual basis, Maine DHHS is not able to accurately calculate and complete its evaluation of program eligibility.

20. Since April 1, 2025, Maine DHHS has experienced harm relating to CDC's role in providing guidance and outreach materials on blood lead testing. Specifically, on April 24, 2025, the U.S. Food and Drug Administration (FDA) alerted health care providers and laboratory staff

of reports that falsely elevated (false positive) results have occurred when using a specific brand of capillary blood collection tubes with the LeadCare point of care testing device. Tests using this brand of collection tubes may overestimate blood lead levels and give inaccurate results. The FDA recommended that the brand of capillary collection tubes not be used with the LeadCare Testing Systems while this issue is being investigated. In Maine, more than half of all blood testing is performed using point of care LeadCare devices. Maine DHHS would rely on the CDC to provide messaging for communicating with health care providers on this issue and direction for appropriate state agency response. To date, there has been no response from CDC on this issue.

21. Since April 1, 2025, Maine DHHS has experienced harm relating to SAMHSA data about drug use. Data from NSDUH, is critical to Maine DHHS' ability to meet federal grant reporting requirements. Additionally, as it relates to Maine DHHS' ability to evaluate topics such as overdose death, substance use disorder programming, and gaps in substance use disorder treatment, without access to NSDUH data Maine DHHS' is unable to calibrate performance metrics, compare Maine's progress against other states and jurisdictions, or conduct key modeling. This results in harm to Maine DHHS' ability to best serve the people of Maine by limiting Maine DHHS' ability to use national data to effectively evaluate, plan for, and provide services.

Conclusion

22. The changes to HHS data and technical expertise described above have limited or removed Maine DHHS' access to mission-critical data and has left Maine DHHS without access to technical guidance upon which it has relied in order to successfully operate its programs and services support the health and welfare of the people of Maine. Additionally, a lack of federal

staff has resulted in delays, or a lack of funding, harming Maine DHHS' ability to plan for and continue to operate its programs to provide critical services to the people of Maine.

Sara Gagné-Holmes
Commissioner, State of Maine Department of Health and Human Services

Date: May 8, 2025

EXHIBIT 49

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF RHODE ISLAND

STATE OF NEW YORK, et al. Plaintiffs, v. ROBERT F. KENNEDY, JR., in his official capacity as SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., Defendants.	Case No. 25-cv-00196

DECLARATION OF ALYSSA CHATTERJEE

I, Alyssa Chatterjee, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the foregoing is true and correct:

1. I am the Early Learning System Director of the Oregon Department of Early Learning and Care (DELC). I am familiar with the information in the statements set forth below either through personal knowledge, in consultation with DELC staff, or from documents that have been provided to and reviewed by me.

2. I submit this Declaration in support of the States' Motion for a Preliminary Injunction.

Professional Background

3. I have been employed as the DELC Early System Learning Director since 2021. I have been employed in child care and early learning policy development and analysis since 2012. I have been in this position since DELC was established as a new agency in 2023. Prior to that I was employed with the Division of Early Learning in the Oregon Department of Education.

4. DELC is an executive agency of the State of Oregon established pursuant to ORS 329A.750. It is responsible for administering funds received by the State of Oregon pursuant to the federal Child Care and Development Block Grant Act of 2014, the Child Care and Development Fund and other federal child care funds and grants received by the State of Oregon.

5. DELC's mission is to unify and strengthen Oregon's early learning and child care system and foster coordinated, culturally appropriate, and family-centered services to meet the needs of children, families, and early learning and care professionals throughout the State of Oregon. DELC's programs include licensing childcare providers, administering Oregon's Employment Related Day Care program for families, and providing technical assistance and training for childcare programs, including Head Start sites.

The Head Start Program

6. The federal Head Start program, founded in 1965, promotes school readiness for children of low income families from birth to 5 years old. Head Start services support early learning and development, health, and family wellbeing.

7. Head Start is administered by the Office of Head Start (OHS) within the Administration for Children and Families (ACF) of the U.S. Department of Health and Human Services (HHS), with operational support primarily from employees working out of OHS Regional Offices. Oregon falls within OHS Region 10.

8. Head Start programs include Early Head Start (EHS) programs for infants, toddlers, and expectant families and Head Start preschool programs for primarily 3- and 4-year-old children. In addition, Head Start includes American Indian and Alaska Native (AIAN) Head Start programs and Migrant and Seasonal Head Start (MSHS) programs serving families working in agriculture.

9. Head Start provides vital services to low-income children and families. In addition to providing high quality child care and early childhood education, Head Start programs connect children and families to wrap around social services and supports. Head Start programs integrate state benefit programs to provide children with meals and snacks during the school day, as well as diapers for young children, enrollment assistance in health insurance plans, and supports for parents including connections to career services and adult education.

10. In Oregon, the Head Start program serves **4783** children and their families at 328 sites located in all of Oregon's 36 counties. The Early Head Start, American Indian and Alaska Native (AIAN) Head Start, and Migrant and Seasonal Head Start (MSHS) programs operating in Oregon serve an additional **2074** children and families at forty-five sites.

11. I am providing this declaration to explain the impacts on Oregon and DELC of the changes to Head Start, including a reduction in staffing, since April 1, 2025. These changes have created a situation whereby DELC must reactively and proactively build coordination and support systems for federal Head Start grantees and develop contingency plans for service continuity to buffer the loss of regional offices and maintain program quality. DELC does not have the funding or personnel with technical expertise to replace full federal program support.

Reliance on HHS Head Start Staff Prior to April 1, 2025

12. Prior to April 1, 2025, DELC regularly relied on OHS for grant oversight, training, technical assistance, monitoring, site visits, and other support to Oregon's Head Start and Oregon Prenatal to Kindergarten programs.

13. For example, OHS staff would routinely manage federal grants, monitor program compliance, and provide ongoing technical assistance to ensure that Head Start and Early Head Start grantees meet national standards. Regional staff serve as the primary liaison between the

federal Office of Head Start and local programs, overseeing quality, supporting improvement, and responding to local needs and emergencies.

14. DELC has 1 position funded by the federal Office of Head Start.

15. The OHS staff with whom DELC communicated and relied upon were primarily located in the Regional Office of Region 10 in Seattle, Washington.

Changes in HHS Head Start Operations Since April 1, 2025

16. Since April 1, 2025, DELC has seen significant changes to the operations of OHS's Head Start Program.

17. Specifically, Oregon's primary point of contact at OHS for managing Head Start grants, monitoring compliance, and supporting quality improvement is no longer available to be contacted and only twelve of twenty-four Head Start grantees in Oregon have been assigned a new OHS staff contact to fulfill the essential functions of support collaboration, coordination, and communication between OHS, DELC, and local Head Start program.

18. OHS advised DELC on April 3, 2025 that effective April 1, 2025 the Regional Office for Region 10 has closed.

19. On April 3, 2025, DELC and all Oregon Head Start Grantees received an email from Laurie Todd-Smith, Ph.D., Deputy Assistant Secretary for Early Childhood Development of ACF confirming the closure of 5 HHS Regional Offices effective April 1, 2025 and requesting that communications to HHS about Head Start be directed to the following email address: ohsrecipientsupport@acf.hhs.gov

Effect on State's Head Start Program

20. Oregon's federally funded Early Head Start and Head Start grantees have been significantly affected by the changes to the HHS Head Start Program described above.

21. HHS Head Start staff are no longer available to offer the same level of training, technical assistance, monitoring, site visits, and other support to Head Start programs.

22. Grantees are experiencing delays in funding and slower response time to inquiries. The delay and/or uncertainty of funding has made it necessary for some grantees to consider and/or implement reduced service delivery and/or consider potential closure of sites. The changes to the Head Start Program have placed a burden on DELC because there are fewer OHS Program staff available to field questions and inquiries from Head Start Programs. Those Programs are now contacting DELC frequently, placing a burden on DELC staff and resources, who are not funded or staffed to provide support for the federal program, which diverts resources away from other key state programs.

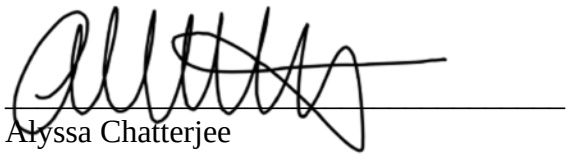
23. There is imminent risk that funding to Head Start programs in Oregon will be delayed because the HHS Head Start staffing cuts will impact HHS's ability to make timely payments to Head Start Programs, who do not operate with financial reserves to continue services. This will in turn harm Oregon because delayed Head Start funding can disrupt local program operations, leading to staff layoffs, reduced services, or temporary closures. This instability affects children by interrupting access to early learning, health services, and developmental support, while placing additional stress on families who depend on the program for affordable care and resources. Prolonged delays also impact staff morale, retention, and community trust in the program's reliability.

24. There is imminent risk the federally funded Oregon Head Start Collaboration Office (HSCO) will experience delays or potential non-renewal of the federal Office of Head Start grant that funds a state position and the functions of the HSCO. This will in turn harm Oregon directly because DELC houses the federally mandated HSCO and Head Start

Collaboration Director. The primary purpose of HSCO grant is to facilitate collaboration among Head Start agencies and entities that carry out activities designed to benefit low-income children from birth to school entry, and their families.

Conclusion

25. The changes to the HHS Head Start Program described above pose a serious threat to school readiness and family stability for some of Oregon's most vulnerable children. Disruptions to local program operations—such as staff layoffs, reduced services, or temporary closures—can interrupt critical early learning, health care, and developmental support that children need to be prepared for kindergarten. Without consistent access to these services, children risk falling behind before they even enter school. At the same time, families who rely on Head Start for affordable child care and vital resources face increased stress and instability, making it harder to maintain employment and meet basic needs. Prolonged delays also erode staff morale, hinder retention, and weaken community trust in the program's reliability at a time when families need it most.



Alyssa Chatterjee

Date: May 7, 2025

EXHIBIT 50

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF RHODE ISLAND

STATE OF NEW YORK, et al. Plaintiffs, v. ROBERT F. KENNEDY, JR., in his official capacity as SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., Defendants.	Case No. 1:25-Civ.-00196

DECLARATION OF DEBRA STANDRIDGE

I, Debra Standridge, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the foregoing is true and correct:

1. I am the Deputy Secretary of the Wisconsin Department of Health Services (WI-DHS). I am familiar with the information in the statements set forth below either through personal knowledge, in consultation with the staff from our Division of Public Health (DPH) and Division of Care and Treatment Services (DCTS).

2. I submit this Declaration in support of the States' Motion for a Preliminary Injunction.

3. I am providing this declaration to explain the impacts on Wisconsin of the cuts to United States Department of Health and Human Services (HHS), including cuts to the Centers for Disease Control (CDC), the Food and Drug Administration (FDA), the Substance Abuse and Mental Health Services Administration (SAMHSA) and National Institute for Occupational Safety and Health (NIOSH).

Reliance on HHS Data and Technical Expertise Generally

4. Prior to April 1, 2025, WI-DHS relied on HHS data, partnerships, technical assistance, training, and funding. HHS provides data and technical assistance to WI-DHS, primarily through the CDC but also through the FDA and other entities. Partnerships, subject matter expertise, and data from HHS support public health surveillance, disease prevention, and health promotion efforts. For example, WI-DHS provides information about specific diseases to the CDC, which then analyzes and disseminates it nationwide in dashboards that paint a picture of nationwide trends and concerns. The CDC also provides data and trend information about health status, behaviors, and resource use. WI-DHS has particularly relied on HHS and its subagencies for support in matters of pregnancy; HIV/AIDS, STIs, viral hepatitis, and tuberculosis; lead; substance abuse and mental health; tobacco; and occupational health. Each of those areas has been significantly adversely impacted since April 1, 2025, as detailed below.

Pregnancy Risk Assessment Monitoring

5. WI-DHS relied on CDC for data relating to the health and well-being of pregnant people and babies, including the Pregnancy Risk Assessment Monitoring System (PRAMS). Wisconsin PRAMS collects data on experiences before, during, and after pregnancy with support from the CDC. The CDC managed and provided access to the online database: PRAMS Integrated Data Collection System (PIDS). PIDS is an essential data collection and data management tool for PRAMS, as it tracks participant communications, serves as a platform for phone interviewing, collects operational measures, and compiles entered data. CDC also supports PRAMS through the hosting and testing of the web version survey.

6. Prior to data collection, CDC leads the survey design process for PRAMS and facilitates submission to the national-level institutional review board (IRB) for approval. Following data collection, CDC provides the Wisconsin PRAMS team with weighted survey data

and data on process measures, such as response rates and technical assistance through monthly meetings with project managers and webinars. CDC aggregates data across all PRAMS sites and provides it to states, students, and researchers through their Automated Research File web portal.

7. The Wisconsin Title V Maternal and Child Health program also relies on PRAMS data to make informed decisions around priority-setting and for evaluation of program progress. Local and Tribal health departments and Wisconsin community organizations use PRAMS data to plan programs addressing the needs of families. PRAMS data are additionally vital to academic research and the study of maternal and infant health outcomes.

8. For nearly two decades, PRAMS has provided robust population-level data on the 60,000 pregnancies and births that occur annually in Wisconsin.

9. As of April 1, 2025, WI-DHS lost access to critical information on the health of mothers and infants, since much of this data is unavailable elsewhere. With the removal of PRAMS data, WI-DHS lost its ability to assess trends in maternal and infant health, to learn about the resource needs of new families, and to engage in critical research for these populations, and ultimately to protect and promote successful birth outcomes.

10. On April 14, 2025, WI-DHS received a Notice of Award (NoA) for the 5th year of a 5-year PRAMS grant (May 1, 2025 through April 30, 2026). The NoA detailed significant CDC-provided supports for PRAMS activities, such as the ones shared above. On April 30, 2025, the Wisconsin PRAMS team received an email from CDC that stating: "CDC can no longer provide the scientific, technical, and information technology assistance resources as described in the Notice of Funding Opportunity RFA-DP-21-001 for the Pregnancy Risk Assessment Monitoring System (PRAMS). CDC will share guidance for revision of workplans and budget documents for the Year 5 budget period starting May 1, 2025 through April 30, 2026 soon." As of May 8, 2025, WI-DHS

has not received CDC guidance on how to proceed with data collection without the support of CDC staff and without access to the data module in PIDS. PRAMS data collection is currently paused with no anticipated start date.

11. CDC has access to raw 2024 Wisconsin PRAMS data through PIDS, but WI-DHS does not have access. On April 4, 2025, the WI-DHS PRAMS team requested to receive raw 2024 Wisconsin PRAMS data from the CDC. As of May 6, 2025, this request has not been fulfilled. Lastly, the CDC PRAMS Automated Research File web portal has also been down since February 1, 2025. Without this portal, WI-DHS and its partners cannot access nationwide PRAMS data.

HIV/AIDS, Viral Hepatitis, Tuberculosis and Other Infectious Diseases

12. WI-DHS relied on CDC for its funding assistance in preventing HIV/AIDS, viral hepatitis, STIs, and tuberculosis. CDC-provided federal funds allowed WI-DHS to provide subject matter expertise in these public health areas to partners, health care providers, and the general public across Wisconsin. These funds also support training of local partners who provide prevention services in their communities. Federal funds allowed WI-DHS to detect and respond to clusters and outbreaks of illnesses, and work with communities to provided targeted interventions.

13. WI-DHS has relied on CDC laboratory's capacity for, and performance of, antibiotic-resistant gonorrhea testing in the Division of STD Prevention's STD Laboratory Reference and Research Branch (SLRRB). These specialized tests have helped WI-DHS to monitor for and detect cases and/or outbreaks of antibiotic-resistant gonorrhea.

14. CDC's Division of Viral Hepatitis (DVH) developed the Global Hepatitis Outbreak and Surveillance Technology (GHOST) system to characterize viral genotypes and transmission links among hepatitis C virus (HCV) infection cases in outbreak settings. Measuring the degree of genetic similarity among HCV strains is useful for identifying transmission links between patients

- a key part of an epidemiologic investigation. Results of a GHOST analysis may include a transmission network diagram. These diagrams help users visualize genetic similarities between HCV strains associated with different cases. Sequences from samples exhibiting a high degree of genetic similarity, likely signify a transmission link.

15. Since April 1, 2025, WI-DHS has needed to delay implementation of a molecular testing pilot which was contributing to work towards new tests for identifying antibiotic resistant gonorrhea. This crucial work is time-consuming and requires numerous samples to show whether a molecular test has capacity to identify antibiotic resistance. This new form of testing offers an alternative to culture-based testing and antimicrobial susceptibility testing of cultured gonorrhea specimens, the current gold-standard for identifying antibiotic resistance which few institutions have capacity for.

16. Additional harm to WI-DHS includes the loss of, and access to, CDC experience. Culturing of gonococcal specimens can be particularly challenging. Losing dedicated CDC staff and a whole lab, with more than a decade's experience testing these samples, will drastically impact the amount of technical assistance WI-DHS receives. This also includes the loss in access to the CDC lab experts who conduct confirmatory testing and advise on the best course of treatment for patients. These losses, combined with the additional loss of the CDC Disease Intervention Resource Branch (DIRB), means WI-DHS has fewer resources available to respond to outbreaks of antibiotic-resistant gonorrhea.

17. On April 1, 2025, the Division of Viral Hepatitis (DVH) Laboratory Branch staff was eliminated, and the lab closed. CDC is now unable to provide viral hepatitis-related laboratory services to WI-DHS and other partners. This impacts WI-DHS's ability to request outbreak support from CDC DVH Laboratory since the lab can no longer receive lab specimens or perform

molecular sequencing. This staff elimination and lab closure further impacts WI-DHS's ability to follow up and investigate identified clusters and outbreaks within the state and hinders WI-DHS's ability to prevent disease spread.

18. CDC GHOST went offline on April 25, 2025. WI-DHS utilizes GHOST for integrated viral hepatitis surveillance and prevention programs in states and large cities in the U.S. Key strategies include viral hepatitis outbreak planning and response, and surveillance for acute hepatitis A, B and C, and chronic hepatitis C.

19. Prior to April 1, 2025, WI-DHS relied on CDC for infectious disease testing, including Hantavirus infection, Chikungunya IgM, polio isolation and genotyping and viral hepatitis specimen samples (e.g. Hepatitis A, B).

20. Testing of confirmation of Hantavirus infection had been done at CDC, but since April 1, 2025 needs to be routed to the California Health Department Lab.

21. Chikungunya IgM testing is now only offered at New York States' Department of Health's Wadsworth Lab.

22. Polio isolation and genotyping had been sent to CDC in the past. This testing would now need to be sent to a third party, such as a commercial reference laboratory. WI-DHS anticipates issues related to payment for the test, shipping and result turnaround time.

Lead

23. WI-DHS relied on CDC for its assistance in monitoring for and responding to lead poisoning, especially in children.

24. For the past several months, WI-DHS has worked with the City of Milwaukee Health Department (MHD) in response to lead paint hazards in Milwaukee Public Schools' buildings. The Healthy Homes and Lead Poisoning Prevention System (HHLPPS) is an application

developed and maintained by CDC's Lead Poisoning Prevention Branch that is used by WI-DHS and Wisconsin local health departments to track blood lead tests among children and follow-up activities such as nursing case management, environmental investigation and lead hazard abatement. CDC's Lead Poisoning Branch was providing technical assistance on how other large urban areas outside of Wisconsin responded to such discoveries. Endorsed by WI-DHS, MHD requested from CDC an Epi-Aid, whereby epidemiologists and other scientists from CDC could provide onsite assistance with lead testing clinics and other response activities. CDC declined the request due to the April 1 staff cuts, so this additional expertise is not available to MHD and WI-DHS while interventions occur to protect the students and staff within MPS from lead exposure.

25. At this time, only one individual remains of the original team who supported HHLPSS at CDC. This comes at a time when CDC was working on two large updates to HHLPSS, a change to the authentication system integrated into HHLPSS, and a project to modernize HHLPSS to allow electronic medical records systems to communicate directly with HHLPSS, so providers have access to all their pediatric patients' blood lead test results. Without the regular updates to this data system that CDC has provided for many years, WI-DHS's ability to track blood lead levels in children and the services local health departments provide in response to high blood lead test results could be significantly hampered, jeopardizing our collective ability to maintain situational awareness about the status of lead poisoning cases and to respond appropriately.

26. Since April 1, 2025, WI-DHS no longer receives CDC updates on recalls related to lead contaminated products.

Substance Abuse and Mental Health

27. Until April 1, 2025, WI-DHS relied on SAMHSA in significant ways to support its critical behavioral health work for the state of Wisconsin. For example, in addition to SAMHSA's

regularly-updated data about drug use, WI- DHS relied on SAMHSA as the uniting national force for best practice guidance. SAMHSA provided technical assistance and support to WI-DHS through their Region 5 office. The regional liaisons facilitated state-to-state communities of practice, state-to-state commissioner convenings, research and technical assistance regarding practice and funding for services and acted as a liaison with the federal partners.

28. SAMHSA conducted monthly State Opioid Treatment Authority (SOTA) calls, which ensured each Opioid Treatment Program (OTP) is federally recognized and licensed through SAMHSA. SAMHSA also worked with the Commission on Accreditation of Rehabilitation Facilities and The Joint Commission for state programs to provide accreditation to treatment programs and a compliance review against federal regulations every three years.

29. WI-DHS relied on the SAMHSA Opioid Treatment Network (OTN) to provide technical assistance regarding opioid treatment services. The SAMHSA OTN extranet contains a database of all waivers and variances for federal exceptions for staff and services for OTPs. The SAMHSA OTN facilitates state-to-state technical assistance requests for peer learning about opioid treatment services.

30. WI-DHS further relied on SAMHSA's Providers Clinical Support System (PCSS), a physician-to-physician technical assistance and prescribers' training system.

31. WI-DHS also relied on the SAMHSA Opioid Rapid Response Program (ORRP). ORRP partners with the Drug Enforcement Administration (DEA) and local law enforcement when a prescriber's license must be removed. DEA notifies the SAMHSA ORRP Coordinator who notifies WI-DHS, so that WI-DHS can compile resources and notify the Division of Medicaid that DEA plans to terminate a license. WI-DHS then provides resources for the affected area of the

state and notifies the prescriber listserv signaling a disruption in services to ensure consumers are served.

32. WI-DHS relied on the SAMHSA Technology Transfer Centers Program (ATTC) to support national and regional activities focused on the delivery of effective substance use disorders treatment and recovery supports. WI-DHS relied on SAMHSA for support and guidance for the Tribal Overdose Prevention Program (TWI-PDO) from Grant Project Officer and Fiscal Officer. WI-DHS relied on SAMHSA for guidance, support calls, and training to manage the transition of the SPARS data management system that was revamped in early 2025. SPARS collects Government Performance and Results Act data measures for federal grants.

