Hearing on the Department of Health and Human Services' Fiscal Year 2019 Budget Request

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HEARING

BEFORE THE

COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED FIFTEENTH CONGRESS

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Hearing on the Department of Health and Human Services'
Fiscal Year 2019 Budget Request

U.S. House of Representatives,
Committee on Ways and Means,
Washington, D.C.

WITNESS

Honorable Alex Michael Azar II
Secretary, U.S. Department of Health and Human Services
Witness Statement

WAYS AND MEANS
CHAIRMAN KEVIN BRADY

Chairman Brady Announces Hearing on the Department of Health and Human Services' Fiscal Year 2019 Budget Request

House Committee on Ways and Means Chairman Kevin Brady (R-TX) announced today that the Committee will hold a hearing on the Department of Health and Human Services' Fiscal Year 2019 Budget Request. **The hearing will take place on Wednesday, February 14, 2018 in 1100 Longworth House Office Building, beginning at 10:00 AM.**

Oral testimony at this hearing will be from the invited witness only. The sole witness will be the Honorable Alex Azar, Secretary, U.S. Department of the Health and Human Services. However, any individual or organization may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit written comments for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, http://waysandmeans.house.gov, select "Hearings." Select the hearing for which you would like to make a submission, and click on the link entitled, "Click here to provide a submission for the record." Once you have followed the online instructions, submit all requested information. ATTACH your submission as a Word document, in compliance with the formatting requirements listed below, **by the close of business on Wednesday, February 28, 2018**. For questions, or if you encounter technical problems, please call (202) 225-3625.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission not in compliance with these guidelines will not be

printed, but will be maintained in the Committee files for review and use by the Committee.

All submissions and supplementary materials must be submitted in a single document via email, provided in Word format and must not exceed a total of 10 pages. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears. The name, company, address, telephone, and fax numbers of each witness must be included in the body of the email. Please exclude any personal identifiable information in the attached submission.

Failure to follow the formatting requirements may result in the exclusion of a submission. All submissions for the record are final.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202-225-1721 or 202-226-3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Note: All Committee advisories and news releases are available at http://www.waysandmeans.house.gov/

DEPARTMENT OF HEALTH AND HUMAN SERVICES'

FISCAL YEAR 2019 BUDGET REQUEST

Wednesday, February 14, 2018
House of Representatives,
Committee on Ways and Means,
Washington, D.C.

The committee met, pursuant to call, at 10:06 a.m., in Room 1100, Longworth House Office Building, Hon. Kevin Brady [chairman of the committee] presiding.

Chairman Brady. The committee will come to order.

Today, our committee is honored to welcome Secretary Alex Azar to testify on President Trump's fiscal year 2019 budget proposals for the Department of Health and Human Services.

Secretary Azar, congratulations on your recent confirmation, and thank you for being here today. We know you are only 2 weeks into this job, so we expect you to know everything. We are still reviewing the effects of the recent reforms and the budget caps adjustments that were included in last week's Bipartisan Budget Act, and we look forward to your testimony.

Over the past year, our committee has been working to improve, strengthen, and streamline healthcare and welfare programs under our jurisdiction. In healthcare, we have taken action to cut needless red tape that makes it more difficult for providers to deliver high-quality care to their patients. We recently advanced targeted bipartisan reforms to improve Medicare for the American people, continuing the drive to strengthen quality and care coordination. And our committee played a first-hand roll in developing comprehensive legislation to repeal and replace the Affordable Care Act.

With the American Healthcare Act that was passed by the House last May, we delivered market-oriented solutions that would truly increase flexibility, reduce costs, and return control of healthcare to the American people, where it belongs.

While this bill is stalled in the Senate, Congress has continued to deliver relief from ObamaCare, including repealing the harmful effects of the individual mandate and the Independent Payment Advisory Board. We also took action to prevent several damaging healthcare taxes from going into effect.