33. WI-DHS relied on SAMHSA for substance use prevention and harm reduction resources, including the following:

i. SAMHSA Opioid Overdose Prevention Toolkit

ii. A Guide to SAMHSA's Strategic Prevention Framework

iii. SAMHSA Center for Substance Abuse Prevention (CSAP) Prevention Strategies

iv. Harm Reduction Framework

v. Substance Use Prevention Communications Toolkit

vi. Registry of Proven Interventions

vii. Substance Misuse Prevention for Young Adults

viii. SAMHSA listservs – information on current trends, etc.

ix. Partners in Prevention

34. WI-DHS relied on SAMHSA for Specialized Funding for Substance Use and Misuse Services. This funding serves people who are disproportionately impacted by mental health

and substance use challenges. WI-DHS relied on the SAMHSA Prevention Technology Transfer Center (PTTC) Network. The PTTC Network is critical to provide additional training, resources, and support for grantees across Wisconsin.

35. WI-DHS relied on SAMHSA for best-practice support for programs like Naloxone Direct that address the overdose epidemic. The state's naloxone saturation plan was developed in partnership with SAMHSA's policy academy. Data shows a decrease in overdose deaths due to saturation efforts like those being done at WI-DHS. SAMSHA provided check-ins after the Naloxone Saturation Academy and support for the in-person meetings with Wisconsin grantees in August 2024. WI-DHS relied on SAMHSA for support and guidance for the 988 Cooperative Agreement Grants and the 988 Improvement Grant, including support and guidance from the Grant Project Officer. SAMHSA acted as a liaison between states and Vibrant Emotional Health, the national 988 administrator. WI-DHS relied on SAMHSA for support and guidance for the Mental Health Block Grant and Substance Use Prevention, Treatment and Recovery Block Grants, including support and guidance for the Grant Project Officer. WI-DHS relied on SAMHSA technical assistance and best practice standards and guidelines across mental health and crisis services. SAMHSA compiled data across research and states to develop these standards and promote quality practice.

36. Since April 1, 2025, WI-DHS has experienced harm relating to SAMHSA's reduced role. This includes the loss of access to best practice guidelines and technical assistance that is regularly provided to states to use as a benchmark for treatment. WI-DHS staff access SAMHSA's standards to ensure quality of care. SAMHSA is no longer holding monthly SOTA meetings. These meetings include SAMHSA staff who have direct contact with the DEA and enforce quality standards from the federal government, passing along updates and information to the states for

quality care. Without SAMHSA's distribution, WI-DHS has lost access to new guidance on best practice across states to navigate Medications for Opioid Disorder (MOUD) services in recent months. WI-DHS lost access to the Addiction Technology Transfer Centers (ATTC), which is no longer available for states to receive information or individualized technical assistance regarding the effective delivery of substance use disorders treatment and recovery supports. With the closing of SAMHSA's Region 5 office, WI-DHS has lost access to resources, expertise, and regional support. The commissioner convening has been canceled. Lastly, WI-DHS has experienced harm relating to SAMHSA cancelling all group meetings for grants. SAMHSA is meeting with WI-DHS grant coordinators in statewide meetings only, not as regional or national groups. All group drop in or open office hours have been cancelled.

Tobacco

CDC's Office on Smoking and Health (OSH)

37. OSH was the lead federal agency for comprehensive tobacco prevention and control and played a critical role in preventing youth tobacco use, which includes smoking, vaping, and other nicotine products, and helping adults to quit smoking. Cigarette smoking is the leading cause of preventable disease, disability, and death in the United States. OSH worked to prevent and reduce cigarette smoking by collecting, studying, and sharing information on cigarette smoking and its effects on health, as mandated by Congress. 15 U.S.C. § 1341 ("Smoking, research, education and information").

38. OSH was administered by the National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), within CDC.

39. OSH managed a tobacco use data portal which provided access to the latest tobacco prevention and control data, graphs, and maps, as well as the State Tobacco Activities

Tracking and Evaluation (STATE) System, which presented data on traditional Medicaid coverage of tobacco cessation treatments in fifty U.S. States and the District of Columbia. This dataset was used by Plaintiff States to assess tobacco cessation policies and served as a national clearinghouse of information for the public.

40. OSH also managed annual submissions of cigarette and smokeless tobacco ingredient reports from manufacturers, packagers, and importers. OSH also monitored tobacco use trends and health impacts in part to inform FDA regulations and enforcement.

41. Further, OSH played an important role in surveillance and surveys, including the state-based Behavioral Risk Factor Surveillance System, National Health and Nutrition Examination Survey, and National Youth Tobacco Survey (NYTS). OSH's national surveillance system provided reliable, consistent, and cost-effective data collection that many states used to evaluate their work and monitor progress in tobacco use prevention. NYTS collected data on tobacco use by high school and middle school students, including which products they were using, how often they use them, and how youth access them. OSH additionally published state-level data on tobacco prevention use in the STATE System.

42. OSH committed to educating the public about the harms of tobacco use, including media campaigns such as Tips from Former Smokers (Tips Campaign) and publications derived from the Publication Catalog and Ordering System. The Tips Campaign ads, which were placed on television, radio, and billboards, encouraged smokers to quit by featuring real people with serious health conditions caused by smoking and secondhand smoke exposure. The 2012–2018 Tips Campaign had a significant positive impact on Americans' health. CDC estimated that over 16.4 million smokers attempted to quit and approximately one million successfully quit because of the Tips Campaign. Smokers who saw Tips Campaign videos reported greater intentions to

quit smoking, and former smokers with higher exposure to the ads were associated with lower odds of relapse. The Tips Campaign was credited with helping to prevent early deaths and save precious government resources.

43. OSH scientists published high-quality reports on tobacco use trends that states utilized to prioritize interventions, monitor progress, and reduce disparities. OSH's Best Practices for Comprehensive Tobacco Control Program Guide advises states on how to develop, implement, and fund an evidence-based tobacco control program. OSH likewise dedicated its publications and resources to the "Publication Catalog and Ordering System" where state agencies and other users could access campaign materials and Surgeon General's reports.

44. OSH maintained the national network of tobacco cessation quitlines to encourage people to quit tobacco use by supporting quitline services in fifty states, two U.S. territories, and Washington, D.C. OSH funded state quitlines to deliver resources such as counseling and medications. The Tips Campaign resulted in a sustained and dramatic increase of calls to quitlines.

45. OSH also provided millions in funding to the National and State Tobacco Control Program. Participating states used OSH funds to prevent kids from using tobacco, reduce secondhand smoke exposure, help people quit smoking, and address disparities in tobacco use.

FDA Center for Tobacco Products (CTP)

46. CTP at FDA oversees the implementation of the Family Smoking Prevention and Tobacco Control Act by setting performance standards for tobacco products, reviewing premarket applications for new and modified risk tobacco products, requiring new warning labels, and establishing and enforcing advertising and promotion restrictions.

47. Among other duties, CTP conducts compliance checks on vendors and retailers to ensure that tobacco products are not sold to those under the age of twenty-one, reviews premarket applications for new tobacco products before they can be marketed in the United States, enforces advertising and promotion restrictions, and educates the public about the risks of tobacco use including the dangers of e-cigarettes and other tobacco products.

48. WI-DHS relied on FDA's public educational campaigns that raised awareness of the risks of emerging and various tobacco products that target youth and other special populations.

49. WI-DHS relied on FDA to take appropriate compliance and enforcement actions based on the inspections that WI-DHS conducted as well as investigations, inspections, monitoring, and reviewing of activities that the FDA CTP conducted to assure manufacturer, wholesaler, distributer, and retailers all complied with the Family Tobacco Control Act.

50. WI-DHS Commercial Tobacco Prevention and Treatment Program (CTPTP) staff and partners also relied on FDA CTP for online resources from the FDA Center for Tobacco Products to inform youth access and prevention work. This includes CTP's website for updated tobacco product marketing orders, submitting complaints regarding sales to underage purchasers and monitoring FDA retail inspection results via the Tobacco Compliance Check Outcome website. Links to websites used most frequently.

Changes in OSH and CTP activity that impact Wisconsin

51. Wisconsin's primary point of contact at OSH for grant monitoring, reporting, and technical assistance, has not been available since February 14, 2025. We have not received answers or guidance regarding our year 5 supplemental application that was submitted in January 2025, nor the RFA that we expected to be released in 2025 for us to apply for the next 5-year

cooperative agreement. We have not received instructions on what final reporting is due to CDC. Only on April 26, 2025 did we receive notification for a 6-month no-cost extension for unspent funds, only two days before the end of our grant period.

52. OSH employees assigned to our WI-DHS Commercial Tobacco Prevention and Treatment Program (CTPTP) informed us that they received reduction in force (RIF) notices from HHS on February 14, 2025. This included our Project Officer and Grants Management Officer both of whom were in their probationary periods at CDC. These employees' responsibilities included providing technical assistance for grant implementation, connecting to other CDC staff and/or other national partners and other states for technical assistance and learning from similar implementation scenarios, grant reporting and monitoring progress, and fiscal reporting.

53. WI-DHS CTPTP no longer has access to OSH education ads through the Media Campaign Resource Center.

54. WI-DHS CTPTP has lost access to parts of OSH surveillance data, including STATE system, Behavioral Risk Factor Surveillance System, National Health and Nutrition Examination Survey, NYTS. Parts of data sets have been removed, some data is not available at all, and some data has not been updated since September of 2024.

55. WI-DHS's CTPTP has lost access to materials that educate on the dangers of smoking and tobacco products and means for quitting, including the Tips from Former Smokers campaign and publications.

56. Wisconsin state tobacco laws and regulations depend on FDA review and approval of new tobacco product applications. If those applications are not properly processed, our state's ability to keep dangerous tobacco products off the shelves will be impacted.

57. Wisconsin CTPTP has been significantly affected by the changes to OSH and CTP described above.

58. In the past, CTPTP relied on OHS and for training, technical assistance, surveillance data, guidance documents, and other support previously provided by OSH.

59. Deprecation of these two subagencies will have an effect on Wisconsin's ability to protect its citizens, especially its youth, from the dangers of smoking and tobacco products. Worse surveillance data of tobacco use will harm WI-DHS's ability to efficiently and effectively deploy its tobacco control tools and resources.

Occupational Health

60. In Wisconsin, NIOSH's state surveillance program funds the Occupational Health and Safety Surveillance Program at WI-DHS.

61. Wisconsin's state surveillance program analyzes Wisconsin's Worker's Compensation data, as well as other data sources such as hospital data, lab data and vital records, to produce public information resources for workforce protection. This includes a Wisconsin Worker's Compensation Dashboard as well as specific journal articles and surveillance briefs. Wisconsin has used Worker's Compensation data recently to identify cow-related injuries among agricultural workers (found to be the second cause of agricultural injuries after farm vehicles), both winter (ice, snow) and summer (heat-related) illness and injury claims across the workforce, and long-COVID claims among health care and protective services professionals. Worker's Compensation data has the potential to address a wide array of worker health questions, such as injury risks to different age groups and sectors (important with an aging workforce and potential shifts in domestic production) and the ability to explore topics as varied as chronic occupational conditions, work-related mental health issues, and days of work lost to work-related violence.

62. Without NIOSH, Wisconsin would not have capacity to analyze this data or maintain and update the Workers Compensation dashboard. The Wisconsin Department of Workforce Development (DWD), which owns the Worker's Compensation data, has long seen the value of analyzing their data but does not have staff or funding to carry out these tasks. WI-DHS's ability to carry out such analyses, using NIOSH funding, has been a particular boon for DWD in its ability to interpret and utilize its data. Thus, a loss of NIOSH funding would directly affect both WI-DHS and DWD.

63. NIOSH funding allows DHS to conduct occupational health epidemiological analyses, investigations, consultation and outreach on topics related to worker health and safety.

64. The loss of NIOSH would also impact Wisconsin's Department of Agriculture, Trade and Consumer Protection (DATCP) on topics ranging from farmworker mental health to worker protection from bird flu.

65. DWD and the WI-DHS occupational health team also have ongoing partnerships to advance workforce health and safety for certain groups of workers with NIOSH support. The Migrant and Seasonal Farm Worker program relies on WI-DHS to provide timely health information to seasonal agricultural employers to help keep their workforce healthy during the growing season. The Youth Apprenticeship Program has partnered with WI-DHS to help employers understand the unique safety and training needs of young workers, who are otherwise at high risk of injury. The NIOSH-funded state surveillance program also assists other WI-DHS and local public health programs when they encounter potential workplace outbreaks or chronic disease risks. This consultation can range from infectious diseases (e.g., avian influenza, blastomycosis, Legionellosis) to reproductive health risks associated with toxic exposures. Without an occupational health team, it would be much harder for these teams to identify the

work-related contribution to an outbreak and develop effective outreach strategies and communications materials for employers, workers, and local public health.

66. Loss of NIOSH would also undermine Wisconsin's ability to monitor adult lead poisoning. Wisconsin's state surveillance team oversees Wisconsin's adult blood lead data collection and carries out associated outreach and education activities aimed at reducing adult, childhood "take-home", and prenatal lead exposure. For instance, NIOSH-funded staff were instrumental in a joint Wisconsin-Minnesota investigation of lead exposures among dozens of workers at Fraser Shipyard. More recently, NIOSH-supported WI-DHS staff have worked to raise awareness of prenatal and take-home lead exposure risks among Wisconsin healthcare providers, maternal-child health programs and early childhood education organizations. The ultimate goal of these efforts is to ensure that pregnant mothers at risk of lead exposure are identified as early as possible to reduce their subsequent lead exposure and ensure specialized support for their pregnancy and newborns. These outreach efforts have recently stalled with the uncertainty surrounding the occupational health program's future.

67. WI-DHS relies on economists, data scientists and others at NIOSH's Center for Workers Compensation Studies to provide expertise on methods and interpretation when working with Worker's Compensation data, given the nuances of that particular dataset. NIOSH's Respiratory Health Division has subject matter experts whose work directly advances Wisconsin's understanding of occupational respiratory disease risks. This is imperative since occupational lung diseases are reportable public health conditions in Wisconsin, and many Wisconsin residents continue to suffer the effects of asbestosis, silicosis, and other severe and chronic respiratory conditions. Similarly, the Division of Field Studies & Engineering produces

scientific findings, tools, and approaches upon which states rely, and which could not be carried out by states alone.

68. WI-DHS is also concerned about the loss of access to NIOSH publications, recommendations, applications and tools. NIOSH publications are the first place to look when states encounter a potentially new or unusual worker health issue—anything from "mushroom worker's lung" to hazards associated with 3D printers. NIOSH's recommendations help inform public health guidance on topics for which no OSHA specific standards exist, such as wildfire smoke exposure or indoor mold. Such NIOSH materials allow WI-DHS to address concerns fielded from employers, workers, local public health and others. WI-DHS has also recommended NIOSH's free workplace apps as valuable health and safety tools for employers to help them identify and address hazards related to extreme heat or noise. These tools will likely become unavailable without NIOSH support.

69. Wisconsin relies on the Health Hazard Evaluation (HHE) program for expert consultation and on-the-ground investigations that are beyond the capacity or expertise of the state health department. The loss of the HHE team deprives states and local communities of a specialized "strike force" that is uniquely positioned to investigate occupational health outbreaks.

70. Other specialized NIOSH programs such as the Coal Miner Health Surveillance Program, World Trade Center Program, Firefighter Cancer Registry and Firefighter Fatality Investigation Program provide key occupational health insights which advance the state of the field and inform public health. State health departments lack the resources to undertake such studies, but benefit from NIOSH's findings. For instance, such programs have informed our field's understanding of smoke inhalation risks (subsequently useful for providing public guidance during wildfire smoke events).

71. DHS would face decreased capacity and increased strain on agency operations if NIOSH did not exist. While direct programmatic funding for Wisconsin's state surveillance program is the most direct example, even with such funding, WI DHS would lose capacity if NIOSH tools and programs were no longer available.

72. For example, Wisconsin's primary public health data reporting system, the Wisconsin Electronic Disease Surveillance System (WEDSS) relies on the NIOSH Occupational Computerized Coding System (NIOCCS) to automatically recode free-text information on people's work into standard industry and occupation categories. This allows WI-DHS to effectively capture and utilize work-related information as relevant for dozens of health conditions. Without NIOCCS, this functionality will be lost, our data system will be impacted. Programmer time would need to be dedicated to removing the defunct fields and new communications and training materials will have to be created and disseminated to WEDSS users. All of these tasks would entail more work for WI-DHS and result in reduced capacity to effectively and efficiently use health data.

73. Wisconsin alone cannot track, anticipate and prevent all possible occupational health hazards among our agricultural, manufacturing, construction, protective services, healthcare and other vital sectors. We rely on the collective knowledge generated and shared by NIOSH and the other states and academic institutions they fund to know what new hazards to look out for or what employer- and worker-friendly interventions have had positive impacts elsewhere. There is a multiplier effect to a dedicated community of occupational health experts that allows our programs to accomplish more than would be possible alone.

74. NIOSH's internal agricultural health and safety program, the Office of Agricultural Safety and Health, was effectively dismantled by the April 1 RIF notices. Staff at

that program provided invaluable leadership and national coordination to the agricultural safety and health community, and their departure leaves a vacuum. One of their key roles was to convene the National Occupational Research Agenda (NORA's) Agriculture, Forestry and Fishing Sector Council. NORA Councils convene experts and key stakeholders to identify the pressing occupational health research needs for a given sector. Such work defines the direction of the field. Without NIOSH's leadership, the future of agricultural safety and health research is at risk. This, in turn, deprives rural communities from needed health and safety advancements.

Conclusion

75. The adverse impacts of the HHS restructuring have been significant for WI-DHS and the people of Wisconsin.

Debra Standridge

DEBRA STANDRIDGE

Date: 05 09 2025

EXHIBIT 51

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF RHODE ISLAND

STATE OF NEW YORK, et al. Plaintiffs, v. ROBERT F. KENNEDY, JR., in his official capacity as SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., Defendants.	Case No. 1:25-cv-00196

DECLARATION OF JENNIE CUNICO

I, Jennie Cunico, MC declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the foregoing is true and correct:

1. I am the Deputy Director of Public Health Operations and Licensing of the Arizona Department of Health Services (ADHS). I am familiar with the information in the statements set forth below either through personal knowledge, in consultation with the Arizona Department of Health Services staff, or from documents that have been provided to and reviewed by me, and if required to testify, would and could competently do so.

2. I submit this Declaration in support of the States' Motion for a Preliminary Injunction.

Professional Background

3. I am a Deputy Director at ADHS. I oversee decision-making on ADHS's program and policy development, implementation and evaluation of public health operations and licensing, and allocation and expenditure of federal and state contracts, grants, and budgets.

I am familiar with the federal funding the ADHS receives and the ways in which those federal dollars impact the programs and services that ADHS provides to Arizonans.

4. ADHS's mission is to promote, protect, and improve the health and wellness of individuals and communities in Arizona.

5. I am providing this declaration to explain the impacts on Arizona of the cuts to HHS, including cuts to CDC and the FDA.

Reliance on HHS Data, Technical Assistance and Resources

6. Arizona relied on CDC for technical assistance on the collection of data relating to the health and well-being of pregnant people and babies, including the Pregnancy Risk Assessment Monitoring System (PRAMS).

7. ADHS uses PRAMS data for needs assessments, reports, policies, and program evaluations across numerous programs. Assessing and monitoring population health is an essential public health service, and PRAMS provides unique insights into experiences around the time of birth that shape programs and policies directly impacting this important sector of the population.

8. ADHS is currently in its fifth-year of a CDC Cooperative Agreement to Support State-Based Safe Motherhood and Infant Health Initiative Programs, which enables ADHS to administer PRAMS pursuant to the CDC's Notice of Funding Opportunity (NOFO) DP-21-001. On April 8, 2025, CDC issued its Notice of Award (NOA) for this cooperative agreement for the May 1, 2025 to April 30, 2026 budget period. This award requires substantial involvement from CDC staff, including day-to-day technical assistance, coordination, and participation in implementing PRAMS.

9. Arizona relied on CDC for its assistance in tobacco prevention, cessation and control.

10. Pursuant to a National State Tobacco Control Program award, administered through the CDC's Office of Smoking and Health (OSH), ADHS delivers Arizona's Tobacco Control Program (ATCP) and the Arizona Smokers Hotline (ASHLine). ATCP implements evidence-based, culturally appropriate policy, systems, and environmental strategies and activities to prevent the initiation of tobacco use (including emerging products and e-cigarettes) among youth and young adults; promote quitting among adults and youth; eliminate exposure to secondhand smoke; and identify and eliminate tobacco-related disparities among population groups. ASHLine provides telephonic counseling services for tobacco cessation efforts statewide.

11. ADHS is currently in the fifth-year of its National State Tobacco Control Program award, which provides funding to support ATCP and ASHLine.

12. Additionally, ADHS has previously relied on OSH for training, technical assistance, surveillance data, guidance documents, and other support critical to the administration of ATCP and ASHLine. These resources included OSH's Best Practices for Comprehensive Tobacco Control Program Guide, which advises states on how to develop, implement, and fund an evidence-based tobacco control program, and its "Publication Catalog and Ordering System" which provided access to campaign materials and Surgeon General's reports.

13. Arizona relied on CDC for its assistance in preventing HIV/AIDS, viral hepatitis, STIs, and tuberculosis.

14. Since 2019, ADHS had an embedded field assignee from the CDC's National Center for HIV, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) who served as a Public Health Advisor for ADHS's STI work and was an expert in congenital syphilis.

15. This Public Health Advisor supported ADHS's case review and linkage to care, conducting case reviews for thousands of congenital syphilis and maternal syphilis infections, and identifying mothers and infants in need of linkage to treatment. She provided technical assistance and subject matter expertise to rural jurisdictions in acute need of services due to increased rates of syphilis and limited testing capacity. She also provided enhanced surveillance, lent expertise to Arizona's Statewide Congenital Syphilis Collaborative, and developed various public health and educational tools and resources.

16. Arizona relied on CDC for its assistance in monitoring for and responding to lead poisoning, especially in children.

17. ADHS receives support from the CDC's Childhood Lead Poisoning Prevention Program (CLPPP) for lead poisoning surveillance statewide. ADHS's current lead poisoning prevention program is set to operate until September 2025.

18. Until recently, ADHS had a designated CLPPP program officer that assisted with program guidance, technical assistance related to deliverables, and subject matter expertise.

19. Arizona relied on CDC's National Center for Environmental Health (NCEH) to develop and implement heat and health mitigation programs and strategies, including through participation in the Environmental Public Health Tracking (EPHT) program and in the Climate and Health Program's Climate-Ready States & Cities Initiative (CRSCI).

20. Through EPHT, ADHS has developed a robust system for monitoring and analyzing the relationship between environmental factors and public health. The EPHT program aims to enhance understanding of disease patterns and their potential environmental links. This allows for the identification of regions and populations that are most vulnerable to heat-related illnesses and other environmental exposures. The data-driven approach informs the development

of targeted interventions, public health campaigns, and resource allocation to effectively prevent and respond to environmental health threats throughout Arizona.