When it comes to the welfare and antipoverty programs under our committee's jurisdiction, we have taken significant actions to strengthen families and communities, and help more Americans move themselves out of poverty and into prosperity. We have advanced bills to improve America's child welfare system so that more of our kids can grow up in a safe home surrounded by a stable family. We reauthorized and then strengthened the Maternal, Infant, and Early Childhood Home Visiting Program, an evidence-based program that provides real help to families in at-risk communities as they strive to build better lives. And we passed numerous bills to help more Americans get back to work. Several of these used the partnership and expertise of our local and State job creators to increase opportunities and on-the-job training for our American workers.

I am pleased that many of these important healthcare and welfare policies were signed into law as part of the Bipartisan Budget Act. But our committee is not going to stop there. Many Americans, including many of my constituents in Texas, are still struggling to access high-quality healthcare at an affordable price. Too many people across the Nation are seeing their families torn apart by the opioid crisis. And too many Americans remain out of work, stuck on the sidelines of our economy, while our local companies struggle to fill job openings. This very issue was just reinforced by a new small business survey from the National Federation of Independent Business.

Of all the small business owners who responded, over one-fifth cited the difficulty of finding qualified workers as their most important business problem. That percentage was larger than any other issue in the survey. We have to find a way to bridge this divide. I am convinced the best way to do that is by expecting and rewarding work in our welfare programs. We are pleased to see this same approach reflected in the President's budget request for HHS.

On healthcare, our committee has developed consensus solutions. We are eager to work with the Trump administration and you to build on them whenever possible. This includes taking actions to reduce the cost of prescription drugs, which I am also pleased to see is a top priority in President Trump's budget. We know the Medicare part D program has delivered good results for seniors and American families. Republicans on this committee led

that successful effort. We want to improve the program and expand access to affordable prescription drugs by working with you and the White House on a market-oriented approach that doesn't shift costs onto the backs of taxpayers.

I believe the best path forward to help the American people is to continue to emphasize competition, new innovations, and individual choice, rather than top-down mandates from Washington that interfere with efficiency and affordability.

Secretary Azar, our Nation faces a number of significant challenges in making our healthcare and our welfare systems work better and longer for the American people. Building off our committee's successful efforts and the family-focused priorities outlined in the President's budget, I am confident we can work together to advance solutions that improve lives. Mr. Secretary, thank you again for being here today. We look forward to your testimony.

And I now yield to the distinguished ranking member, Mr. Neal, for the purposes of his opening statement.

Mr. Neal.

Mr. Neal. Thank you, Mr. Chairman.

And certainly a word of welcome, Mr. Secretary. We look forward to your testimony, the first, I believe, that you will be offering to a congressional committee, and we are pleased that you are here.

My goal, like the chairman noted, is to obviously advocate for the best possible opportunities for our constituents. That includes developing policies that help to create jobs; deliver high-quality, low-cost healthcare; and generally help all Americans make a better life for their families.

The budget that President Trump has presented leans against these goals. Instead, it would create more obstacles for families to navigate as they try to make ends meet and move up the economic ladder.

Last year, President Trump and our Republican colleagues ran through a $2.3 trillion tax cut for the wealthiest and strongest among us. In his budget, the President now attempts to fill the deficit role by slashing critical health and family programs instead of building on them to expand middle class opportunities to move up. The budget sabotages healthcare programs by

ripping the rug out from under the middle class and cuts the healthcare programs these hardworking Americans rely upon.

Under the Trump budget, millions more of Americans will lose their health insurance, and healthcare costs will continue, then, to increase. The Republican-Trump budget attacks preexisting condition protections by allowing companies to charge more for less coverage or to deny coverage altogether. It creates an age tax where seniors will be charged significantly more due to their age. For millions of Americans, this budget would cost their healthcare premiums to skyrocket.