21. ADHS's participation in CRSCI enabled Arizona to benefit from NCEH's technical expertise in key areas. This support included guidance on effectively administering the EPHT program, reviewing and updating essential school health toolkits to address environmental health concerns, and ensuring that communication materials adhere to best public health messaging practices.

22. The NCEH also provided valuable strategic input, helping Arizona align its efforts with national standards and connect with other states engaged in similar initiatives, thus fostering a collaborative environment for sharing knowledge and best practices in environmental public health.

23. ADHS also utilized EPHT's Heat and Health Tracker in order to gain critical insights into the burden of heat-related illnesses in the state. By leveraging the tracker's capabilities, ADHS could monitor near-real-time and historical trends in heat-related emergency department visits and hospitalizations. This allowed for the identification of high-risk geographic areas and vulnerable populations, such as the elderly or individuals with pre-existing medical conditions. This detailed data informed the development and targeted implementation of public health interventions, including the strategic placement of cooling centers and the distribution of timely heat safety messaging to communities in need.

24. Furthermore, the Health and Health Tracker enabled ADHS to evaluate the effectiveness of implemented heat mitigation strategies by analyzing changes in the incidence of heat-related illnesses following interventions. This ultimately contributed to a more data-driven and responsive public health approach to extreme heat in Arizona.

25. Collectively, these programs address some of the most impactful health issues in Arizona: maternal and infant health, tobacco use, congenital syphilis, and heat related illnesses and deaths. All of these reflect strategic ADHS initiatives carried out in conjunction with community partners.

Changes to HHS Data, Technical Assistance and Resources Since April 1, 2025

26. Since April 1, 2025, Arizona has experienced harm related to the inability to gather and process data on the health and well-being of Arizona's pregnant people and babies, including PRAMS.

27. Upon information and belief, all federal PRAMS teams have been terminated.

28. On April 30, CDC informed ADHS that it could no longer provide the scientific, technical, and information technology assistance resources described in NOFO DP-21-001. As a result, ADHS cannot plan or start the PRAMS data collection process under its current NOA, which began on May 1, 2025.

29. Although CDC has stated that it would share guidance for revision of workplans and budget documents for the current funding period, it has provided no specific timeline for doing so.

30. CDC has yet to provide ADHS with access to its 2024 raw dataset through the PRAMS Integrated Data Collection System (PIDS).

31. Additionally, CDC has thus far not been responsive to ADHS's request for guidance on access to its 2024 raw dataset and to PIDS, which ADHS needs to collect birth cohort data for 2025.

32. As a result, ADHS has assumed responsibility for all data quality and assurance tasks previously performed by the CDC, such as data cleaning, calculated variable generation, dataset weighting, and codebook creation.

33. In addition, the PRAMS Automated Research File Data Portal Access Form, which is accessible to researchers via the cdc.gov website, is not available, which has resulted in Arizona taking on the burden of data requests from researchers, putting strain on staff and local resources.

34. ADHS is also awaiting confirmation on funding for the current year of its NOA to administer PRAMS.

35. Furthermore, ADHS does not yet know if federal funding to administer PRAMS will be available for its next five-year funding cycle and has received no communication about this from CDC.

36. Without PRAMS, Arizona would lose a critical source of data on the health of mothers and infants, making it more challenging for state health agencies and programs to understand and meet the needs of this population.

37. Since April 1, 2025, Arizona has experienced harm related to CDC's role in tobacco prevention, cessation and control.

38. Specifically, ADHS no longer has an OSH program officer to support its National State Tobacco Control Program award that supports both ATCP and ASHLine.

39. ADHS has also not received additional funding for the supplemental year of its National State Tobacco Control Program award, which was anticipated on April 28, 2025.

40. Instead, on April 26, 2025, ADHS received a six-month extension to the year five budget and project period. The extension notes that it is "due to organizational changes at HHS/CDC."

41. ADHS has not received any further communication about the status of the supplement year of its award and it remains without access to a designated point of contact at OSH.

42. Since April 1, 2025, Arizona has experienced harm relating to CDC's role in preventing HIV/AIDS, viral hepatitis, STIs, and tuberculosis.

43. ADHS's Public Health Advisor and NCHHSTP field assignee, who had supported epidemiological STI efforts statewide since 2019, was terminated on April 1, 2025.

44. As a result, ADHS has lost capacity and expertise for STI related public health work in the state. This loss reduced to our ability to complete critical cross matches and identify parents and babies with syphilis that need be treated. This will impact our rural regions disproportionately as they lack capacity and expertise to deliver these public health services.

45. Since April 1, 2025, Arizona has experienced harm relating to CDC's role in monitoring for and responding to lead poisoning, especially in children.

46. Upon information and belief, CLPPP and its designated project officer for ADHS were impacted by the reduction in force at HHS.

47. CLPPP cancelled a meeting with ADHS's CLPPP project officer scheduled in March.

48. The last direct contact that ADHS received from CLPPP was on March 26, 2025, and communication continues to be extremely limited.

49. The loss of the project officer has impacted ADHS's ability to consult with subject matter experts for lead prevention and to receive guidance on grant deliverables.

50. Since April 1, 2025, Arizona has experienced harm related to CDC's role in providing heat health related resources and expertise through NCEH.

51. On April 1, 2025 the Chief of the CDC's EPHT Program Services Team informed ADHS via email that all program staff had been placed on administrative leave and cancelled all scheduled EPHT meetings. The email noted that staff had "no additional information about how this impacts our recipients or partners."

52. On April 1, 2025, ADHS received an email from Climate and Health Program staff stating that program staff had been placed on administrative leave and that only one staff member would retain access to its email systems. The email stated, "We have no additional information about how this impacts our recipients or partners."

53. Additionally, ADHS can no longer rely on EPHT's Heat and Health Tracker for up-to-date information about heat exposure and related health outcomes, as it is no longer being maintained or updated with new data.

54. Without the support of these CDC NCEH programs, resources, and staff expertise, ADHS will no longer be able to rely on this crucial resource for timely information, which severely limits our ability to monitor and respond to heat-related risks across the state.

Conclusion

55. These changes risk significant harm to public health in Arizona because the sudden absence of national expertise hinders the implementation of several important public health programs, places more burden on state agency staff, and creates barriers to critical data sources used to inform public health practice.

Jennie Cunico

Jennie Cunico, MC

Date: May 8, 2025

EXHIBIT 52

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF RHODE ISLAND

STATE OF NEW YORK, et al. Plaintiffs, v. ROBERT F. KENNEDY, JR., in his official capacity as SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., Defendants.	Case No. 1:25-cv-196

DECLARATION OF KRISTIN J. CUMMINGS, MD, MPH, ATSF

I, Kristin J. Cummings, MD, MPH, ATSF, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the foregoing is true and correct:

1. I am the Branch Chief of the Occupational Health Branch (OHB) at the California Department of Public Health (CDPH). I have personal knowledge of the facts set forth in this declaration, and if required to testify, would and could competently do so.

2. Since December 2022, I have served at CDPH as Public Health Medical Administrator and Branch Chief of the Occupational Health Branch, which includes the Hazard Evaluation System and Information Service (HESIS). I joined CDPH in June 2019 as Public Health Medical Officer and Chief of HESIS in the Occupational Health Branch. Prior to CDPH, I received an undergraduate degree from Harvard University in 1994 and a Master of Public Health degree and Doctor of Medicine degree from Johns Hopkins University in 1999 and 2000, respectively. I trained in Internal Medicine at Stanford University and Occupational Medicine at West Virginia University. I am board certified by the American Board of Internal Medicine and the American Board of Preventive Medicine (Occupational Medicine). From 2005 through 2018,

I served as an Epidemic Intelligence Service Officer for the Centers for Disease Control and Prevention (CDC) (2005-2007), Medical Officer (2007-2015), and Branch Chief (2015-2018) in the Respiratory Health Division of the National Institute for Occupational Safety and Health (NIOSH) in Morgantown, West Virginia. From 2020 until April 2025, (when it was disbanded), I was a member of the National Academies of Sciences, Engineering, and Medicine's Standing Committee on Personal Protective Equipment for Workplace Safety and Health. In 2025, I earned the designation of American Thoracic Society Fellow (ATSF), for significant contributions to the field of pulmonary medicine.

3. I submit this Declaration in support of the States' Motion for a Preliminary Injunction.

Background on CDPH and NIOSH

4. CDPH's mission is to protect public health and shape positive health outcomes for individuals, families and communities in California. The Occupational Health Branch promotes safe and healthy workplaces through prevention activities.

5. OHB furthers its mission by identifying and evaluating workplace hazards, tracking patterns of work-related injury and illness, developing training and informational materials, providing technical assistance to others to prevent work-related injury and illness, working with partners to develop safer ways to work, and recommending protective occupational health standards.

6. It is my understanding and belief that as a result of the massive reduction in force (RIF) across the U.S. Department of Health and Human Services, over 90% of the staff of NIOSH, housed in the CDC, have been placed on administrative leave and will be permanently terminated on or after June 2, 2025.

7. For decades, CDPH has relied on NIOSH to provide invaluable research, guidance on injury and illness prevention, and certifications required under the law. Since the 1970s, NIOSH has served as the nation's leading occupational health research and public health agency. The Occupational Health and Safety Act requires the federal government to provide research and resources for the benefit of the states and the country as a whole.

8. CDPH has depended on NIOSH to help CDPH fulfill its mandates to investigate the causes of morbidity and mortality from work-induced diseases; develop recommendations for improved control of work-induced diseases; maintain a thorough knowledge of the effects of industrial chemicals and work practices on the health of California workers; provide technical assistance in matters of occupational disease prevention and control to the California Department of Industrial Relations and other governmental and nongovernmental agencies, organizations, and private individuals; collect and summarize statistics describing the causes and prevalence of work-induced diseases in California; establish and maintain an occupational lead poisoning prevention program that includes an occupational lead poisoning registry, investigation of cases of occupational lead poisoning, and training of employers, employees and health professionals regarding prevention of occupational lead poisoning; provide reliable information of practical use to employers, employees, representatives of employees, and other governmental agencies on the possible hazards to employees of exposure to toxic materials or harmful physical agents; collect and evaluate toxicological and epidemiological data and any other information that may be pertinent to establishing harmful effects on health of exposure to toxic materials or harmful physical agents; recommend to the Chief of the Division of Occupational Safety and Health (Cal/OSHA) that an occupational safety and health standard be developed whenever it has been determined that a substance in use or potentially in use in places of employment is potentially

toxic at the concentrations or under conditions used; and use individually identifiable information from workers' compensation benefits claims for the purposes of establishing and maintaining a program on occupational health and occupational disease prevention.

9. The RIF has resulted in immediate harms to CDPH and Californians across the state.

Authoritative Resources on Workplace Exposures, Health Effects, and Prevention

10. Prior to the RIF, NIOSH developed scores of evidence-based, thoroughly researched, and up-to-date guidance documents on workplace health and safety. These include Criteria Documents, Current Intelligence Bulletins, Alerts, and other documents. OHB has relied on many of these publications on a daily basis to inform its work.

11. For example, NIOSH published recommended exposure limits (RELs) and immediately dangerous to life or health (IDLH) values for toxic chemicals and other hazards in the workplace. NIOSH set those concentrations based on high-quality and comprehensive scientific evidence, including *in vitro* and *in vivo* experimental data, medical reports, and epidemiologic studies conducted at NIOSH and elsewhere. NIOSH's research on exposure limits is reliable because it used well-documented methods, included data from a range of studies, included review by expert peers, offered opportunity for public comment and response, and was subject to revision as new information became available. NIOSH's exposure limits informed OHB's evolving understanding of numerous chemicals in California workplaces and guided our recommendations to employers, Cal/OSHA, and others.

12. NIOSH produced similarly valuable research on hazard assessments related to heat exposure, and exposure to wildfire smoke and air pollution. Moreover, NIOSH proposed helpful engineering controls and other tools and techniques to reduce or prevent exposure.

NIOSH's studies represented the cutting edge and helped OHB adapt to new findings and protect California workers from adverse health effects of workplace exposures.

13. NIOSH also developed and maintained the NIOSH Pocket Guide to Chemical Hazards, which provided general industrial hygiene information for hundreds of chemicals or classes of chemicals, and the NIOSH Manual of Analytical Methods, a collection of sampling and analytical methods for workplace exposure monitoring. These were authoritative resources used by CDPH to provide technical assistance to workplaces with chemical exposures that need to be understood and monitored.

14. The RIF eliminated the staff responsible for conducting this research and publishing these essential data, recommendations, and resources. OHB does not possess the resources or capacity to replicate NIOSH's research efforts at the state level.

National Coordination of Occupational Safety and Health Surveillance

15. As part of its extramural research programs, NIOSH funded 23 states, including California, to systematically collect, analyze, and interpret occupational health data, a process termed "public health surveillance." The data collected helps CDPH understand the burden, patterns, and causes of job-related injuries, illness, exposures, and fatalities.

16. Since 1987, NIOSH has awarded funding to CDPH (for the 2021-2026 period, approximately $3,525,000 total), through a competitive application process, and the funding was used for important health and safety work. NIOSH's coordination among the participating states helped OHB to refine its methodology, learn about innovative approaches used in the other states that could be applied in California, and participate in a national network of experts who could share their experiences, particularly about novel or emerging issues detected through public health surveillance. For instance, OHB learned from NIOSH and partner states about new causes

of work-related asthma, silicosis, and injuries that were being recognized elsewhere. With that critical, timely information, OHB could then investigate whether those exposures were happening to California workers and develop prevention strategies.

17. As a result of the RIF, there are no longer any employees at NIOSH to coordinate this important program, and it has completely shut down. The abrupt end to the public health surveillance program will have drastic consequences.

18. For example, the program helped OHB review hospital discharge records and contact patients who were treated for asthma to better understand if workplace exposures led to their chronic condition. Additionally, with the patient's permission, CDPH would visit certain workplaces to identify causes of illness and prevent further exposure. This public health surveillance can no longer continue.

19. Additionally, NIOSH's program supported CDPH's pesticide illness program to collect, analyze, and interpret data on illnesses related to pesticides; CPDH's occupational lead poisoning program to collect, analyze, and interpret data on lead poisoning in the workplace; and CDPH's Fatality Assessment and Control Evaluation ("FACE") program, which conducted investigations of fatalities in the workplace to learn about contributing factors and develop recommendations for prevention. The coordination of these programs by NIOSH has ended.

20. Since 2021, CDPH has received additional NIOSH funding (approximately $80,000 per year) and programmatic support for a special project for silicosis related to artificial stone (quartz) countertop fabrication. Silicosis is an irreversible, potentially deadly lung disease that occurs when countertop workers inhale silica during cutting, grinding, and polishing of artificial stone. With NIOSH support, CDPH has detected more than 300 silicosis cases, including at least 31 lung transplants and at least 15 deaths, among California countertop

fabrication workers. This special project, which was scheduled to continue through August 2026, offered state-of-the-art medical tests to participating workers to study early identification of silicosis, when cessation of exposure and treatment may be most beneficial. To develop a protocol for early detection of silicosis, CDPH intended to recruit 100 countertop workers to undergo screenings; approximately 50 have been recruited to date. Because the funding from NIOSH will not continue, the additional approximately 50 workers that California planned to recruit for this program will not be screened. Furthermore, by ending the project prematurely and collecting less information than planned, we may not have sufficient statistical power to make conclusions about which testing modalities are best for early detection of silicosis. Thus, the failure to complete the project could have adverse health effects for the thousands of countertop workers in California who could benefit from its findings.

21. Additionally, prior to the RIF, NIOSH operated a B Reader Program, which trained and certified physicians in the International Labour Organization (ILO) International Classification of Radiographs of Pneumoconiosis. Pneumoconiosis refers to dust-related lung disease, and includes silicosis, coal workers' pneumoconiosis (Black Lung), and asbestosis. The program helped certified physicians, known as B Readers, classify chest x-rays in a uniform manner, facilitating communication about workers' chest x-rays across the country.

22. Some Cal/OSHA regulations require employers to offer chest X-rays to their employees. Under the regulations, those X-rays must be classified by a NIOSH-certified B Reader. In addition, CDPH uses B Readers in its public health surveillance for occupational lung diseases including silicosis.

23. The RIF shut down the B Reader certification program. As a result, CDPH will no longer have access to certified physicians who can classify chest X-rays for pneumoconiosis.

24. NIOSH's coordination of public health surveillance programs supported CDPH's efforts to collect, analyze, and interpret life-saving data. Without the program, workers in California could be at an increased risk of negative health outcomes.

National Personal Protective Technology Lab

25. CDPH also relies on NIOSH's National Personal Protective Technology Lab (NPPTL), which certifies respirators and studies other personal protective equipment. Prior to the RIF, NIOSH tested every respirator model to ensure it complied with regulations. The federal Occupational Safety and Health Administration (OSHA) and Cal/OSHA require employers to select and provide NIOSH-certified respirators to employees when respirators are required in the workplace.

26. Because NIOSH must certify any new respirator models, manufacturers may decide to only produce old models, in which case, workers may lose the opportunity to benefit from new, improved models that have undergone rigorous testing by NIOSH and could better protect their safety and health.

27. Moreover, NIOSH certifications lapse periodically. Thus, without NIOSH's NPPTL, workers may eventually rely on respirators that are not NIOSH certified, which could further jeopardize workers' safety and health.

28. NPPTL employed approximately 100 staff, about half of whom were dedicated to the respirator certification program. CDPH does not have the expertise or capacity to replicate a respirator certification program like NPPTL's.

29. Our branch currently has a contract with NPPTL ($1,621,587 total over 4 years, through September 2027) to conduct a project on respiratory protection for California workers and members of the public. The project is intended to develop and evaluate a respirator fit testing

training program to support effective respiratory protection across California. Fit testing assures that a tight-fitting respirator seals to the face and that contaminated air is filtered by the respirator before it reaches the wearer. Many workers and members of the public do not have access to respirator fit testing, which is a specialized service generally accessible only to certain workers through their employers' respiratory protection program. This project is intended to increase the state's capacity to offer fit testing to workers and the general public.

30. The RIF eliminated the NIOSH staff collaborating with OHB. Those staff provided expert feedback on a variety of technical issues, like conducting anthropometric measurements. Without that staff, we cannot conduct the project as planned. Notably, we will not have access to the technology they were developing to use a mobile application for cell phones to capture the 3-D geometries of faces, which would make respirator fit testing more efficient. As a result, Californians who choose to wear respirators but do not otherwise have access to fit testing will not have a way to confirm that the respirator is providing adequate protection.

31. From 2020 until April 24, 2025, I represented CDPH as a member of the National Academies of Sciences, Engineering, and Medicine's Standing Committee on Personal Protective Equipment for Workplace Safety and Health ("COPPE"). Since 2005, COPPE was funded through a contract between NIOSH and the National Academies to provide a forum for discussion of scientific and technical issues relevant to the development, certification, deployment, and use of personal protective equipment, standards, and related systems to ensure workplace safety and health. On April 24, 2025, I was informed by the National Academies that they had received a contract termination notification from CDC and that the regularly scheduled meeting for May 13-14, 2025, and all other activities under the contract, had been canceled. The

loss of COPPE means a loss in access to the latest information on personal protective equipment that benefits California workers.

32. I supervise Dr. Ximena Vergara, OHB's HESIS Chief. I approved her participation on the planning committee for a National Academies of Sciences, Engineering, and Medicine workshop titled "Personal Protective Equipment for Influenza A (H5N1) in High-Risk Farm Settings: A Workshop." This workshop was to be held in June 2025 and was highly relevant to CDPH, as California has been addressing an outbreak of H5N1 influenza ("bird flu") affecting poultry and dairy farms. California has detected 38 cases of H5N1 infections in humans, 36 of which were in dairy farm workers; this is the highest number of cases identified in any state, with a total of 70 cases reported nationally. On April 24, 2025, Dr. Vergara was informed by the National Academies that they had received a contract termination notification from CDC and that the workshop would be canceled. The loss of the H5N1 workshop means that California will not benefit from what would have been an expert discussion of personal protective equipment needs and best practices, which OHB would have used to better protect Californians from H5N1 infection.

Health Hazard Evaluation Program

33. Prior to the RIF, NIOSH's Health Hazard Evaluation (HHE) Program provided technical assistance to employers, employees, and state agencies. Through the HHE Program, states, local jurisdictions, and employers could request assistance from the HHE Program regarding a variety of workplace health concerns. The HHE Program conducted extensive medical testing and exposure assessments to help employees, employers, and state and local public health agencies understand potential health hazards at workplaces and ways to prevent work-related illness.

34. CDPH relied on HHE Program staff's expertise to understand new and emerging exposure and health issues affecting California workers. CDPH does not have the capacity that the HHE Program had to replicate these evaluations of workplaces as requested.

35. It is my understanding that the vast majority of HHE Program staff received RIF notices and are no longer able to perform their programmatic roles. This is evident from the NIOSH HHE Program website, which currently states "Due to the reduction in force across NIOSH, no new health hazard evaluation requests can be accepted." It is my understanding that not only are new requests not being accepted, but in addition, at least six open California HHE Program requests will not be completed. These include a request for assistance at a hospital where workers were concerned about exposure to a chemical disinfectant and asthma; a request for assistance at a tile installer where workers were concerned about exposure to silica; and a request for assistance at a hospital where workers were concerned about the health effects of exposure to waste anesthetic gas and surgical smoke. These HHE Program requests involve issues where the scientific evidence base is still developing, and NIOSH's ability to conduct onsite evaluations and collect new data to answer specific questions is critical to protecting workers' health. CDPH cannot answer these questions adequately using existing information.

36. In the case of the hospital where workers were concerned about exposure to a chemical disinfectant, NIOSH staff traveled to California on multiple occasions to learn about the facility and evaluate the health impacts of the chemical disinfectant, peroxyacetic acid. I participated in the initial walk-through visit led by NIOSH staff. Last summer, over the course of a week, HHE Program staff collected air samples and tested hospital workers for asthma. Two OHB staff assisted NIOSH with data collection. This weeklong visit was a significant investment of time and resources for both NIOSH and CDPH.

37. When the RIF Directive was issued, HHE Program staff were in the process of drafting their report about the chemical. Because those staff received RIF notices, the HHE Program will not finish the report. By preventing the report's finalization, the RIF wastes the major investment that the HHE Program made through its evaluation at the hospital. The hospital management will not know whether the chemical negatively impacts the health of its workers. OHB will not be able to incorporate the report's findings into its illness prevention efforts across the state. Because this chemical is commonly used in the healthcare industry, the HHE Program's report would have provided valuable insight for hospital workers and their employers.

NIOSH Industry and Occupation Computerized Coding System

38. Another key NIOSH resource is the NIOSH Industry and Occupation Computerized Coding System (NIOCCS), which is a web-based software tool that automates industry and occupation information into standardized codes.

39. Our branch uses NIOCCS coding to maintain our occupational disease registries, including our analysis of death registries, workers' compensation claims, and pesticide illnesses. NIOCCS allows OHB to quickly and accurately assign industry and occupation codes to health-related data. I am not aware of commercially available software that could be used in place of NIOCCS. Instead, the only alternative available would be to assign codes manually, which is a time-consuming process that requires specific training and expertise.

40. NIOCCS coding helps OHB identify and support worker populations at risk of injury or illness. For example, we use the software to identify which industries and occupational groups experience higher than average death rates. Once OHB determines the at-risk occupational group, we can design education and outreach for employers and workers to promote prevention.

41. The RIF eliminated the ongoing support required to maintain the NIOCCS system. Because NIOCCS is a software tool, it will eventually become outdated and no longer operable. OHB does not have staff or resources to code the data by hand. As a result, we will be less efficient in identifying and supporting some of the most vulnerable workers in the state.

NIOSH Centers at the University of California

42. University of California Berkeley, UC San Francisco, UCLA and UC Irvine receive NIOSH funding for Education and Research Centers (ERCs) located in Northern California and Southern California. The ERCs are vital to training the next generation of occupational safety and health professionals. Many experts in the field, including in OHB, were educated at an ERC. These include physicians trained in Occupational Medicine residencies, nurses trained in Occupational Nursing, industrial hygienists trained in master's and doctoral industrial hygiene programs, and epidemiologists trained in master's and doctoral occupational epidemiology programs. NIOSH is the sole agency in the United States that supports this specialized training, which is important to maintaining a workforce of occupational health professionals that can identify, treat, and prevent work-related injuries, illnesses, and fatalities. CDPH relies on the ERCs to train future occupational public health practitioners.

43. The California Labor Lab receives NIOSH funding for a Total Worker Health Center based at UC San Francisco. The mission of the California Labor Lab is to extend the pursuit of health and safety for workers in traditional employment to those in a wide range of alternative arrangements in partnership with affected communities. CDPH relies on the California Labor Lab for its expertise in the mitigation of health and safety issues that arise from alternative work arrangements, such as temporary work and contract work.

44. UC Davis receives NIOSH funding for the Western Center for Agricultural Safety and Health. The mission of this center is to improve health and safety of agricultural workers through innovative research, interactive trainings, and tailored outreach. CDPH relies on the expertise of this center's staff in the mitigation of health and safety issues that impact California's agricultural workers.

45. It is my understanding that the RIF could limit the activities of the ERCs, California Labor Lab, and Western Center for Agricultural Safety and Health, reducing the expertise available to CDPH and making it more difficult for CDPH to prevent workplace injuries and illness.

46. I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

EXECUTED on May 8, 2025 in Richmond, California.

Kristin J. Cummings, MD, MPH, ATSF
Branch Chief, Occupational Health Branch
California Department of Public Health

EXHIBIT 53

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF RHODE ISLAND

STATE OF NEW YORK, et al. Plaintiffs, v. ROBERT F. KENNEDY, JR., in his official capacity as SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., Defendants.	Case No.

DECLARATION OF STEVEN BLESSING

I, Steven Blessing, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the foregoing is true and correct:

1. I am the Director of the Delaware Division of Public Health. I am familiar with the information in the statements set forth below either through personal knowledge, in consultation with the Delaware Division of Public Health's staff, or from documents that have been provided to and reviewed by me.

2. I submit this Declaration in support of the States' Motion for a Preliminary Injunction.

Professional Background

3. I am the Division Director at the Delaware Division of Public Health. I have over 30 years of public health experience, including academic research and administration of a wide range of public health programs. I hold an undergraduate and graduate degrees in political science and business.

4. Delaware Division of Public Health's mission is to protect and promote the health of all people in Delaware.

5. The Delaware Division of Public Health, centrally located in Dover, Delaware, administers more than 300 public health programs, oversees a workforce of over 800 personnel, and manages millions of dollars in state and federal funding.

6. I am providing this declaration to outline the serious impacts that funding reductions have on Delaware's public health system. These cuts hinder our ability to identify, test for, and respond to emerging infectious diseases, and they threaten critical prevention efforts, such as reducing tobacco and vaping use among youth, which have long-term implications for chronic disease and population health. Additionally, cutting funds for the PRAMS program significantly weakens our capacity to collect essential data on maternal and infant health, data that guides evidence-based policies, programs, and interventions designed to improve health outcomes for mothers and babies across the state.

Reliance on HHS Data and Technical Expertise

7. Prior to April 1, 2025, Delaware relied heavily on data, technical assistance, and resources from HHS, including the CDC and FDA, to guide its tobacco prevention and control efforts. Support from the Office on Smoking and Health and the Center for Tobacco Products has been essential in implementing best practices, driving policy changes, and responding to emerging threats like youth vaping, contributing to major declines in cigarette use among both adults and youth.

8. Delaware relied heavily on US Health and Human Services (HHS), including Center for Disease (CDC) and the Food and Drug Administration (FDA) for their assistance in tobacco prevention and control, including the State Tobacco Activities Tracking and Evaluation (STATE) System, and resources for Delaware's Tobacco Quitline. Support from Occupational Safety and Health (OSH) and Center for Tobacco Products (CTP) has enabled the Delaware

Tobacco Prevention and Control Program to implement best practices and policy system environment changes within communities that have ultimately led to a significant decline in cigarette use among both adults and youth (adult cigarette use decreased 37% since 2011 and youth cigarette use decreased approximately 92% since 1999). However, it is critical to retain the support of OSH and CTP with the surge of youth vaping and emergence of new tobacco products. OSH and CTP provided vital surveillance and evaluation activities that informed about youth behaviors related to tobacco use which better equipped states for addressing the issues.

Conclusion

9. Delaware's Tobacco Prevention and Control Program has been significantly supported by HHS, including the CDC and FDA, to address tobacco use and promote public health. Key resources such as the State Tobacco Activities Tracking and Evaluation (STATE) System and Delaware's Tobacco Quitline, along with support from the Office on Smoking and Health (OSH) and the Center for Tobacco Products (CTP), have allowed Delaware to implement best practices and policy changes that have led to a substantial decline in cigarette use—37% among adults since 2011 and 92% among youth since 1999. However, ongoing support from OSH and CTP remains critical, especially in the face of rising youth vaping and the emergence of new tobacco products. Their surveillance and evaluation efforts are crucial in helping Delaware respond effectively to evolving tobacco use trends.

Steven Blessing

Steven L. Blessing, MA
Division of Public Health, Director

Date: May 7, 2025

EXHIBIT 54

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF RHODE ISLAND

STATE OF NEW YORK, et al. Plaintiffs, v. ROBERT F. KENNEDY, JR., in his official capacity as SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., Defendants.	Case No. 25-cv-00196

DECLARATION OF LAUREN GILWEE

I, Lauren E. Gilwee, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the foregoing is true and correct:

1. I am the Policy Director of the Maryland Department of Labor, Division of Workforce Development and Adult Learning (herein "DWDAL"). I have personal knowledge of the facts set forth in this declaration, and if required to testify, would and could competently do so.

2. I submit this Declaration in support of the States' Motion for a Preliminary Injunction.

Professional Background

3. I am a Policy Director at the Maryland Department of Labor and have served in that role since 2019 (except during a brief leave of absence from March through November 2023). I joined DWDAL in 2017 following a decade of professional work in education and workforce development. My previous experience includes overseeing integrated academic and

occupational programming for adult learners at Baltimore City Community College, as well as instructing English as a Second Language, Spanish, and middle school Career and Technical Education. I proudly hold a Bachelor of Arts degree from Loyola University New Orleans and a Master's Degree from the University of New Orleans.

4. DWDAL's mission is to improve the lives of all Marylanders by implementing innovative, responsive practices that nurture a skilled workforce, connect people to good jobs, and ensure businesses have the skilled workforce they need to compete in the global economy.

5. DWDAL is the state's primary workforce development entity, administering a wide range of federally funded workforce development activities, including but not limited to those authorized by the Workforce Innovation and Opportunity Act (WIOA) such as numerous sector-specific initiatives, Maryland's 33 American Job Centers, relevant federal and state tax credit processing, 23 Adult Education providers, and academic and occupational programming in state prisons. DWDAL is also the State Apprenticeship Agency, supporting over 12,200 Registered Apprentices and 195 active programs. The Division has an annual budget of $188,000,000 and approximately 440 full-time staff.

The Federal Poverty Guidelines

6. The federal poverty guidelines are used by federal, state, local, and tribal agencies in numerous ways, including to assess eligibility for certain means tested programs.

7. The United States Department of Health and Human Services (herein "HHS") maintains the federal poverty guidelines and updates them annually.

8. Once produced by HHS, the United States Department of Labor (herein "USDOL") determines and annually publishes the Lower Living Standard Income Level (herein "LLSIL") guidelines. *See e.g.* U.S. Dep't of Labor, *Workforce Innovation and Opportunity Act*

(WIOA) 2024 Lower Living Standard Income Level (LLSIL), 89 Fed. Reg. 26935-26937 (April 16, 2024).

9. DWDAL relies on the HHS federal poverty guidelines and subsequent USDOL LLSIL figures to determine eligibility and priority of service for means-tested programs, specifically Title I Adult and Youth programs of the Workforce Innovation and Opportunity Act (herein "WIOA") 29 U.S.C. § 3101 et. seq (2015), which collectively served 4,859 Marylanders during the previous fiscal year (7/1/2023 to 6/30/2024).

10. The HHS guidelines also are pertinent to determining eligibility for Temporary Assistance for Needy Families (herein "TANF") and Supplemental Nutrition Assistance Program (herein "SNAP") benefits. DWDAL must confirm TANF and SNAP eligibility when certifying that an individual qualifies for the federal and state-match Work Opportunity Tax Credit.

Harm from Delay or Failure to Maintain the Federal Poverty Guidelines

11. Any delay in issuing the federal poverty guidelines or inaccuracy in or failure to do so would have catastrophic consequences for the State of Maryland and Maryland's workforce system and job seekers.

12. For example, Maryland would no longer have timely and accurate guidelines for the calculation of "low income individual," as required under WIOA for Youth program eligibility and Adult program priority of service. The definition of "low income individual" at 29 U.S.C.A. § 3102(36(A)(ii) includes an individual in a family with a total income that does not exceed the higher of (I) the poverty line or (II) 70 percent of the Lower living standard income level. WIOA further defines "Lower living standard income level" as "that income level (adjusted for regional, metropolitan, urban, and rural differences and family size) determined

annually by the [United States] Secretary of Labor based on the most recent lower living family budget issued by the Secretary at 29 U.S.C.A. § 3102(36)(B)."

13. WIOA is intended to support hard-to-serve populations including those experiencing poverty, Unemployment Insurance beneficiaries, and recipients of TANF and SNAP.

14. WIOA Title I Youth program eligibility requires that individuals demonstrate that they are "low income" using the established LLSIL figures for a given year. For example, certain programming is available only to "In-School-Youth." To qualify as an In-School-Youth, a participant must be attending school, be of a certain age, *be low income*, and demonstrate one more criterion such as being an ex-offender or an English language learner. 29 U.S.C.A. § 31649(a)(1)(B)(VIII) and (C)(iii).

15. The WIOA Title I Adult program requires participants to be 18 years of age, a U.S. citizen or authorized to work in the United States, and to have completed Selective Service registration as required by law (if applicable). Once determined eligible, participants are triaged using an established Priority of Service provision that includes "low income individuals." 29 U.S.C.A. § 3174(a)(3)(E).

16. American Job Centers throughout the State of Maryland provide a full range of assistance to job seekers and businesses. Job seeker services include career exploration assistance, referrals to training programs, placement services, resume preparation assistance, and workshops to enhance job seeking skills and work readiness.

17. Without the required guidelines and figures from the federal agencies, American Job Center practitioners would not be able to confirm whether a participant's income level

qualifies or prioritizes them for programming (including occupational training, supportive services, and coverage of career-specific licensing/exam fees).

18. This would cause harm in the form of uncertainty for State officials who would have to expend resources fielding questions regarding the applicable guidelines and/or calculating their own replacement guidelines (if permissible under state and federal law). The administrative burden would also increase if different states were to use different applicable guidelines levels.

19. In addition to employment preparation, WIOA Title I funds may be used for "supportive services" that support jobseekers as they attend occupational training, study for licensing exams, etc.

20. Supportive services include critical help with transportation assistance, childcare costs, temporary housing, referrals to healthcare and legal aid, assistance with uniforms and work appropriate attire and tools including protective gear and eyeglasses and/or food assistance. 20 CFR §§ 681.570 (Supportive Services for Youth), 663.800 (Supportive Services for Adults).

21. Youth and low-income individuals throughout Maryland will be particularly harmed if they are unable to access these supports as they look to enter or reenter the workforce.

22. Access to WIOA resources supports both jobseekers and businesses, and helps to drive the economy in Maryland. If low-income individuals are unable to access these services, it keeps Marylanders out of the workforce and Maryland employers without the skilled talent they require to operate and remain competitive. Additionally, it will place an unnecessary burden on other public benefits like Unemployment Insurance, SNAP, and TANF as unemployed individuals may not be able to sustain themselves and their families. Those connected to the

criminal justice system may recidivate without access to these resources and employment support, creating harm and extra costs for Maryland's correctional entities.

23. Finally, if unable to spend federal funds due to the lack of required HHS and LLSIL eligibility criteria, the State will experience fiscal harm as WIOA dollars will be subject to return or recapture. For the current fiscal year, Maryland received $16,228,876 for WIOA Title I Youth programming and $15,663,684 for WIOA Title I Adult services. United States Department of Labor, Employment and Training Administration, Training and Employment Guidance Letter No. 12-23. In future years, much of this formula allocation would remain unspent without the aforementioned guidelines that enable Maryland to expend this funding consistent with state and federal law.

Lauren E. Gilwee

Lauren E. Gilwee

Date: 08/05/2025

Signature: Lauren E. Gilwee (May 8, 2025 15:56 EDT)

Email: laurene.gilwee@maryland.gov

EXHIBIT 55

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF RHODE ISLAND

STATE OF NEW YORK, et al. Plaintiffs, v. ROBERT F. KENNEDY, JR., in his official capacity as SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., Defendants.	Case No. 25-cv-00196

DECLARATION OF SARAH NEVILLE-MORGAN

I, Sarah Neville-Morgan, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the foregoing is true and correct:

1. I am the Assistant State Superintendent of the Division of Early Childhood at the Maryland State Department of Education (MSDE). I am familiar with the information in the statements set forth below either through personal knowledge, in consultation with MSDE staff, or from documents that have been provided to and reviewed by me.

2. I submit this Declaration in support of the States' Motion for a Preliminary Injunction.

Professional Background

3. I am an Assistant State Superintendent at MSDE. I was appointed to this position in April 2025. Prior to that, I spent over 22 years working for the state of California, most recently in the California Department of Education as a Deputy Superintendent of Public Instruction from May 2019 to December 2024.

4. MSDE is responsible for ensuring a rigorous and world-class educational experience for every Maryland student, in every neighborhood, that prepares each student to be college and career ready. The main mission of MSDE's Division of Early Childhood is to improve early education in Maryland so that young children are well prepared for school. The Division is composed of the Office of Child Care, the Office of Early Learning and Instruction, the Office of Family Support Services, and the Head Start Collaboration.

The Head Start Program

5. The federal Head Start program, founded in 1965, promotes school readiness for children of low income families from birth to 5 years old. Head Start services support early learning and development, health, and family wellbeing.

6. Head Start is administered by the Office of Head Start (OHS) within the Administration for Children and Families (ACF) of the U.S. Department of Health and Human Services (HHS).

7. Head Start programs include Early Head Start (EHS) programs for infants, toddlers, and expectant families and Head Start preschool programs for primarily three- and four-year-old children. In addition, Head Start includes American Indian and Alaska Native (AIAN) Head Start programs and Migrant and Seasonal Head Start (MSHS) programs serving farmworker families.

8. Head Start provides vital services to low-income children and families. In addition to providing high quality child care and early childhood education, Head Start programs connect children and families to wrap-around social services and supports. Head Start programs integrate state benefit programs to provide children with meals and snacks during the school day,

as well as diapers for young children, enrollment assistance in health insurance plans, and supports for parents including connections to career services and adult education.

9. The Head Start program is largely administered at the federal level by HHS employees working out of HHS Regional Offices.

10. In Maryland, the Head Start program serves 7,774 children and their families at 202 centers employing 2,362 staff. This includes 5,765 funded Head Start preschool seats and 2,009 funded Early Head Start seats. Since 2003, the state's Head Start Collaboration Office has been housed at MSDE. In addition, MSDE is the administrator of the Head Start collaboration grant ($125,000) and provides technical assistance in aligning Head Start services with those of early learning programs in the public schools.

11. Maryland grant recipients receive approximately $150 million in direct funding from HHS to implement Head Start Programs at non-profit organizations across the state as well as public school sites in Calvert County and Montgomery County.

12. I am providing this declaration to explain the impacts on Maryland as a result of the changes to Head Start, including a reduction in staffing, since April 1, 2025. These changes have created a situation whereby grant recipients are concerned about the status of their funding requests, several of which are still pending HHS review. The grant period for some recipients ends June 30, 2025, so they are unable to budget and plan effectively for the coming year. This impacts Maryland families due to the instability of knowing if programs are able to enroll them in Head Start for the upcoming program year as well as staffing and programs' ability to offer contracts to hire and retain their teaching and support staff.

Reliance on HHS Head Start Staff Prior to April 1, 2025

13. Prior to April 1, 2025, HHS had designated program specialists to communicate with grant recipients, and HHS Head Start staff responded to correspondence within 48-72 hours. Grant recipients regularly relied on HHS Head Start staff whenever issues arose that required technical assistance.

14. HHS Head Start staff offered training, technical assistance, monitoring, site visits, and other support to Maryland Head Start programs.

15. For example, HHS Head Start staff would routinely offer specialized training on eligibility, recruitment, selection, enrollment, and attendance policies; serving children with disabilities; Child and Adult Care Food Program participation; coaching and instructional practices for educators; and fiscal management.

16. The HHS Head Start staff with whom MSDE and Maryland grant recipients communicated and relied upon were primarily located in the Regional Office of Region III, in Philadelphia, Pennsylvania.

Changes in HHS Head Start Operations Since April 1, 2025

17. Since April 1, 2025, there have been significant delays in communication with HHS staff, including extended wait times for grant application approvals. There have also been some lingering difficulties in accessing the Payment Management System.

18. Our state's primary point of contact at HHS for the Head Start Collaboration Office was removed, and we have been reassigned to another HHS staff member. We have also been told that Maryland is now in the Southeast Region with a total of 8 states, the District of Columbia, the U.S. Virgin Islands, and Puerto Rico. There were only 5 states and the District of Columbia in our region previously. Our new Regional Office is in Atlanta, Georgia.

19. On April 3, 2025, MSDE received an email from Laurie Todd-Smith, Ph.D., Deputy Assistant Secretary for Early Childhood Development of ACF confirming the closure of five HHS Regional Offices effective April 1, 2025.

Effect on State's Head Start Program

20. Maryland grant recipients have reported delays in funding and slower response time to inquiries. For example, Community Action Council of Howard County submitted a grant application in January 2025 and on May 2, 2025, received an email from HHS indicating that final decisions will be made in time for summer 2025. Previously, however, this decision would have been made by April 1, allowing the program to budget and plan accordingly. The pending application is for approximately $2.5 million, and the program serves 140 children and families. Additionally, Montgomery County Community Action Agency submitted a grant application in January 2025 but has not yet received any further communication from HHS. This pending application is for approximately $6 million, and the program serves 648 children and families. Both of these programs will run out of grant funding on June 30, 2025.

Conclusion

21. The changes to the HHS Head Start Program described above risk significant harm to young children and their families in Maryland. If funding decision are not made timely, the result will be that Head Start preschool programs will possibly have to lay off staff, decrease the number of available slots, and children who are not served will enter school further behind their peers. Ultimately, this will undermine the state's efforts to narrow the achievement gap.

Sarah Neville-Morgan

Sarah Neville-Morgan

Date: May 8, 2025

EXHIBIT 56

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF RHODE ISLAND

STATE OF NEW YORK, et al. Plaintiffs, v. ROBERT F. KENNEDY, JR., in his official capacity as SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., Defendants.	Case No. _____

DECLARATION OF PHILLIP A. SANCHEZ

I, Phillip A. Sanchez, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the foregoing is true and correct:

1. I am the Director of the Alcoholic Beverage Control Division of the New Mexico Regulation and Licensing Department. I am familiar with the information in the statements set forth below either through personal knowledge, in consultation with the New Mexico Health Care Authority AND New Mexico Department of Health staff, or from documents that have been provided to and reviewed by me.

2. I submit this Declaration in support of the Plaintiffs' Motion for a Preliminary Injunction.

Professional Background

3. I am the Director of the Alcoholic Beverage Control Division (ABC) of the New Mexico Regulation and Licensing Department. I have been ABC Director, or Acting Director, since April 1, 2023. Before that I was attorney for the division, beginning in June 2019. As division attorney, before the New Mexico Tobacco Products Act was enacted, I was responsible

for assisting the New Mexico Department of Health and New Mexico Regulation and Licensing Department with the drafting of the legislation that would become the Tobacco Products Act in 2021. Once the Tobacco Products Act was passed, I drafted the promulgated rules pursuant to the Tobacco Products Act that would be adopted by the division.

4. The ABC's mission is to protect the health, safety, and welfare of citizens of New Mexico or those entering New Mexico, by: (1) ensuring that licensees for the manufacture, distribution, and retail sales of tobacco products, meet the requirements for such licensure; (2) resolving enforcement actions against licensed manufactures, distributors and/or retailors for violations of the New Mexico Tobacco Products Act and Rules promulgated thereto (TPA), including, but not limited to, the sale of tobacco products to minors, and the manufacture, distribution, or retail sale of tobacco products that are packaged or labeled in a manner that is knowingly attractive to minors; and (3) investigating or reporting to law enforcement authorities, alleged violations of the TPA. NMSA 1978, Sections 61-37- 3 and -4, and 22-23.

5. The ABC has one location in the Toney Anaya Building, 2550 Cerrillos Rd., Santa Fe, New Mexico 87505. The ABC "has authority over all matters relating to the issuance, denial, suspension, revocation and other administrative penalties or transfer of licenses under the TPA. The Director may request the New Mexico State Police, Department of Public Safety to provide investigatory and enforcement support as deemed necessary." NMSA 1978, Section 61-37-22. The ABC coordinates with the New Mexico Department of Health, New Mexico Health Care Authority, and New Mexico Department of Public Safety in taking measures to reduce tobacco product sales to minors.

Office on Smoking and Health (OSH)

6. OSH was the lead federal agency for comprehensive tobacco prevention and control and played a critical role in preventing youth tobacco use, which includes smoking, vaping, and other nicotine products, and helping adults to quit smoking. Cigarette smoking is the leading cause of preventable disease, disability, and death in the United States. OSH worked to prevent and reduce cigarette smoking by collecting, studying, and sharing information on cigarette smoking and its effects on health, as mandated by Congress. 15 U.S.C. § 1341 ("Smoking, research, education and information").

7. OSH was administered by the National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), within the Centers for Disease Control and Prevention (CDC) of the U.S. Department of Health and Human Services (HHS).

8. OSH managed a tobacco use data portal which provided access to the latest tobacco prevention and control data, graphs, and maps, as well as the State Tobacco Activities Tracking and Evaluation (STATE) System, which presented data on traditional Medicaid coverage of tobacco cessation treatments in fifty U.S. States and the District of Columbia. This dataset was used by Plaintiff States to assess tobacco cessation policies and served as a national clearinghouse of information for the public.

9. OSH also managed annual submissions of cigarette and smokeless tobacco ingredient reports from manufacturers, packagers, and importers. OSH also monitored tobacco use trends and health impacts in part to inform FDA regulations and enforcement.

10. Further, OSH played an important role in surveillance and surveys, including the state-based Behavioral Risk Factor Surveillance System, National Health and Nutrition Examination Survey, and National Youth Tobacco Survey (NYTS). OSH's national surveillance system provided reliable, consistent, and cost-effective data collection that many states used to

evaluate their work and monitor progress in tobacco use prevention. NYTS collected data on tobacco use by high school and middle school students, including which products they were using, how often they use them, and how youth access them. OSH additionally published state-level data on tobacco prevention use in the STATE System.

11. OSH committed to educating the public about the harms of tobacco use, including media campaigns such as Tips from Former Smokers (Tips Campaign) and publications derived from the Publication Catalog and Ordering System. The Tips Campaign ads, which were placed on television, radio, and billboards, encouraged smokers to quit by featuring real people with serious health conditions caused by smoking and secondhand smoke exposure. The 2012–2018 Tips Campaign had a significant positive impact on Americans' health. CDC estimated that over 16.4 million smokers attempted to quit and approximately one million successfully quit because of the Tips Campaign. Smokers who saw Tips Campaign videos reported greater intentions to quit smoking, and former smokers with higher exposure to the ads were associated with lower odds of relapse. The Tips Campaign was credited with helping to prevent early deaths and save precious government resources.

12. OSH scientists published high-quality reports on tobacco use trends that states utilized to prioritize interventions, monitor progress, and reduce disparities. OSH's Best Practices for Comprehensive Tobacco Control Program Guide advises states on how to develop, implement, and fund an evidence-based tobacco control program. OSH likewise dedicated its publications and resources to the "Publication Catalog and Ordering System" where state agencies and other users could access campaign materials and Surgeon General's reports.

13. OSH maintained the national network of tobacco cessation quitlines to encourage people to quit tobacco use by supporting quitline services in fifty states, two U.S. territories, and

Washington, D.C. OSH funded state quitlines to deliver resources such as counseling and medications. The Tips Campaign resulted in a sustained and dramatic increase of calls to quitlines.

14. OSH also provided millions in funding to the National and State Tobacco Control Program. Participating states used OSH funds to prevent kids from using tobacco, reduce secondhand smoke exposure, help people quit smoking, and address disparities in tobacco use.

15. OHS is largely administered at the federal level by HHS employees working out of HHS Regional Offices.

Center for Tobacco Products (CTP)

16. CTP oversees the implementation of the Family Smoking Prevention and Tobacco Control Act by setting performance standards for tobacco products, reviewing premarket applications for new and modified risk tobacco products, requiring new warning labels, and establishing and enforcing advertising and promotion restrictions.

17. CTP was administered by the Food and Drug Administration (FDA) of the U.S. Department of Health and Human Services (HHS).

18. Among other duties, CTP conducts compliance checks on vendors and retailers to ensure that tobacco products are not sold to those under the age of twenty-one, reviews premarket applications for new tobacco products before they can be marketed in the United States, enforces advertising and promotion restrictions, and educates the public about the risks of tobacco use including the dangers of e-cigarettes and other tobacco products.

19. Our state tobacco laws and regulations depend on FDA review and approval of new tobacco product applications. If those applications are not properly processed, our state's ability to keep dangerous tobacco products off the shelves will be impacted.

Effect on State's Tobacco Program

20. Deprecation of these two subagencies will have an effect on New Mexico's ability to protect its citizens, especially its youth, from the dangers of smoking and tobacco products. Fewer compliance checks by the CTP will lead to more sales of tobacco products, exposing the youth of New Mexico to a risk of becoming addicted to nicotine products and suffering known health harms.

/s/ Phillip A Sanchez
Phillip A. Sanchez

Date: May 6, 2025

EXHIBIT 57

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF RHODE ISLAND

STATE OF NEW YORK, et al. Plaintiffs, v. ROBERT F. KENNEDY, JR., in his official capacity as SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., Defendants.	Case No. 1:25-cv-00196

DECLARATION OF RAJNI CHAWLA, EXECUTIVE DEPUTY COMMISSIONER OF THE NEW YORK STATE OFFICE OF TEMPORARY AND DISABILITY ASSISTANCE

I, RAJNI CHAWLA, declare as follows:

1. I am the Executive Deputy Commissioner of the New York State Office of Temporary and Disability Assistance (OTDA). I am familiar with the information in the statements set forth below either through personal knowledge, in consultation with OTDA staff, or from documents that have been provided to and reviewed by me.

2. I submit this Declaration in support of the States' Motion for a Preliminary Injunction.

3. As OTDA's Executive Deputy Commissioner, I am the principal assistant to the Commissioner of OTDA. I advise on matters of policy and co-manage the operations of the agency with the Commissioner.

4. The mission of OTDA is to help vulnerable New Yorkers meet their essential needs and advance economically by providing opportunities for stable employment, housing, and nutrition. The agency's vision is to empower New Yorkers to improve their financial security and household stability in support of strong families and communities.

5. OTDA administers a wide range of programs that provide services and support to low-income families and individuals. OTDA oversees programs administered through social services districts (districts), including Supplemental Nutrition Assistance Program (SNAP), Home Energy Assistance Program (HEAP), and Public Assistance (PA), and provides policy guidance and systems support to the districts in implementation of OTDA programs, as well as monitoring and quality assurance of district operations and adjudication of fair hearings reviewing district determinations.

The Federal Poverty Guidelines

6. The Federal Poverty Guidelines are used by federal, state, local, and tribal agencies in numerous ways, including to assess eligibility for certain means tested programs.

7. The U.S. Department of Health and Human Services (HHS) maintains the Federal Poverty Guidelines and updates them annually.

8. New York State relies on the Federal Poverty Guidelines to determine eligibility for means-tested benefit programs, including, but not limited to SNAP, HEAP, and PA, which collectively reach millions of New Yorkers.

9. Additionally, the State also utilizes the Federal Poverty Guidelines to calculate thresholds for child support orders where orders may otherwise cause financial distress for the court-ordered payor parent.

Harm from Delay or Failure to Maintain the Federal Poverty Guidelines

10. Delay or inaccuracy in the computation of the Federal Poverty Guidelines could result in significant harm to New York State.

A. SNAP, HEAP, and PA

11. Delayed or inaccurate Federal Poverty Guidelines will likely create disruptions and uncertainty for individuals and families applying for and in receipt of SNAP, HEAP, PA, as

well as other OTDA-overseen programs that utilize PA eligibility standards, such as Emergency Assistance to Families (EAF), Emergency Safety Net Assistance (ESNA), Temporary Housing Assistance, and Family Homeless and Eviction Prevention Supplements (FHEPS), because these programs are means tested and rely on Federal Poverty Guidelines to determine eligibility and to calculate entitlement amounts.

12. Delayed or inaccurate Federal Poverty Guidelines will likely result in some miscalculated issuances or erroneous eligibility determinations. In the instance of miscalculation, a recipient could either receive less than they were entitled to receive, or more, causing the State to expend resources to recoup the over-issuance.

13. The State will also need to expend resources to address disruption and uncertainty. OTDA is tasked with issuing guidance to social services officials regarding the applicable Federal Poverty Guidelines to be used for determining eligibility for these programs. Delayed or inaccurate Federal Poverty Guidelines will lead to the expense of State resources to field questions from districts, advocates, and applicants/recipients generated by the disruption.

14. Erroneous eligibility determinations for means tested benefits by districts could result in increased fair hearings requests, placing a burden on New York State to conduct hearings, reach decisions, and notify households and social services officials of decisions within mandated timeframes.

15. A delay will also necessitate additional system work. Yearly system changes based upon the annually revised Federal Poverty Guidelines require significant production time and are built into New York State's production schedule one year in advance. If the Federal Poverty Guidelines are delayed, the system update will need to be rescheduled, which will generate additional programming and testing to accommodate the rescheduling.

B. Child Support Standards

16. The failure to issue timely and accurate Federal Poverty Guidelines will result in the inability of the State to update statewide guidelines as required by federal law. The statewide guidelines are used for the calculation of child support obligations by parents, attorneys, and the New York State courts, and failure to update the Federal Poverty Guidelines would cause uncertainty in the validity of the calculations and resulting child support orders.

17. Without revising the 2025 Federal Poverty Guidelines standard next year, millions of low-income New Yorkers could be at risk of incorrect eligibility and benefit amount determinations that are critical to obtaining and maintaining financial security.

18. I declare under penalty of perjury under the laws of the States of New York and Rhode Island and the United States of America that, to the best of my knowledge, the foregoing is true and correct.

DATED this 8th day of May, 2025, at Albany, New York.

Rajni Chawla
OTDA Executive Deputy Commissioner

EXHIBIT 58

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF RHODE ISLAND

STATE OF NEW YORK, et al. Plaintiffs, v. ROBERT F. KENNEDY, JR., in his official capacity as SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., Defendants.	Case No. 1:25-cv-00196

DECLARATION OF MANOJ VERMA

I, Manoj Verma, hereby declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the foregoing is true and correct:

1. I am over the age of 18, competent to testify as to the matters herein, and make this declaration based on my personal knowledge.

2. I am the Comprehensive Child Welfare Information System (CCWIS) Director for the Washington State Department of Children, Youth, and Families (DCYF). DCYF is an agency that receives federal funds through Title IV Subpart E of the Social Security Act (Title IV-E agency). CCWIS is a case management information system that Title IV-E agencies may elect to develop and then receive a more favorable federal reimbursement if the system meets federal requirements. *See* 45 C.F.R. §§ 1355.52-1355.55.

3. In my role, I communicate with the U.S. Department of Health and Human Services Administration for Children and Families Division of State Systems (DSS). DDS supports state Title IV-E agencies in developing and operating child welfare information systems. Each state with a Title IV-E agency, like DCYF, is assigned a DDS analyst whose role is to respond to questions,

provide technical assistance, and serve as the primary contact. Amit Rastogi was a DDS analyst assigned to work Title IV-E agencies in Washington, including DCYF.

4. On April 1, I received an email from Amit Rastogi, informing me that the DDS federal team "is Riffed as of today." I received this email from the email address I used to regularly communicate with Amit Rastogi in my normal course of business. A true and correct copy of the email is attached as Exhibit 1.

5. I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Dated this 8th day of May, 2025, at Olympia, Washington.

Manoj Verma 05/08/2025

Manoj Verma
Comprehensive Child Welfare Information System Director
Washington Department of Children, Youth, and Families

Exhibit 1

From: Rastogi, Amit (ACF)
To: Verma, Manoj (DCYF); Doran, Christian (DCYF); Kukas, Kevin (DCYF)
Subject: DSS update
Date: Tuesday, April 1, 2025 6:23:29 AM

External Email

We just got notified that the DSS federal team is Riffed as of today.
Sorry for a very short notice, I am not sure what next for us.
It was a pleasure working with the state team, keep in touch.
My personal email: arusty@gmail.com.
Thanks,
Amit Rastogi
Information Technology Specialist
ACYF/CB/Division of State Systems
Administration for Children and Families
U.S. Department of Health and Human Services

EXHIBIT 59

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF RHODE ISLAND

STATE OF NEW YORK, et al.,

Plaintiffs,

v.

ROBERT F. KENNEDY, JR., et al.,

Defendants.

C.A. No. 25-cv-196

DECLARATION OF ELIZABETH HERTEL (MICHIGAN)

I, ELIZABETH HERTEL, pursuant to 28 U.S.C. § 1746, hereby declare that the following is true and correct:

1. I am the Director of the Michigan Department of Health and Human Services (MDHHS).

2. Through my role, I have personal knowledge of the matters set forth below or have knowledge of the matters based on my review of information and records gathered by my staff.

3. MDHHS is responsible for providing services and administering programs to improve the health, safety, and prosperity of the residents of the State of Michigan.

4. MDHHS partners with federal agencies on 130 different programs. In 2024, federal funds helped support 3 million people in Michigan receiving assistance to put food on the table, cover childcare costs, get needed medical attention and keep utilities on in homes. Federal funds allowed MDHHS to be able

to respond to 205,383 calls, texts, and chats from individuals needing behavioral health crisis support as well as providing health care coverage for 3.3 million people, including 1.2 million children in Michigan.

5. MDHHS receives federal funds from multiple federal agencies, including the United States Department of Health and Human Services (HHS), United States Department of Agriculture (USDA), Environmental Protection Agency (EPA), among others.

6. I submit this declaration in support of Plaintiffs' motion for preliminary injunction and to explain the impacts on MDHHS of the cuts to HHS, including cuts to the Centers for Disease Control and Prevention (CDC).

I. Infectious Diseases Laboratory Testing

7. The CDC has operated a network of specialized laboratories to test for a wide range of health threats, including Hepatitis C, influenza, HIV/AIDS, among others. With this network of laboratories, the CDC has long provided testing capacity to state and local public health agencies. The CDC's lab testing infrastructure has been critical in identifying diseases, monitoring outbreaks, and guiding public health interventions.

8. Beginning on April 1, 2025, the CDC initiated the closure of several critical laboratories and ceased testing for various diseases, including shuttering the CDC's Division of Viral Hepatitis laboratory and the STD Laboratory Reference and Research Branch, and ceased tests for Hepatitis C. The closures and sudden loss of capacity have raised significant concerns among public health officials,

including those at MDHHS. These closures and losses disrupt essential disease surveillance and outbreak response capabilities. In turn, these disruptions have required state agencies to fill in the sudden gaps in testing capacity in order to prevent disease outbreaks.

9. MDHHS runs a network of laboratories through its Bureau of Laboratories. The MDHHS Bureau of Laboratories is enmeshed within the network of laboratories run by the CDC and those run by other states' public health agencies. MDHHS relies on CDC laboratories to test for various diseases.

10. The MDHHS Bureau of Laboratories relies on CDC laboratories because their capacity enables them to provide information about infectious diseases across the country and within Michigan, as well as diseases spreading across state lines.

11. Since April 1, 2025, the MDHHS Bureau of Laboratories has been impacted by the reduction-in-force at the CDC in multiple ways. First, the Bureau of Laboratories has been directly impacted by the closure of the CDC Viral Hepatitis Laboratory Branch, which discontinued hepatitis testing. Additionally, the MDHHS Bureau of Laboratories has not received consistent communication from the CDC regarding test discontinuations. At this time, it is unclear which tests the remaining CDC laboratories prioritize because the CDC's website documentation has conflicting information. The MDHHS Bureau of Laboratories reports that Hepatitis A Nucleic Acid Test (NAT) and Genotyping were recently listed as unavailable, but, without any notice, were suddenly made available again.

As a result of sporadic changes to test offerings by CDC laboratories, the MDHHS Bureau of Laboratories has been unable to determine which tests to prioritize with confidence.

12. Additionally, the MDHHS Bureau of Laboratories anticipates higher submission rates to its labs because of the CDC's recent discontinuation of testing for Hepatitis C. The MDHHS Bureau of Laboratories serves as the National HIV and Hepatitis C virus NAT Reference Center in cooperation with the CDC and the Association of Public Health Laboratories (APHL). Test volumes submitted to MDHHS have increased steadily since 2021. The MDHHS Bureau of Laboratories anticipates submission rates to further increase due to the CDC's recent discontinuation of testing for Hepatitis C. But if MDHHS shifts its lab capacity to Hepatitis C testing, the MDHHS Bureau of Laboratories staff will have less capacity to respond to other public health emergencies.

13. Additionally, the MDHHS Bureau of Laboratories has also been impacted by the CDC's announcements of other specimens that it can no longer process, such as trypanosoma cruzi and botulism rule out molecular testing. Testing samples submitted to the CDC, if untested, must go to another lab for testing. Some of these specimens are now being sent to the New York state public health laboratory. The MDHHS Bureau of Laboratories is currently evaluating where to shift its capacity in order to compensate for the loss of CDC lab testing. The MDHHS Bureau of Laboratories reports that immediate testing needs are Hepatitis A NAT, viruses that cause genital ulcers, as well as varicella zoster virus

and Herpes Simplex Virus NAT testing. Adjusting MDHHS's testing capacity to meet needs in these areas is necessary to ensure that public health officials can track outbreaks and that residents of Michigan have access to these important tests.

14. The MDHHS Bureau of Laboratories has also experienced a lack of central coordination for the testing that was discontinued by the CDC. Without the CDC's full capacity, there will be no central coordinating agency for outbreak response.

15. Moreover, the MDHHS Bureau of Laboratories has also reported difficulty contacting CDC staff. CDC personnel have attended fewer of MDHHS's state-to-state calls and APHL activities. The CDC's Laboratory Outreach Communication System calls are being canceled more frequently than in the past.

16. Additionally, the MDHHS Bureau of Laboratories is experiencing response issues with the CDC's Federal Select Agent Program (FSAP). For example, the MDHHS Bureau of Laboratories reached out to the CDC's FSAP program two times to try to schedule an inspection for a renovated laboratory space. Several weeks have passed, but the FSAP program has not responded.

17. Moreover, the delays have also impacted guidance documents. For example, the CDC's staff reductions delayed the rollout of an updated testing strategy, the CDC Hospital Acquired Infection (HAI) group's tiered testing strategy.

II. Public Health

18. In addition to the impacts to laboratory testing, the CDC cuts have had significant impacts on MDHHS' public health work.

19. MDHHS relies on a partnership with many CDC program areas for infectious disease detection and response activities across many unique conditions. Federal staffing changes at the CDC since April 1 have disrupted and impacted that work significantly. MDHHS staff report that communications with CDC subject matter experts is now slow, reduced, or sometimes non-existent. There is also confusion regarding points of contact and a reduced knowledge base, as key program staff are no longer with the CDC. As a result, the CDC has failed to provide timely response to inquiries of urgent nature, reduced or eliminated national calls, and can no longer effectively serve as a national coordinator of infectious diseases efforts.

20. MDHHS staff report multiple examples of the CDC's loss in capacity. First, the CDC no longer sends out-of-state travel notifications about potential disease exposures to Michigan residents. This includes diseases with critical timelines, like measles. Second, MDHHS staff reports that the CDC was not available to coordinate a recent multi-state effort to investigate a complex and urgent case of human rabies. Third, the CDC is no longer hosting 50-state calls on the Highly Pathogenic Avian Influenza response, and CDC staff have expressed uncertainty about whether they will be able to host calls that focus on the critical

intersection of animal and human health. These changes risk significant harm to public health in Michigan.

21. Overall, the mass termination of CDC personnel appears to have created a climate of fear for remaining staff, thereby undermining the ability of remaining CDC staff to effectively carry out their jobs by supporting state health departments like MDHHS.

A. Reliance on HHS Data and Technical Expertise

22. For decades, state and local health departments have relied on HHS for critical data systems and technical expertise. HHS's data systems and expertise cover a wide range of topics, including maternal health, lead detection, HIV/AIDS and STIs, and environmental public health.

23. Prior to April 1, 2025, MDHHS relied on HHS for public health data, data systems, and technical expertise in all of these areas and more. But beginning with the staff cuts on April 1, HHS's systems and expertise began to unravel. The sudden staff terminations at HHS left MDHHS without access to updated health data, data systems, and the technical assistance necessary to make informed decisions about public health. Timely, high-quality data is necessary to identify emerging health crises and address disparities in care. But the sweeping workforce reductions at HHS undermine MDHHS's ability to serve the people of Michigan effectively.

i. HIV/AIDS, Viral Hepatitis, STIs, and Tuberculosis.

24. MDHHS also relies on the CDC for its assistance in preventing HIV/AIDS, viral hepatitis, STIs, and tuberculosis. Since April 1, 2025, MDHHS has been impacted by the CDC's staff cuts in these areas. Some of the MDHHS Bureau of HIV and STI Programs' regular meetings with the CDC have been cancelled, and communication from the CDC related to notices of grant awards has been very delayed. The CDC's inability to answer direct questions related to funding and how to navigate executive orders has made things difficult for MDHHS and its funded partners. For example, presidential executive orders concerning "diversity, equity, and inclusion" affect contract language, work plans, and the work of MDHHS grant subrecipients, but MDHHS has not received adequate guidance from the CDC about how to interpret this executive order.

25. Communications from the CDC have become infrequent in recent months, to the detriment of MDHHS's efforts to reduce the threat of HIV and other STIs. The CDC terminated the division that funds three survey projects in the Bureau of HIV/STI programs. One survey program has already been terminated, and the status of two others remains uncertain. The CDC manages all functions related to the National HIV Behavioral Surveillance, including data collection software and training on the survey methodology. The HIV/STI program uses data from this survey to identify prevention needs of people in the Detroit area. In the absence of those CDC staff, MDHHS no longer receives communications or guidance about the system, survey, protocols, or training. MDHHS staff had planned to

attend the 2025 field training at the CDC from May 15 to May 19. All travel has been paid for, but the CDC has provided no information about the field training. Further, MDHHS has not received guidance on evaluation requirements for the HIV prevention, surveillance, and Ending the Epidemic grant (OMB 0920-0696). MDHHS staff have reported that multiple grantee and subrecipient meetings at the CDC have been cancelled, depriving MDHHS staff of the opportunity to hear from experts on emerging topics in the field and to discuss how other states are operationalizing new or emerging issues in HIV prevention and surveillance.

26. MDHHS staff also report that HHS has failed to formalize certain guidance documents in a timely manner. Notably, the CDC has not formalized guidance on the use of doxycycline for postexposure prophylaxis, which has reduced provider adoption of that practice in Michigan. Failure to enable providers to adopt new practices will diminish those providers' ability to more effectively control STIs.

ii. CDC Division of Reproductive Health

27. The CDC Division of Reproductive Health was eliminated on April 1.

28. MDHHS relied on the CDC Division of Reproductive Health for data relating to the health and well-being of mothers and children, including the Pregnancy Risk Assessment Monitoring System (PRAMS). PRAMS is a joint surveillance project of the CDC Division of Reproductive Health and state health departments.

29. The termination of the entire CDC PRAMS team has impacted MDHHS's PRAMS activities quite significantly. The CDC shut down its PRAMS

Integrated Data Collection System (PIDS), which made PRAMS data usable. MDHHS received access to Michigan's 2024 PRAMS data prior to the PIDS being shut down. But MDHHS staff would normally rely on the CDC PRAMS team to statistically weight the Michigan PRAMS data to render the data useable. Because the 2024 Michigan PRAMS data is not currently weighted, it is unusable. To use the data, MDHHS would be required to contract with a survey statistician to properly weight this data, expending significant resources that would otherwise have been available from CDC staff.

30. Furthermore, without access to the CDC-supported PIDS data management system, MDHHS has been forced to develop its own in-house data management system to continue its 2025 Michigan PRAMS data collection activities. This effort required significant resources and expense. MDHHS also does not have the expertise needed to develop a data management system like the CDC PIDS platform. As a result, MDHHS's PRAMS efforts will be worse without having the CDC PRAMS team available to maintain the PIDS data management system.

31. In addition, the MDHHS Division of Maternal & Infant Health, which regularly relied on staff at CDC Division of Reproductive Health, has experienced delayed responses on time-sensitive issues, including the availability of grants and funds. And there has been no official communication on federal grants management staff turnover, and no new contacts have been provided.

iii. Lead Monitoring Programs

32. MDHHS relied on the CDC for its assistance in monitoring for and responding to lead poisoning, especially in children. The MDHHS Environmental Health Bureau handles lead monitoring and has been impacted by CDC staff cuts. From MDHHS's understanding, there have been significant staff cuts at the CDC Childhood Lead Poisoning Prevention Program (CLPPP). Since then, the MDHHS Environmental Health Bureau has received zero communication from CLPPP. The MDHHS Environmental Health Bureau used to have monthly meetings with its CLPPP project officer, but these meetings have been cancelled.

33. Additionally, the CDC used to send regular email notices about newly identified food and consumer products containing lead, which informed public health officials about lead hazards of concern to the public. These email notices have stopped.

iv. Environmental Public Health Programs

34. The MDHHS's staff working on the Modernizing Environmental Public Health Tracking to Advance Environmental Health Surveillance program has received less frequent communication from CDC staff since April 1. MDHHS staff used to have monthly calls with their CDC Project Officer; those calls have ended. MDHHS had been participating with the CDC and other funded states in a number of workgroups focusing on public health programming in the states; those workgroups have halted. MDHHS had a Data Call and a Continuation Application due in April, but the CDC provided limited and inconsistent guidance as to how to

proceed and whether to submit that application. Workgroups typically develop guidance documents (e.g., the Census Transition Workgroup), but groups have not been meeting and thus products could not be finalized and disseminated. Because the Spring Data Call was canceled, the CDC Tracking Data Explorer will not be updated with state-level data on drinking water, biomonitoring, or radon.

B. Chronic Disease and Injury Control programs

35. MDHHS also relies on CDC staff to assist its chronic disease and injury control programs. On April 1, 2025, many of the CDC staff responsible for assisting MDHHS were placed on administrative leave through June 2. These CDC staff assist MDHHS administer the following CDC programs in Michigan: (1) State Public Health Approaches to Addressing Arthritis, (2) Advancing Health Equity in Asthma Control through EXHALE Strategies, and (3) Improving the Health of People with Mobility Limitations and Intellectual/Developmental Disabilities through State-Based Public Health Programs, (4) Building Our Largest Dementia (BOLD) Infrastructure, (5) Michigan Overdose Data to Action (MODA), (6) Preventing Suicide in Michigan Men (PRiSMM), (7) Rape Prevention and Education Program, and (8) Violent Death Reporting System (VDRS). These significant staffing shortages and loss (or potential loss) of CDC contracts have left MDHHS with little or no guidance, caused cancellations of scheduled technical assistance calls, and created uncertainty regarding the future of these programs.

36. The MDHHS Division of Child and Adolescent Health has also been impacted by staff cuts at HHS. The annual training for Personal Responsibility

Education Program (PREP) teen pregnancy prevention grantees has been postponed indefinitely by the Administration for Children and Families (ACF) within HHS.

III. Tobacco Monitoring

A. Office on Smoking and Health (OSH)

37. Cigarette smoking is the leading cause of preventable disease, disability, and death in the United States. The Office on Smoking and Health (OSH) within the CDC was the lead federal agency for comprehensive tobacco prevention and control. But on April 1, 2025, OSH was effectively shuttered by HHS in the March 27 Directive.

38. Before it was shuttered, OSH worked to prevent and reduce cigarette smoking by collecting, studying, and sharing information on cigarette smoking and its effects on health, as mandated by Congress. 15 U.S.C. § 1341 ("Smoking, research, education and information"). Its functions include regulating smoking, vaping, and other nicotine products, and helping adults to quit smoking. And it played a critical role in preventing youth tobacco use.

39. OSH managed a tobacco use data portal, which provided access to the latest tobacco prevention and control data, graphs, and maps, as well as the State Tobacco Activities Tracking and Evaluation (STATE) System, which presented data on traditional Medicaid coverage of tobacco cessation treatments in every state and the District of Columbia. This dataset was used by MDHHS to assess tobacco cessation policies and served as a national clearinghouse of information for the public.

40. OSH also managed annual submissions of cigarette and smokeless tobacco ingredient reports from manufacturers, packagers, and importers. OSH monitored tobacco use trends and health impacts in part to inform FDA regulations and enforcement.

41. Further, OSH played an important role in surveillance and surveys, including the state-based Behavioral Risk Factor Surveillance System, National Health and Nutrition Examination Survey, and National Youth Tobacco Survey (NYTS). OSH's national surveillance system provided reliable, consistent, and cost-effective data collection that MDHHS used to evaluate its work and monitor progress in tobacco use prevention. OSH additionally published state-level data on tobacco prevention use in the STATE System.

42. OSH committed to educating the public about the harms of tobacco use, including media campaigns such as Tips from Former Smokers (Tips Campaign) and publications derived from the Publication Catalog and Ordering System. The Tips Campaign ads, which were placed on television, radio, and billboards, encouraged smokers to quit by featuring real people with serious health conditions caused by smoking and secondhand smoke exposure. The 2012–2018 Tips Campaign had a significant positive impact on Americans' health. The CDC estimated that over 16.4 million smokers attempted to quit and approximately one million successfully quit because of the Tips Campaign. Smokers who saw Tips Campaign videos reported greater intentions to quit smoking, and former smokers with higher exposure to the ads were associated with lower odds of relapse. The

Tips Campaign was credited with helping to prevent early deaths and save precious government resources.

43. OSH scientists published high-quality reports on tobacco use trends that states utilized to prioritize interventions, monitor progress, and reduce disparities. OSH's Best Practices for Comprehensive Tobacco Control Program Guide advises states on how to develop, implement, and fund an evidence-based tobacco control program. OSH likewise dedicated its publications and resources to the "Publication Catalog and Ordering System" where state agencies and other users could access campaign materials and Surgeon General's reports.

44. OSH maintained the national network of tobacco cessation quitlines to encourage people to quit tobacco use by supporting quitline services in fifty states, two U.S. territories, and Washington, D.C. OSH funded state quitlines to deliver resources such as counseling and medications. The Tips Campaign resulted in a sustained and dramatic increase in calls to quitlines.

45. OSH also provided millions in funding to the National and State Tobacco Control Program. Participating states used OSH funds to prevent kids from using tobacco, reduce secondhand smoke exposure, help people quit smoking, and address disparities in tobacco use.

B. Center for Tobacco Products (CTP)

46. The Center for Tobacco Products (CTP) within the FDA oversaw the implementation of the Family Smoking Prevention and Tobacco Control Act by setting performance standards for tobacco products, reviewing premarket applications for new and modified risk tobacco products, requiring new warning

labels, and establishing and enforcing advertising and promotion restrictions. But on April 1, 2025, HHS terminated the staff at the CTP, effectively shuttering it.

47. Among other duties, CTP conducted compliance checks on vendors and retailers to ensure that tobacco products are not sold to those under the age of twenty-one, reviewed premarket applications for new tobacco products before they can be marketed in the United States, enforced advertising and promotion restrictions, and educated the public about the risks of tobacco use including the dangers of e-cigarettes and other tobacco products.

C. Effect on MDHHS's Tobacco Program

48. MDHHS relies on both OSH and CTP for its tobacco regulation programs. As a result, MDHHS will be significantly affected by the staff cuts at OSH and CTP described above. The functional elimination of these two subagencies will lessen MDHHS's ability to protect its citizens, especially its youth, from the dangers of smoking and tobacco products. The reduction of surveillance data of tobacco use will harm MDHHS's ability to efficiently and effectively deploy its tobacco control tools and resources. Fewer compliance checks by the CTP will lead to more sales of tobacco products, exposing the youth of Michigan to a risk of becoming addicted to nicotine products and suffering known health harms.

49. The MDHHS Division of Chronic Disease and Injury Control has already been impacted by the shuttering of OSH. In April, MDHHS expected a $2,347,639 annual grant extension from OSH. The MDHHS's Tobacco Section sent many emails and made many calls that had not been answered about its OSH grant and extensions. In late April, the Tobacco Section was informed by federal grant

administrators that it would merely receive the remaining funds that had been previously allocated, approximately $69,000 through October 2025, which is far less than the approximately $2.3M dollar annual grant award that is needed to continue operations. Thus, no new funding from the CDC OSH will be allocated to MDHHS starting after April 29.

50. In addition, the MDHHS Tobacco Section received significant support and resources from the CDC OSH that was critical to its successful Tobacco Control Program. Those resources and forms of support included monthly meetings with an OSH project officer for technical assistance; monthly OSH State Tobacco Control Program Webinars with updates, educational presentations, resources, media resources, and technical assistance; monthly OSH Media and Education Webinars with technical assistance; new education campaign ideas and resources, and TIPS campaign updates and resources; meetings with the OSH communication staff for technical assistance on communication strategies, including Media Campaign Resource Center (MCRC) campaigns; weekly OSH newsletters with trainings, webinars, journal articles, data, state program highlights, and other resources to support state Tobacco Control Program programs; regular meetings between OSH and Michigan's Tobacco Control Program evaluators on technical assistance, data, and program evaluation strategies; and any additional meetings with MDHHS's OSH project officer, communications staff, policy staff, and evaluators, as requested. Michigan's Tobacco Control Program and communities often utilized these resources to help guide program efforts and develop new programs.

51. Collectively, if MDHHS does not receive both support and funds from OSH, it will lose $2,347,639 in grant funding and other resources from OSH. These funds and resources support several things.

52. First, the OSH grant supports most of the Michigan Quitlink, which provides services to all Michigan residents for tobacco dependence treatment at a cost of $1,290,511 annually. The Quitlink provides tobacco dependence treatment to all residents and will be difficult to maintain without the CDC OSH funding. This may result in higher rates of tobacco use among youth and adults and higher health care costs. Michigan currently spends $4.55 billion on smoking-related health care costs annually and $1.33 billion on smoking-related Medicaid health care with Quitlink services. With fewer Quitlink services, these costs could rise in Michigan.

53. Second, the OSH grant funding allowed the MDHHS Tobacco Control Program to fund local communities, including local health departments, to prevent commercial tobacco use among youth, promote and provide tobacco dependence treatment among youth and adults, conduct public education campaigns, reduce smoking-related disparities among communities with high tobacco use rates, and evaluate effectiveness of programs in local communities. It also provided funding for healthcare provider trainings on tobacco dependence treatment and increasing resources for schools to address vaping among students. Without the OSH grant, MDHHS's activities in these areas will cease, potentially increasing tobacco use rates and decreasing cessation rates.

54. Third, OSH provided "Tips from Former Smokers" campaigns, media technical assistance, and a large array of free media print/radio/TV/social media creative through the Media Campaign Resource Center (MCRC). Without these resources, fewer people will have awareness of and utilize tobacco dependence treatment, including the Michigan Quitlink.

55. Fourth, OSH provided regular data and peer reviewed articles to support the MDHHS Tobacco Control Program's work to prevent initiation and treat tobacco dependence. Without this data and these resources, data-driven program decisions will be limited, and MDHHS will have decreased information of populations with high tobacco use rates and less access to effective strategies to reduce tobacco use.

56. Fifth, the OSH grant funded 11 positions and six grants, including the $1.3 million Quitlink. As of April 29, 2025, state funding is the sole source for staffing, program, and services. Without federal funds or increased state funding, reductions in community contracts, enforcement, and staffing will occur.

57. Beyond those impacts, MDHHS's day-to-day operations will be impacted by terminations at OSH and CTP. Prior to April 1, 2025, MDHHS regularly relied on OSH and CTP staff for many aspects of the day-to-day operation of the state's tobacco program.

58. MDHHS depends on the FDA's CTP compliance checks to restrict tobacco sales to minors. Michigan's FDA Tobacco Retailer Inspection Program is the only statewide program to monitor retailer compliance with federal law

prohibiting the sale of tobacco products to underage youth. It currently supports eight full-time staff. Inspections conducted under this program have shown a decrease in tobacco sales to youth from 34.5% in FY 2021/22 to 23.8% in FY2024/25. Since April 1, 2025, the FDA has been unable to provide the following services to MDHHS: (1) approve and process MDHHS's request for additional funds to remain fully operational during the 2-month contract extension on the normal approval timeline, resulting in no inspection activity during the first two weeks of May (inspection staff were temporarily transferred to other funding); and (2) issue a solicitation for new state funding (FY2025/26 beginning May 30, 2025). The impacts of these losses could result in the dismantling of Michigan's inspection program, laying off of eight full-time staff, and the loss of $1.485m/annually.

59. In sum, the changes at OSH and CTP will directly impact MDHHS's tobacco programs and risk significant harm to young children and their families in Michigan.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Dated: May 9, 2025

Elizabeth Hertel, Director
Michigan Department of Health and Human Services

EXHIBIT 60

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF RHODE ISLAND

STATE OF NEW YORK, et al. Plaintiffs, v. ROBERT F. KENNEDY, JR., in his official capacity as SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., Defendants.	Case No. 1:25-cv-00196

DECLARATION OF VALERIE M. KATO

I, VALERIE M. KATO, declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the foregoing is true and correct:

1. I am the First Deputy Director of the Hawai‘i State Department of Health (DOH). I am familiar with the information in the statements set forth below either through personal knowledge, in consultation with DOH staff, or from documents that have been provided to and reviewed by me.

2. I submit this Declaration in support of the States’ Motion for a Preliminary Injunction.

3. I have held my position since July 2023 when I was appointed by Governor Josh Green. Before this date, I served as legal counsel to the DOH and was the Supervising Deputy Attorney General of the Health Division at the State of Hawai‘i Department of the Attorney General. As of the date of signing this declaration and until May 12, 2025, I am the Acting Director of Health.

4. DOH's mission is protect and improve the health and environment for all people in Hawai‘i.

5. DOH has offices on the islands of Kaua‘i, O‘ahu, Maui, Moloka‘i, and Hawai‘i. DOH's goals are to promote health and well-being; prevent disease and injury; promote healthy lifestyles and workplaces; promote the strength and integrity of families and communities; prevent pollution and promote and preserve a clean, healthy and natural environment by promoting resource conservation and protecting and enhancing air and water quality; and assure basic physical and mental health care that is affordable, appropriate, assured quality, available, and accessible.

6. I am providing this declaration to explain the impacts on Hawai‘i of the cuts to HHS.

7. Hawai‘i's Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program has relied on HHS for data relating to the health and well-being of pregnant people and babies, including the Pregnancy Risk Assessment Monitoring System (PRAMS), tobacco data from FDA's Center for Tobacco Products (CTP), and the CDC's Social Vulnerability Index (SVI) to meet federal requirements and identify at-risk communities. As of May 2025, new data collection for all three sources has been halted. This loss of updated data limits Hawaii's ability to target services, meet reporting mandates, and demonstrate program improvement.

8. Hawai‘i's Pediatric Mental Health Care Access (PMHCA) Program has relied on data from the PRAMS, tobacco use data, injury surveillance, disability data from the National Center on Birth Defects and Developmental Disabilities (NCBDDD), and the National Survey on Drug Use and Health to identify key trends, inform evidence-based approaches, and guide the program's focus on behavioral, mental, and developmental disorders in children and adolescents.

Hawai‘i has lost access to this data when access to public facing websites was terminated. Given the broad and complex nature of pediatric mental health and its impact on families, these data sets play a pivotal role in identifying priority populations, emerging concerns, and effective intervention strategies. They enable PMHCA to tailor its services and respond to the evolving mental health landscape across different states.

9. Hawai‘i’s PMHCA Program has relied on technical assistance from the Health Resources and Services Administration (HRSA), which is now limited. HRSA’s technical assistance has been critical to the successful implementation of the PMHCA Program in Hawai‘i. Regular technical assistance was utilized by PMHCA to help with modeling to the program’s specific needs, enhancing outreach, improving quality, and guiding data collection and evaluation efforts. However, in recent months, there have been limitations to receiving technical assistance and a pause in data and evaluation support, which will hinder the program’s ability to fully assess its impact. Data sets and technical assistance are crucial to the program’s ability to drive meaningful improvements in mental health care access and outcomes for children and families.

10. DOH has relied on HRSA’s Maternal and Child Health Bureau (MCHB) as a federal partner in the Title V Maternal and Child Health (MCH) Services Block Grant. This partnership is a cooperative effort between the federal government and individual states to improve the health and well-being of mothers and children. MCHB provides funding, subject matter expertise, technical assistance, data, performance measurement standards, and other analytical resources to states to address various MCH challenges, including reducing infant mortality, improving access to prenatal and postnatal care, and supporting children with special health care needs. DOH has not had regular monthly and quarterly meetings with MCHB staff

since January 31, 2025. Emails have gone unanswered because, as we understand it, HRSA staff have not been allowed to communicate with states unless approved by a cabinet-level appointee. MCHB staff were not allowed to attend the Association of Maternal and Child Health Programs annual meeting in March 2025. Key update presentations by MCHB leadership were cancelled due to communication restrictions. Title V grant application and annual report guidance, as well as technical support for this year's required 5-year needs assessment were shuttered from January 31, 2025 through April 28, 2025 with the release of the annual Title V guidance for the (FY) 2026 Application/FY 2024 Annual Report.

11. The Food and Drug Administration (FDA) contracts with DOH to inspect facilities utilizing mammographic x-ray machines in Hawai‘i through the Mammography Quality Standards Act (MQSA). This process ensures that best practices, pursuant to FDA regulation, are followed at each facility. Prior to such regulation, breast cancer was often diagnosed incorrectly or too late, leading to negative outcomes. DOH recently lost all ability to execute the inspection of mammographic x-ray facilities in the state due to the loss of FDA technical guidance and training. Specifically, Hawai‘i has lost access to the following federal resources: training modules required to certify new inspectors; active qualified inspectors who have trained DOH staff in the past; the Mammography Program Reporting and Information System (MPRIS), a FDA database required to schedule and perform inspections; and mammography experts who are instrumental in providing several tools to facilitate accuracy and troubleshoot the inspection process before, during, and after each inspection, and who are only available to FDA certified inspectors via a hotline service. Hawai‘i does not currently have any FDA certified inspectors.

12. As of November 2024, DOH was in the process of training two individuals to become MQSA inspectors. This requires passing a rigorous three-part training regime, including

two virtual courses, a hands-on training in Washington, D.C., and numerous shadowing events to learn from active inspectors. Due to changes at the FDA, the training sequence was interrupted, causing DOH's in-person course and shadowing opportunities to be postponed for an indefinite period. As a result, and as mentioned in paragraph 11, DOH is unable to utilize FDA's resources to complete MQSA inspections, as DOH does not itself have anyone that is currently certified.

13. If mammographic x-ray facilities go uninspected and unregulated in the absence of FDA support and guidance, the standard of care for mammography would decline. The absence of proper quality assurance would likely cause a significant public health risk. For example, early warning signs of breast cancer may be overlooked because of poor x-ray image quality or poor radiologic technologist practices, resulting in unnecessary loss of life. This risk would only increase as more time without proper regulation passes.

14. DOH has relied on the FDA's Center for Tobacco Products (CTP) for tobacco enforcement and public health efforts. Without CTP, trusted and research-based materials would be eliminated, language-accessible resources would be limited, compliance with federal benchmarks would be jeopardized, and tobacco-related health disparities would deepen. There would be a lack of education and training, including a lack of funding to provide tobacco education in schools and health care settings, and a lack of education for parents about the dangers of vaping for children and teens. In addition, there would be a lack of regulation of the safety of vaping equipment and continued marketing of flavored vapes and nicotine products, particularly to children and teens.

15. DOH has relied on CDC for its assistance in preventing HIV/AIDS, viral hepatitis, STIs, and tuberculosis. Hawai‘i is a small state with limited personnel and resources. DOH may not have staff members with specific expertise needed for more complex

and rare problems. We therefore rely on CDC for assistance when problems exceed our expertise or resources, especially in complex situations such as outbreaks of antibiotic resistant gonorrhea or tuberculosis. Currently, there are no HHS staff working on a national strategy for preventing HIV/AIDS, viral hepatitis, and STIs. Hawai‘i is no longer able to reach out to CDC for guidance on strategic planning and federal policy efforts on these issues.

16. The closure of the CDC's STD Laboratory Reference and Research Branch (SLRRB) has greatly hampered the testing of sexually transmitted infection (STI) samples. The CDC has not yet provided guidance on where STI samples should be referred. As a result, public health laboratories are left to independently coordinate with one another to determine available testing capabilities and resources.

17. For example, STI samples exhibiting antimicrobial resistance (with the exception of *N. gonorrhoeae suspected of cephalosporin-resistance*) are now being submitted to the Antimicrobial Resistance Laboratory Network (ARLN) Regional Laboratory. However, DOH is still awaiting clear guidance on submission criteria and specific testing requirements because not all regional ARLN laboratories provide the same service. This may result in additional costs for Hawai‘i if the regional ARLN laboratories are unable to cover sample shipment expenses. Furthermore, depending on which public health laboratory receives the samples, DOH may need to establish a contractual relationship with the ARLN to formalize the arrangement, resulting in additional administrative burden to the state.

18. Most concerning, the elimination of SLRRB negatively impacts DOH's ability to address antibiotic resistant gonorrhea. Since 1986, DOH had partnered with SLRRB to monitor trends in antimicrobial susceptibilities of *N. gonorrhoeae* strains in Hawai‘i. DOH received technical support from SLRRB in late 2023 when an isolate of concern was identified. After

molecular analysis, SLRRB identified that isolate to be an *N. gonorrhoeae* clone with a known ceftriaxone-resistance mechanism. This discovery of gonorrhea with suspected resistance to cephalosporins, the only class of antibiotics that can cure gonorrhea, led to Hawai‘i receiving additional technical support from CDC's epidemiology team on case follow-up efforts. Without SLRRB, our CDC partners have informed us that there is currently no alternative workflow in place for confirming isolates of concern, meaning there are no commercial labs available to do the particular technical work that SLRRB did. As a result, Hawai‘i will no longer be able to identify resistant gonorrhea and implement the public health measures needed to stop its spread.

19. In addition, the discontinuation of Hepatitis A testing by CDC's Infectious Disease Laboratory will have a significant impact on Hawai‘i. Testing will need to be coordinated with the California Department of Public Health Laboratory and/or the Wadsworth Center in New York to provide Hepatitis A testing services. Hepatitis B testing is currently being referred to the Oregon Public Health Laboratory, which has confirmed it will continue to accept and process samples from Hawai‘i for now.

20. DOH has relied on the CDC's Disease Intervention Training Centers (DITCs) for training, technical assistance, and capacity-building services for DOH's Disease Intervention Staff (DIS), which will now end on July 29, 2025. Hawai‘i has utilized DITC-led training in our DIS training plan for the past five years. DOH had been awaiting DITC's release of Principles, Practices, and Pathways to Disease Intervention (3PDI), a replacement course for CDC's Passport to Partner Services, but the release is now unlikely to occur. 3DPI was supposed to be an improved training for DIS that would be more comprehensive and hands-on than the Passport to Partner Services. Standardized, relevant, and competency-based training from experienced

professionals is essential for DIS. The likely loss of 3PDI negatively impacts DOH's ability to train staff and build capacity.

21. DOH relied on the CDC's National Center for Environmental Health (NCEH) for technical assistance around environmental health issues after the August 8, 2023 wildfire on the island of Maui. CDC's National Institute for Occupational Safety and Health (NIOSH) was particularly helpful in assessing environmental health impacts to first responders and workers. The Emerging Environmental Hazards and Health Effects Branch also provided technical assistance after the disaster. Support included advice and helping with logistics of distributing proper personal protective equipment, guidance on assessing and mitigating post-fire health risks to the public, technical assistance related to syndromic surveillance to assess environmental health impacts in the wake of the disaster and other technical and logistical support. The lack of support from this group in the future will impair Hawai'i's environmental health response to large disasters where the needs outstrip the state's resources.

22. DOH has relied on the CDC's Climate and Health Program for heat and health risk data to understand how increasing temperatures might impact health in the state. The CDC program had been working with DOH to establish an environmental heat model that would help account for Hawai'i's microclimates in assessing heat risk. That unique expertise is not available in Hawai'i and would have helped the state identify high risk areas and conditions to prevent heat related illnesses in the elderly and children. The Climate and Health Program also provided support in reviewing DOH's Hawai'i climate and health vulnerability assessment, which will be an inferior product without the Program's technical assistance.

23. DOH relied on the HHS Region 9 office for technical assistance, policy guidance, and communication with other states. Closure of the San Francisco office cut off support that

understood Hawai‘i’s unique issues. This impacts Hawai‘i by delaying assistance, reducing program relevance, and weakening communication and coordination. Without the support of the San Francisco office, Hawai‘i will have more difficulty learning from the successes and failures of other states regarding issues such as testing and treating for syphilis and decreasing the number of children with congenital syphilis.

24. As of January 31, 2025, the collection of data for the CDC’s Pregnancy Risk Assessment Monitoring System (PRAMS) has been paused. PRAMS collects information across the preconception, prenatal, and postpartum periods, thereby capturing a comprehensive array of risk factors that impact maternal and infant health outcomes. Concurrently, access to the PRAMS Integrated Data Collection System (PIDS), which houses previously collected state-level data, has been significantly limited. Due to the absence of ongoing data collection and restricted access to the PIDS system, the State of Hawai‘i is currently unable to gather essential state-specific data necessary to monitor health behaviors, access to care, and receipt of services among recently pregnant women. PRAMS annual data files also serve as a vital source of nationwide estimates on various maternal and infant health indicators—data which is not available through any other national source. These data enable states to assess trends over time on key issues such as infant sleep positioning, rates of unintended pregnancies, and patterns of health insurance coverage before, during, and after pregnancy.

25. As of April 1, 2025, elimination of the CDC’s Division of Reproductive Health, where the PRAMS project resided, also eliminated the position of DOH’s primary PRAMS data analyst, a PhD-trained CDC Maternal and Child Health Epidemiology Assignee available to DOH through a Memorandum of Agreement with the CDC. On April 29, 2025, DOH received a notice from the CDC that its agreement with DOH would be terminated as of June 1, 2025. This

is despite the fact that, upon information and belief, the Epidemiology Assignee received a Reduction-in-Force notification and was placed on a leave of absence on April 1, 2025. The stopping of data collection and elimination of technical assistance will result in significant decreased ability to reduce health disparities and increase better outcomes for women, children, and families of Hawai‘i.

26. These changes risk significant harm to the State of Hawai‘i because they drastically reduce the state’s capacity to protect and preserve the public health of its residents without reasonable or adequate prior notice.

VALERIE M. KATO

Date: May 9, 2025

EXHIBIT 61

An official website of the United States government
Here's how you know

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CDC Publishes New HIV Surveillance Reports

AT A GLANCE

CDC publishes 3 new HIV surveillance reports.

Dear Colleague

Today, the Centers for Disease Control and Prevention (CDC) published three new HIV surveillance reports:

- *Estimated HIV Incidence and Prevalence in the United States, 2018-2022;*
- *Monitoring Selected National HIV Prevention and Care Objectives by Using HIV Surveillance Data, United States and 6 Territories and Freely Associated States, 2022; and*
- *Diagnoses, Deaths, and Prevalence of HIV in the United States and 6 Territories and Freely Associated States,*

2022.

All data are also available on NCHHSTP AtlasPlus. These data can assist HIV prevention partners in focusing prevention efforts, allocating resources, monitoring trends, and determining gaps and successes in HIV prevention.

Estimated HIV Incidence and Prevalence*: Key Findings

The new HIV incidence estimates show that national prevention efforts are continuing to move in the right direction overall, although substantial disparities exist. The estimated number of new HIV infections in 2022 (31,800) decreased 12% compared with 2018 (36,200), driven by a 30% decrease among young people aged 13-24 years. Increases in preexposure prophylaxis prescriptions, viral suppression and HIV testing likely contributed to the decline. Data also show significant declines geographically, with estimated new HIV infections decreasing 16% in the South in 2022 compared with 2018. In 2022, HIV incidence in Ending the HIV Epidemic (EHE) (phase I) jurisdictions decreased 21% among persons aged ≥ 13 years, compared with the 2017 EHE baseline year. There were no increases in HIV incidence for any populations in 2022 compared with 2018.

Although data demonstrate continued progress in HIV prevention, longstanding social and economic factors continue to contribute to health inequities—particularly among Black/African American (hereafter referred to as Black) persons and Hispanic/Latino persons. Among women overall, in 2022, 47% (2,800) of estimated new HIV infections were among Black women. New HIV infections attributed to male-to-male sexual contact (MMSC) accounted for 67% (21,400) of estimated new infections. New HIV infections among gay, bisexual, and other men who have sex with men (MSM) were about 16% lower among Black men in 2022 (7,400) compared with 2018 (8,800) and 20% lower among White men in 2022 (4,400) compared with 2018 (5,500). Although the number of new HIV infections remained about the same among Hispanic/Latino MSM (8,200 in 2018 and 8,300 in 2022), due to the declines among other groups, Hispanic/Latino men accounted for 39% of estimated new HIV infections among gay, bisexual, and other MSM in 2022.

It is estimated that 1.2 million persons in the United States were living with diagnosed and undiagnosed HIV at the end of 2022. More people with HIV were aware of their status in 2022 than in 2018, with a slight increase from 86% to 87%. Knowledge of HIV status increased among persons aged 13-24 years, Asian persons, Black persons, Hispanic/Latino persons, persons in the South, and among males with infections attributed to MMSC. Knowledge of HIV status decreased among persons aged 35-44 years (84% in 2022 compared with 86% in 2018).

Monitoring Report: PrEP Coverage

This CDC *Monitoring Report* does not include data on PrEP coverage. CDC has paused PrEP coverage reporting for one year to address a formula error that affects a subset of race/ethnicity data, update overall PrEP coverage estimates using newly available data sets, and determine the best way to present PrEP coverage. CDC believes this update will yield greater precision and a more complete picture of the PrEP coverage landscape in the United States.

Earlier this year a formula error was found in the calculation used to determine the number of people with indications for PrEP by race/ethnicity. This only affects the PrEP coverage estimates for two groups – White persons and persons of other races/ethnicities – and does not affect the overall PrEP coverage estimate or estimates by sex or by age

group. It does, however, affect all years of PrEP coverage data (2017-2022). CDC does not expect general trends in disparities to change, but magnitudes of certain disparities are expected to shift (i.e., current PrEP coverage estimates for White persons are likely an overestimate).

Furthermore, in March 2024, data were made available to CDC that can improve the representativeness of the number of persons prescribed PrEP in the United States. In the coming months, CDC also expects to have updates to the data sets used to estimate the number of persons with indications for PrEP. Pausing PrEP coverage reporting for the next year will allow CDC to update all PrEP coverage estimates (2017-2022) using newly available data sets, rather than simply correcting the formula error using current data sources.

CDC plans to resume PrEP coverage reporting in the next *Monitoring Report*, currently scheduled for publication in June 2025. Until updated estimates are published, CDC advises against citing specific PrEP coverage data points and instead recommends referencing general trends and disparities.

Monitoring Report: Key Findings

Among persons who received diagnoses of HIV infection during 2022, 82% were linked to care within one month of diagnosis. Asian persons had the highest percentage of linkage to care within one month (88%), and Native Hawaiian/other Pacific Islander persons (74%), American Indian/Alaska Native persons (78%), Black persons (78%), and women (80%) had the lowest percentages. Among persons with diagnosed HIV and alive at year-end 2022, 65% were virally suppressed at the most recent viral load test. The lowest percentages of viral suppression were among Black persons (61%) and women overall (64%). Despite overall progress in eliminating perinatally acquired HIV, in 2022, the rate of perinatally acquired HIV among Black persons was 5 times the overall annual rate of 1.1 per 100,000 live births. To meet national HIV goals and ensure that all persons with diagnosed HIV receive high quality care and treatment, prevention efforts must address the drivers of social inequities and other barriers to care that cause and exacerbate health disparities.

HIV Diagnoses**: Key Findings

In 2022, in the United States and 6 territories and freely associated states, there were 38,043 HIV diagnoses, more than half of which (52%) occurred among people living in the South. Compared to 2018, in 2022, the number of HIV diagnoses among gay, bisexual, and other MSM overall (67%) and the number of HIV diagnoses among Black gay, bisexual, and other MSM (35% of MSM) remained stable. White persons accounted for almost half (47%) of all HIV diagnoses attributed to injection drug use. Notably, compared with 2018, in 2022, HIV diagnoses increased among transgender women (25% increase), Hispanic/Latino gay, bisexual, and other MSM (22% increase), Hispanic/Latino persons overall (17% increase), and males who inject drugs (7% increase). HIV diagnoses decreased among persons aged 13–24 years (14% decrease) and Black women (10% decrease). Although Black women accounted for only 9% of HIV diagnoses overall in 2022, among cisgender women, Black women accounted for 50% of HIV diagnoses and, among transgender women, Black women accounted for 41% of HIV diagnoses. Finally, HIV diagnosis data show that the rate of HIV-related deaths declined 25%, highlighting the effectiveness of early diagnosis and linking people with diagnosed HIV to quality care and treatment.

Overall, data from these reports demonstrate that expanding the reach of HIV testing, PrEP, and treatment have been

effective – but our reach must extend even further, and progress must be faster, to achieve our national goal of ending new HIV infections in the United States. This requires sharpening our collective focus on efforts that address inequities and their drivers, including racism and other social and structural determinants of health, and ensuring that whole person approaches to HIV prevention, care, and treatment are brought to scale and equitably reach all people who need them to stay healthy.

Thank you for your continued support for HIV prevention in the United States.

Sincerely,

/Robyn Fanfair/

Robyn Neblett Fanfair, MD, MPH
Captain, USPHS
Director
Division of HIV Prevention
National Center for HIV, Viral Hepatitis, STD, and TB Prevention
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EXHIBIT 62

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF RHODE ISLAND

STATE OF NEW YORK, et al. Plaintiffs, v. ROBERT F. KENNEDY, JR., in his official capacity as SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., Defendants.	Case No. 1:25-cv-00196

DECLARATION OF MANISHA JUTHANI, M.D.

I, Manisha Juthani, M.D., declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the foregoing is true and correct:

1. I am the Commissioner of the State of Connecticut Department of Public Health ("Department"). I have personal knowledge of the facts set forth in this declaration, and if required to testify, would and could competently do so.

2. I submit this Declaration in support of the States' Motion for a Preliminary Injunction.

Professional Background

3. I received my medical degree from Cornell University Medical College and have been a practicing infectious disease physician for over 20 years. I have served as Commissioner of the Department since September 20, 2021.

4. The Department's mission is to protect and improve the health and safety of the people of Connecticut by assuring the conditions in which people can be healthy; preventing

disease, injury and disability; and promoting the equal enjoyment of the highest attainable standard of health, which is a human right and a priority of the state.

5. The Department has oversight of infectious disease control and prevention; environmental and occupational health; drinking water; healthcare facilities and healthcare practitioners. The Department also operates the state public health lab, coordinates responses to public health emergencies, serves as the repository for state vital records, funds public health initiatives throughout Connecticut, and engages in numerous other activities to protect and enhance public health in the state.

6. I am providing this declaration to explain the impacts on the Department of the cuts to HHS, including cuts to CDC and the FDA.

Impacts on Infectious Disease Control and Prevention

7. As more fully described below, the sweeping reductions in force (RIFs), layoffs, communications freezes, and program eliminations, particularly at the Centers for Disease Control and Prevention (CDC) including the National Center for Immunization and Respiratory Diseases (NCIRD) Partnerships Branch, and the Food and Drug Administration (FDA) have delayed the Department's ability to complete grant applications, created an information vacuum which has caused confusion, diminished public trust and health equity, and interfered with the Department's ability to conduct an outbreak investigation.

8. The sudden pause in CDC communications, starting on Jan. 28, 2025, occurred during the most critical period of the Immunization Program 5-year Cooperative Agreement development. Office hours, during which Department staff previously were able to communicate with federal project managers, were canceled, technical issues with the electronic grant system went uncommunicated, and the Department was left without clear instruction on updated

deliverables. This delayed the Department's ability to complete the grant, communicate expectations to partners, and secure necessary funding, especially for our Immunization Information System (IIS) and local health department (LHD) contracts. Routine conference calls across federal program areas were canceled and there was no communication from federal project officers regarding the 14-day delay in the notice of award (NOA) for the Strengthening STD Prevention and Control for Health Departments cooperative agreement.

9. Access to critical communications and public health alerts from the CDC was cut off during the influenza season and was associated with cessation of real time updating of national influenza statistics. This included statistics on highly pathogenic avian influenza (HPAI) H5N1 during a period when the virus was widespread in wild birds and spilling over into commercial and backyard poultry flocks. The Department was unable to rely on influenza statistics normally provided by CDC to help track the spread of human influenza infections, including infections with HPAI H5N1.

10. On March 31, 2025, the members of the Healthcare Infection Control Practices Advisory Committee (HICPAC) within the CDC were terminated. For more than 30 years, the HICPAC provided hundreds of recommendations for national standards for infectious disease control including hand washing, mask wearing and isolating sick patients in health care settings such as nursing homes and hospitals. The CDC fully implemented over 90 percent of HICPAC's recommendations over the years. Without HICPAC, current national health guidelines may not be updated when better practices emerge based on new scientific research, the spread of drug-resistant bacteria, or when a major health event, such as the Covid-19 pandemic, occurs.

11. Public trust and health equity was diminished when information on CDC's website disappeared. Federal websites were taken down on January 31, 2025, to comply with

certain executive orders. No notice was provided to the Department and other jurisdictions. The Department discovered the absence of key materials like Vaccine Information Statements (VISs)—legally required documents—on its own. This created confusion among providers and delayed updates to the Department's website, press releases, and public guidance.

12. The Department's ability to conduct an outbreak investigation was impacted by the closure on April 1, 2025, of the CDC Division of Viral Hepatitis (DVH) Molecular Epidemiology and Bioinformatics Laboratory. As part of an acute Hepatitis C investigation that DPH had been leading since January of 2025, blood samples were collected and sent to the CDC DVH laboratory for evaluation to characterize viral genotypes and potential transmission links among individuals. This laboratory was shut down before this testing could be completed and before the team who performed this specialized testing could take any steps to share this knowledge with other laboratorians so this important work could continue. This has severely and detrimentally impacted the ability of this investigation to continue.

13. The elimination of the NCIRD Partnership Branch, which supported equity-driven education campaigns like Partnering for Vaccine Equity (P4VE), directly harms community-based providers and local health departments working with underserved populations. These efforts helped plan vaccine clinics, reduced provider burden, and ensured resources were translated, culturally appropriate, and timely. Their elimination will have long-term effects on minority and low-income populations' access to preventative care.

14. Elimination of federal topical calls for laboratories and infectious disease activities across all infectious disease program areas—such as those for Vaccine-Preventable Diseases (VPD) and Respiratory Virus Disease (RVD)—deprives frontline providers of real-time

trends, protocols, and case definitions. This hampers providers' response to outbreaks such as measles and RSV.

15. Staff eliminations or reductions within CDC and FDA jeopardize timely vaccine approvals, safety monitoring, and schedule updates. Providers are left with outdated or incomplete information, increasing liability, hesitancy, and gaps in coverage, all of which are particularly harmful during rapidly evolving respiratory seasons or emergency responses.

16. To summarize, the Department can no longer depend on timely federal guidance, consistent communication, or foundational support from CDC and FDA. This has directly impaired our ability to administer grants, conduct surveillance, support providers, and protect the health of Connecticut residents. The staff eliminations and reductions throughout HHS have resulted in a massive loss of public health subject matter expertise and leadership, leaving a huge void from which it will take decades to recover. These actions will result in duplication of efforts on the state level as there is no longer a coherent national group of public health subject matter experts and leaders from whom to seek guidance.

Impacts on Occupational Health

17. The National Institute for Occupational Safety and Health (NIOSH) has effectively been eliminated by RIFs. NIOSH's mission was to prevent injury, illness, and death in the workplace. NIOSH was responsible for the evaluation and approval of ALL respirators (N95, half-facemask, full facemask, self-contained breathing apparatus (SCBA), controlled air purifying respirators (CAPRs), and powered air purifying respirators (PAPRs) through the NIOSH Respiratory Approval Program. This program has been terminated. Now, there is no independent organization in the United States evaluating respirators and ensuring that they provide the level of protection advertised by their manufacturers. This places all workers who

use respirators to protect themselves from exposure to certain infectious diseases such as tuberculosis at risk of exposure to such diseases.

18. NIOSH also performed Health Hazard Evaluations (HHEs), which are boots on the ground evaluations of workplace illnesses, hazards, and other emerging threats. The HHS RIFs have resulted in the termination of these evaluations. The Department can no longer request NIOSH to evaluate any workplace hazards, and the Department itself lacks the capacity to perform these activities. Cessation of these activities endangers the health of American workers.

19. The Department currently receives funding from NIOSH to support the Connecticut Fundamental Surveillance Program, which will terminate on June 30, 2025, unless action is taken. The Department has been unable to reach any contact at NIOSH concerning this funding.

Impacts on Maternal Health and Health Equity

20. The entire staff of the HSS regional office in Boston was eliminated. This affects the Division of Regional Operations partners in New England, which impacts the New England section of National Health Service Corps (NHSC). The NHSC supports more than 17,000 primary care medical, dental and behavioral health providers through scholarships and loan repayment programs. The NHSC, which has existed for more than 50 years, has increased access to quality health care in communities with significant shortages of health professionals. Since the staff was eliminated, it has been challenging to obtain technical assistance for NHSC programs at all levels of the program. Prospective applicants have had very long call-wait times to the Health Resources and Services Administration (HRSA), and technical glitches related to the site application process on HRSA's end have increased. There has been less frequent communication

to the Department about these program opportunities from HRSA. Site visits, which are crucial to maintaining the integrity and quality assurance of NHSC, appear to be on hold.

21. Prior to April 1, 2024, the Department was assisted by a CDC Epidemiologist Assignee, who had been an integral member of the Maternal Child Health (MCH) Title V Needs Assessment process. Due to the federal RIFs, our assignee informed us that she would no longer be with the CDC and she would not be available to assist the Department. This assignee provided crucial expertise in data analysis, survey design, and collaboration with our community partners. Her contributions were essential for analyzing existing health data, developing key indicators, and developing data products such as the Maternal and Child Health Block Grant (MCHBG) fact sheets. The loss of her expertise has created immediate challenges, including delays in completing the MCH data landscape and assistance in writing the MCH Title V Needs Assessment summary. The overall timeline for the Needs Assessment may be significantly affected due to these delays and the need to find alternative solutions. The remaining team members are now tasked with absorbing some of these responsibilities, potentially impacting their capacity for other critical tasks.

22. Although the Department received a grant award on April 11, 2025, for the Pregnancy Risk Assessment Monitoring System (PRAMS), the Department was notified on April 1, 2025, that the CDC project officer and support staff who directly support PRAMS had been placed on administrative leave. The project officer and support staff had been instrumental in providing essential technical assistance for the PRAMS Integrated Data Collection System (PIDS) and offered vital support to the statisticians who were responsible for weighing the PRAMS data. At this time, the PIDS is down and therefore, the Department has no way to report any PRAMS data.

23. The sudden loss of key personnel has generated a significant amount of uncertainty regarding the future direction and stability of the MCH Title V Needs Assessment and PRAMS project. The team is concerned about these vacancies, the potential delays to our work, and the long-term implications for the project's continuation, including the potential loss of federal funding altogether. The loss of national surveillance programs, such as PRAMS, undermines LHD and provider efforts to address maternal vaccination, chronic disease prevention, and reproductive health disparities. These tools are essential to support local programs aimed at high risk or underserved populations.

Impacts on Tobacco Control and Prevention, Sexual Violence Prevention, Asthma, Alzheimer's Disease & Related Dementias

24. The CDC grant supporting the Department's Tobacco Control Program ends on April 28, 2025. Due to recent organizational changes at HHS/CDC, the entire Office of Smoking and Health (OSH) team, including the Department's CDC Project Officer, has been terminated. CDC has confirmed that decisions regarding the future of the DPH20-2001 – National and State Tobacco Control Program awards are pending. CDC has communicated that a no-cost extension will take effect on April 29, 2025, and run through October 29, 2025, allowing continued use of remaining funds, and that additional updates will be provided when available. The Department is currently planning for expected funding shortfalls while determining how long we can support 2.6 full-time equivalent staff and activities currently funded by this grant.

25. On April 1, 2025, the Department was notified that the entire staff of the Healthy Aging Branch in the CDC's Division of Population Health had been terminated. This office was responsible for activities that contribute to a comprehensive approach to helping older adults live long, productive, and independent lives. This work includes Alzheimer's work to address

Alzheimer's disease and the severe burden it places on the American public. Without staff, the future of this important work is unclear.

26. On April 1, 2025, the Department was notified that all Program Services staff in the CDC's Division of Environmental Health Science and Practice within the Asthma and Air Quality Branch had been terminated and that the Department should "look for future support from the Office of Grant Services." No additional information concerning this future support has been provided.

27. On April 1, 2025, the Department was notified that the CDC's subject matter experts in sexual violence within the Division of Violence Prevention of the National Center for Injury Prevention and Control had been placed on administrative leave. This has resulted in a lack of technical assistance following the submission of the Department's Annual Progress Report in this area, no planning guidance on the upcoming funding year, and no input on updates to Connecticut's State Action Plan – a key document that guides Connecticut's sexual violence prevention efforts. Without CDC to facilitate interstate collaboration, there is a risk that recent gains in this critical area will be undone.

28. The absence of accessible CDC contacts to answer program or budget questions or provide technical assistance has created significant communication gaps. This has caused confusion and concern among state staff and LHDs who depend on federal guidance and stable funding to implement their prevention efforts and to stay aligned on public health interventions.

Impacts on Lead Reduction Program

29. The Department receives grant funding from the CDC for its Childhood Lead Prevention Program, the goal of which is to prevent lead poisoning and promote wellness through education and a wide range of program activities that relate to childhood lead poisoning

prevention. On April 1, 2025, the Department learned that all CDC staff assigned to this grant, including the project officer, had been dismissed. One contact, a Grant Management Specialist, is left to assist with high level questions only. The Department submitted its grant application for year five on April 11, 2025, but did not receive an automated receipt as previously was the case.

Climate and Health

30. The Department receives federal grant funding under the CDC Building Resilience Against Climate Effects (BRACE) framework which is a five-step process that allows health officials to develop strategies and programs to help communities prepare for the health effects of climate change. On April 1, 2025, the Department was notified that all CDC Climate and Health program staff had been placed on administrative leave. That staff was responsible for all aspects of grant administration, including providing critical technical support to grant recipients, including the Department. As a result of RIFs in this area, the Department has been unable to receive feedback from the Climate and Health Science Team on existing curriculum development work, unable to access resources on extreme heat technical tools that the Climate and Health Program created and presented to recipients previously, and unable to obtain guidance from the Climate and Health Translation and Evaluation team on how to prioritize funding opportunities for additional activities related to adaptation actions. In addition, the Department has been unable to meet and collaborate with the Heat Adaptation Community of Practice which allowed grant recipients to share work and prepare for the impending heat season. Out of an abundance of caution, given the RIF in Climate and Health staff, the Department has paused the execution of four contracts with municipalities to engage in local heat and air quality planning. The RIFs also forced the Department to cancel the annual Climate and Health Symposium which is the only statewide forum on climate and health topics and is a critical tool

for statewide preparedness and public education. Finally, the Department has put on hold planning for extreme heat and other adaptation activities for the 2025-2026 grant cycle due to concerns about the NOA and the absence of program staff.

31. The sweeping RIFs, layoffs, freezing of communications, and program eliminations at HHS impede the Department's ability to protect public health. These actions have and will continue to cause immediate and lasting harm to the Department and the people of the State of Connecticut.

I declare under penalty of perjury under the laws of the United States that, to the best of my knowledge, the foregoing is true and correct.

Executed on May 9th, 2025, at Hartford, Connecticut

Manisha Juthani, M.D.

EXHIBIT 63

HEALTH

Why CDC cuts are being called ‘the greatest gift to tobacco industry in the last half-century’

The Office on Smoking and Health at the CDC is no more, putting state quitlines and national data on youth tobacco use at risk

Adobe

By Sarah Todd April 14, 2025

Reporter, Commercial Determinants of Health

In the earliest ads, Terrie Hall wears a scarf around her throat to cover the artificial voice box that helps her speak. She talks about smoking on the day of her surgery; how she wishes she'd recorded her voice so her grandchildren would know how she used to sound.

Two years later, just days before her death from cancer at age 53, Hall insisted on filming again from her hospital bed in North Carolina. In these ads, she's not wearing scarves or her shining blond wig anymore. She urges people who smoke to keep trying to quit until they succeed. "I don't want anybody to have to go through what I'm going through."

Hall was one of dozens of people who have been featured in the Tips From Former Smokers campaign that launched in 2012, run by a division of the Centers for Disease Control and Prevention. The ads have been a remarkably effective tool in the push to help Americans stop smoking: When the television spots air, calls to the state-run 1-800-QUIT-NOW hotlines go up. When they stop, calls go back down. The CDC estimates that in the first five years of the campaign alone, an estimated 1 million Americans quit smoking, preventing 129,100 premature deaths.

But as of April 1, the Office on Smoking and Health — responsible for the Tips campaign along with other projects aimed at spotting trends in tobacco use and preventing it at the national and state levels — is effectively shuttered, the roughly 120 full-time employees who worked there dismissed along with the contractors who lost their jobs in February. That's left the future of OSH initiatives unclear, including not just the Tips campaign, which continues to air for now, but also the annual National Youth Tobacco Survey, which helped spur federal action on the alarming uptake of Juul and other e-cigarettes among teenagers a few years back. States and U.S. territories, which received the bulk of OSH's $240 million in funding, relied on the agency's support to run quit hotlines — which provide callers with counseling as well as access to medications — and to introduce other anti-tobacco initiatives like cigarette taxes or restaurant smoking bans. OSH was also responsible for Surgeon General's reports on tobacco use, which in recent years had focused on topics like health disparities in tobacco-related disease and death, smoking cessation, and e-cigarette use among young people.

Amid the 10,000 job cuts so far this month at the U.S. health department, what happened to OSH is "the greatest gift to the tobacco industry in the last half century," said Tim

McAfee, who headed the division from 2010 to 2017.

As nicotine pouches like Zyn gain popularity among young adults and Philip Morris International rolls out a pilot program in Austin, Texas, for its heated tobacco device Iqos, there is no longer an office responsible for spotting emerging trends in the use of tobacco products, McAfee and three recently fired agency employees told STAT.

"This isn't even DOGE business as usual," said McAfee. "There were drastic cuts throughout CDC. But there was nothing like what they did to OSH."

A spokesperson for the Department of Health and Human Services wrote that it is "committed to investigating any potential roof [sic] causes of the chronic disease epidemic. Critical programs within the CDC will continue as part of Secretary Kennedy's vision to streamline operations and create a more efficient HHS."

National Jewish Health, a respiratory hospital that operates quitline services in many states, said that it had not been notified about any changes to funding since OSH was shut down. CDC funds cover 75% of smoking quitline costs in five states and two U.S. territories, and at least 25% of costs in an additional 18 states, according to the North American Quitline Consortium.

The end of OSH comes alongside dramatic changes at the Center for Tobacco Products at the Food and Drug Administration, including the elimination of the center's management and regulation divisions and the ouster of top tobacco regulator Brian King and head scientist Matthew Farrelly. Sometimes perceived by outsiders as redundant offices, they performed different but complementary roles: the FDA's tobacco office regulates products, while the CDC's focused on people, monitoring and attempting to reduce tobacco use.

Since OSH's program providing coordinated tobacco control support to states and territories began in 1999, the percentage of American adults who smoke has fallen from nearly a quarter to 10.8%, while smoking among high school students fell from 28% in 2000 to 1.4% last year. Former OSH employees now worry that progress will not only stall but be reversed.

Without continued investment from the federal government, “more people will start smoking and fewer people will quit smoking,” said Maggie Mahoney, a contractor who worked with OSH until February when her position was eliminated.

“There are some states where a large portion, if not a majority of their resources for tobacco prevention, were coming from CDC,” said an OSH employee affected by the cuts, who requested anonymity because of potential retaliation. “So I’m worried some states will either severely pare back their prevention activities or even close them down.” Twenty-two U.S. states still do not have comprehensive smoking bans for workplaces, restaurants, bars, and casinos.

The first months of the new Trump administration have been largely positive for the tobacco industry. In January, the administration withdrew a proposed ban on menthol cigarettes. Tobacco companies have also been urging government officials to crack down on illegal vapes from China, which was the subject of a congressional hearing last week. White House chief of staff Susie Wiles previously lobbied on behalf of tobacco company Swisher International. And Health Secretary Robert F. Kennedy Jr. reportedly popped a nicotine pouch from a tin of Tucker Carlson’s brand ALP during his confirmation hearings in January. “The right more generally has been embracing nicotine,” River Page wrote in January for The Free Press.

Tobacco companies are also faring well in the markets. Philip Morris International stock is up 72% from the same time a year ago, Altria Group is up 36%, and British American Tobacco is up 43%.

“It’s a perfect time to shut down the capacity of society to track what’s actually happening to our children,” McAfee said.

Kennedy was on a press tour out West last week touting plans to combat chronic disease in the U.S., often emphasizing concerns about the effects of food additives and dyes. But smoking remains the leading cause of preventable death and disease, making the elimination of the agency all the more confounding to ex-OSH employees.

“If you’re really worried about the ingredients in cereal,” said one former worker, “wait until you find out about the thousands of chemicals that are contained in cigarettes.”

STAT's coverage of chronic health issues is supported by a grant from Bloomberg Philanthropies. Our financial supporters are not involved in any decisions about our journalism.

EXHIBIT 64

bloomberg.com

RFK Jr. Ousts Top Officials in Bid to Overhaul US Health Agency

Rachel Cohrs Zhang

9–11 minutes

First came Robert F. Kennedy Jr.'s ouster of a top official at the Department of Health and Human Services' vaccine division. Then, the HHS chief pushed out the people overseeing new drug reviews and tobacco, while placing on leave Anthony Fauci's successor at the National Institutes of Health.

The efforts to push out senior leaders overseeing scientific research and reviews of medicines and tobacco products go further than the effort to streamline the department that agency officials had publicly described.

The sweeping cuts also allow Kennedy to reshape the country's health policy and communications, providing a road map for where the new health chief is directing his focus. Among the 10,000 people cut on Tuesday, some entire divisions were gutted including groups working on sexually transmitted diseases, environmental health, global health and birth defects, according to people familiar with the matter. Big swaths of the agency's communications and federal records teams were also laid off.

A worker wheels out the belongings of a fellow employee who was

dismissed on April 1.Photographer: Al Drago/Bloomberg

The moves have already rattled investors, health officials and employees, many of whom lined up to enter their offices this morning only to realize that their access was cut off. The S&P Biotech ETF fell as much as 2.4% on Tuesday, following a 3.9% drop Monday after the resignation of top vaccine official Peter Marks.

HHS did not provide additional comment beyond an X post by Kennedy. The agency has previously said drug and medical device workers, along with food reviewers and inspectors will be spared from the cuts.

“Let’s restore @HHSgov health agencies to their rich tradition of gold-standard, evidence-based science to tackle the chronic disease epidemic and Make America Healthy Again,” he said in a video with the new heads of the FDA and NIH.

Dismissal notices coming from deputy assistant secretary for human resources Thomas Nagy notifying people they were terminated came around 5 a.m. in Washington, DC.

Among the most concerning to former government workers were those at the FDA, which regulate new drug approvals and oversee the health and safety for everything Americans eat and ingest.

“The FDA as we’ve known it is finished, with most of the leaders with institutional knowledge and a deep understanding of product development and safety no longer employed,” former commissioner Robert Califf wrote in a LinkedIn post Tuesday. Califf, who led the agency during the Obama and Biden administrations, said he was inundated with messages about the cuts. “I believe that history will see this a huge mistake.”

Read More: Fauci's Successor Put on Leave as RFK Jr. Reshapes Agencies

Robert F. Kennedy Jr.Photographer: Al Drago/Bloomberg

Slimming Down

Kennedy had announced sweeping cuts to HHS last week with plans to shrink to 62,000 employees from 82,000. The secretary had announced plans to consolidate the department's 28 divisions into 15 and cut regional offices from 10 to five. HHS said these cuts will save the government $1.8 billion.

As the cuts unfolded Tuesday, a picture emerged of parts of health agencies being cut in ways that could upend things as core to the agency — and global business — as drug approvals.

Among those impacted were Peter Stein, a top FDA official who oversaw reviewers that evaluate new drugs, make approval decisions and decide whether the benefits of drugs outweigh the risks, according to an email viewed by Bloomberg.

"I received an email indicating that I've been removed as OND Director and offered a position in patient affairs — which I have declined," Stein wrote.

Stein's removal raised questions about Kennedy's broader strategy. RBC Capital Markets analyst Brian Abrahams said in a note Tuesday that the mass layoffs appear to be happening "without regard for any particular policy, continuity, seniority level, or ability."

Abrahams said the department associated with drug reviews was an area of the FDA that was once considered protected.

"It seems that at best new drug reviews and engagement with drug developers will slow," Abrahams said, saying it could take months or even years to hire and train new personnel.

Any slowdown in drug approvals out of the FDA has the potential to undo work that the agency has done to speed up those processes in recent years, according to Scott Gottlieb, who was FDA commissioner during Trump's first term.

"Today, the cumulative barrage on that drug-discovery enterprise threatens to swiftly bring back those frustrating delays for American consumers, particularly affecting rare diseases and areas of significant unmet medical need," Gottlieb said.

Stein's departure followed the ouster of Marks, who oversaw the division of FDA that approves vaccines, insulins and complex injectable medicines.

In his resignation letter, Marks cited Kennedy's efforts to spread misinformation about the safety of vaccines. "I was willing to work to address the Secretary's concerns regarding vaccine safety and transparency," he said. "However it has become clear that truth and transparency are not desired by the Secretary, but rather he wishes subservient confirmation of his misinformation and lies."

Sudden Changes

The FDA's chief tobacco regulator was also removed from his position Tuesday. "It is with a heavy heart and profound disappointment that I share I have been placed on administrative leave," wrote Brian King, who served as director of the FDA's Center for Tobacco Products, in an email to staff obtained by Bloomberg Law.

Also affected by dismissals were most of the FDA's press office, according to people familiar with the cuts.

Employees affected by the reduction-in-force notice were locked out of HHS computer systems immediately, meaning the work on the programs they ran was effectively halted and they were unable to communicate with partners. In their layoff notices, FDA staff were told to contact LaKeisha McClendon, the agency's equal employment opportunity representative, if they felt the decision was discriminatory, according to a copy of an email seen by Bloomberg. But McClendon left the FDA in early March, according to an automatic response from her email address listed in the layoff note. Attempts to reach McClendon were not returned.

Despite Kennedy's prior career in environmental activism, the Centers for Disease Control and Prevention made cuts at a division that houses several programs including one for climate and health, an asthma and air quality branch, a lead poisoning prevention and surveillance branch, and more.

In an internal CDC email seen by Bloomberg News, Aaron Bernstein, director for the National Center for Environmental Health and the Agency for Toxic Substances and Disease Registry, wrote: "I have learned that [the Division of Environmental Health Sciences and Practice] has been slated to be eliminated in its entirety."

Demonstrators protest the layoffs of federal workers on Feb. 17.Photographer: Stefani Reynolds/Bloomberg

And while Kennedy's public health agenda centers on addressing chronic disease, the CDC cut parts of its chronic disease and health promotion center that worked on surveillance of Alzheimer's

disease, smoking prevention and preventing pregnancy complications.

Besides shrinking the agency's workforce, Kennedy is also working to reshape its structure by cutting the number of divisions almost in half. Those moves include combining units of HHS focused on public health, substance abuse, mental health and occupational safety into a new entity called the Administration for a Healthy America. The division of HHS responsible for preparing for pandemics will be relocated to the Centers for Disease Control and Prevention, and 1,000 employees will be transferred there as a result.

In some cases, whole units were culled, raising questions about how work is going to continue. For example, the entire CDC FOIA office — nearly two dozen people — received reduction in force notices starting that they would immediately be placed on administrative leave. All FOIA personnel at FDA and NIH were also dismissed, a person familiar with the matter told Bloomberg News. The CDC has seen a massive uptick in FOIA requests this year. It's the second busiest year since Covid, the person said.

During his first address to HHS personnel after he was sworn in, Kennedy, who routinely used the FOIA to obtain a wide range of records from the health agencies, promised a new era of "radical transparency" and remarked that the public wouldn't need to use FOIA. HHS has received at least 2,000 FOIA requests this fiscal year and expects its backlog to grow to 9,000.

Democrats have blasted Kennedy's plans, saying they will disrupt services and undermine medical research.

"Their plan is putting lives in serious jeopardy," Washington

Senator Patty Murray said.

— With assistance from Sophie Alexander, Ike Swetlitz, Nyah Phengsitthy, Zahra Hirji, Gerry Smith, John Tozzi, Anne Cronin, and Jason Leopold

EXHIBIT 65

POLITICO

The FDA fired its tobacco enforcers. Now it wants them back.

The agency asked laid-off workers to return after gutting the office that penalizes stores for selling tobacco to minors.

A sign for the Food And Drug Administration is seen outside of the headquarters on July 20, 2020, in White Oak, Maryland. | Sarah Silbiger/Getty Images

By **ADAM CANCRYN** and **LAUREN GARDNER**
04/14/2025 04:45 PM EDT

The Food and Drug Administration earlier this month fired dozens of staffers responsible for going after retailers who illegally sell tobacco to minors.

Now it's begging them to come back.

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Senior FDA officials asked laid-off employees in recent days to temporarily return after mass cuts decimated the agency's ability to penalize retailers that sell cigarettes and vapes to minors, four federal health officials familiar with the matter said.

The scramble followed HHS Secretary Robert F. Kennedy Jr.'s termination of roughly 10,000 employees, which included everyone in the FDA office charged with preparing and seeking fines against stores that repeatedly violate a ban on selling tobacco to customers under 21.

The FDA typically files more than 100 complaints a week seeking so-called civil money penalties against retailers, the officials said. But after the April 1 mass firings carried out across the Department of Health and Human Services, that operation ground to a halt, effectively eradicating the agency's main weapon against illegal tobacco sales.

"You could not have done a better job of eliminating tobacco enforcement than by doing this," said one of the officials, who were granted anonymity for fear of retaliation. "It was the perfect pinpoint strike."

The cuts prompted a sprint by the few remaining officials to seek extensions for the active complaints against retailers slated to go before the HHS board charged with reviewing them, another one of the officials said. And inside the FDA, they raised fears about the agency's ability to continue enforcing the tobacco sales laws that health experts credit for helping drive an extended decline in youth smoking.

Tobacco use among middle and high school students hit the lowest point in a quarter-century in 2024, according to the National Youth Tobacco Survey.

Without aggressive federal oversight, stores would face far less incentive to turn away underage buyers. That could open the door to a reversal in youth tobacco use rates, experts said, undercutting the fight against chronic disease that Kennedy has vowed to make the centerpiece of his agenda. The civil penalties office also served as a key tool in combating growing sales of illicit vapes.

People who smoke cigarettes, use e-cigarettes or other tobacco products primarily begin before they turn 18, research shows, elevating their risk for a

range of chronic diseases like lung cancer and heart disease.

Advertisement

AD

“It’s a prescription for allowing retailers to roll the dice and sell to minors with less concern that they will ever be caught,” Mitch Zeller, who ran the FDA’s Center for Tobacco Products for nearly a decade before retiring in 2022, said of the cuts. “Everybody agrees that retailers should not sell to minors — it doesn’t get any more red, white and blue than this program.”

Top FDA officials have yet to lay out a long-term plan for ensuring oversight of retailers’ tobacco sales.

But in the interim, senior leaders are seeking volunteers among those who Kennedy fired to return from administrative leave and help maintain continuity until they’re officially terminated on June 2.

As of Friday, more than two dozen staffers had agreed to return, a development one of the officials attributed in part to workers’ fears of being denied severance benefits if they refused.

In a statement, HHS spokesperson Andrew Nixon said that all laid-off employees may be asked to work temporarily until their government service ends on June 2.

“This decision is focused on ensuring that the transition is as seamless as possible, minimizing any disruption to the agency’s mission and operations, Nixon wrote. “HHS fully supports this approach, which aims to maintain public health services while managing the reorganization process effectively.”

Though some senior FDA officials within the Center for Tobacco Products are still trying to get the office fully reinstated, others have warned returning staffers that there is likely no path to being permanently rehired.

“There was no workforce planning in advance of this,” said the first official. “There was no continuity planning.”

It remains unclear why HHS gutted the office focused on civil penalties, which is known within FDA’s tobacco enforcement apparatus as the Division of Business Operations. The Center for Tobacco Products is funded entirely by user fees paid by industry, meaning the terminations won’t create any taxpayer savings. Instead, officials said, it may end up costing money; the fines that the FDA collects from retailers are funneled directly to the federal treasury.

Kennedy, who has singled out smoking as particularly detrimental to Americans' health, argued in a recent CBS News interview that all the jobs eliminated across HHS were either administrative or deemed redundant.

"In some cases, we cut programs, but we only did that when we consolidated them into another program," he said. "So the task will continue, their mission will continue. The people are still there for the most part."

Yet within the FDA, the officials said the cuts effectively collapsed its tobacco enforcement operation. The agency's process consists of three stages: A warning letter sent to a retailer after its first offense, followed by civil penalties for subsequent offenses, with a ban on all tobacco sales reserved for the most egregious violators.

Kennedy's cuts spared the teams that handle warning letters and the complete bans. Indeed, the FDA is still posting warning letters to purveyors of tobacco products.

But without a well-staffed office to seek fines against stores for repeated sales to minors, the agency won't have the capacity to follow up on retailers who ignore the warning letters — or to build the cases necessary to shut down the worst offenders.

FILED UNDER: HEALTH AND HUMAN SERVICES, FDA, TOBACCO

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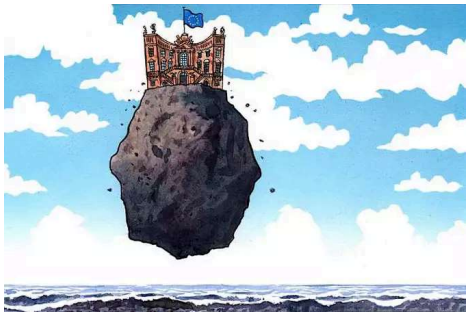

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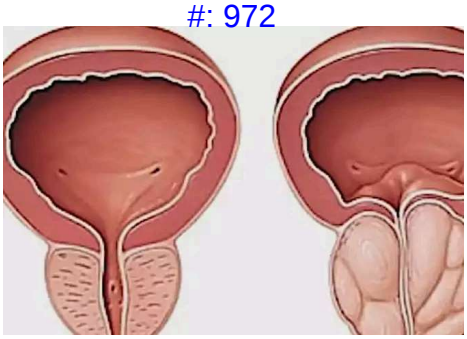

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