The Trump budget cuts $1.4 trillion from Medicaid and another half trillion for Medicare. As more and more baby boomers enroll in Medicare, now is the time to strengthen and sustain the program, and we could have done that by adding critical benefits such as dental, vision, and hearing coverage, not to arbitrarily cut it. $1.4 trillion cuts in Medicaid will lead to cuts in healthcare for children, individuals with disabilities, and people who need long-term care. Medicaid in our time in Congress has now become a middle class benefit. It is the reason that your parents aren't living in your attic, and it is a key component of the opiate and health treatment programs that we all wish to address.

Medicare and Medicaid and other health programs are more important than ever as our Nation struggles to find effective, long-term solutions to the opiate crisis. Everyone in this room has a family member or knows someone who is directly impacted by an opiate or other drug-related disorder. Slashing programs that are designed to help those individuals is not the responsible path.

Healthcare is a crucial part of the economy here in the United States. In my district alone, hospitals are the largest employers. And I must tell you, with satisfaction and pride, in Massachusetts, they are first-class citizens and first-class employers. Cuts to healthcare programs would offer significant job losses as proposed in this budget. The budget alone cuts more than $200 billion in payments to hospitals, threatening additional closures. This proposal would dismantle protections for struggling families and supports for Americans getting and keeping good jobs.

The Trump budget cuts employment services for job seekers and employers, limits access to community colleges for trade-affected workers, and reduces the number of working families receiving assistance in many States. It makes no additional job training investments for workers who need to upgrade their

skills, slashes Meals on Wheels, child and adult protective services, substance abuse programs, and other key programs, by eliminating the social services block grant. These proposals directly undermine the fight against opiate abuse. It also proposes that Congress stop providing guaranteed multiyear funding for Maternal, Infant, and Early Childhood Home Visiting Programs, which is currently authorized through 2023.

Instead of focusing on giving the strongest and the wealthiest amongst us a $2 trillion cut in their taxes, we should be breaking down the obstacles so that middle class families can indeed get ahead.

And I yield back, Mr. Chairman.

Chairman Brady. Thank you, Mr. Neal.

Today's sole witness is Alex Azar, Secretary of U.S. Department of Health and Human Services. The committee has received your written statement, Mr. Secretary. It will be made part of the formal hearing record. And we reserve 5 minutes to deliver your oral remarks.

Secretary Azar, welcome, and you may begin when you are ready.

STATEMENT OF HONORABLE ALEX MICHAEL AZAR II, SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Secretary Azar. Well, thank you very much.

Chairman Brady and Ranking Member Neal and members of the committee, thank you very much for inviting me here to discuss the President's budget for the Department of Health and Human Services for fiscal year 2019. It is just a great honor to be here with you today, and I cannot tell you the honor of my life that it is to be able to serve as Secretary of Health and Human Services.

HHS's mission is to enhance and protect the health and well-being of all Americans, and it is a vital one. And the President's budget clearly recognizes this fact. The budget makes significant strategic investments in HHS's work boosting discretionary spending at the Department by 11 percent in fiscal year 2019 to $95.4 billion. Among other targeted investments that we are proposing, that is an increase of $747 million for the National Institutes of Health, a $473 million increase for the Food and Drug Administration, and a

$157 million increase over 2018 funding for emergency preparedness across the Department.

The President's budget especially supports four particular priorities that we have laid out for the Department, issues that the men and women of HHS are already hard at work on: fighting the opioid crisis, increasing the affordability and accessibility of health insurance, tackling the high price of prescription drugs, and using Medicare to move our health system to a more value-based direction.

First, the President's budget brings a new level of commitment to fighting the crisis of opioid addiction and overdose that is stealing more than a hundred American lives from us every single day. Under President Trump, HHS has already dispersed unprecedented resources to support access to addiction treatment. The budget would take this investment to $10 billion in a joint allocation to address the opioid epidemic and related mental health challenges.

Recognizing that we need private sector and State level innovations to defeat the epidemic, the budget supports HHS's work in disseminating best practices around prescribing, pain management, and addiction treatment, and invests $500 million to launch an NIH public-private partnership to develop new addiction treatments, new overdose reversing drugs, and nonaddictive approaches to pain.

Second, we are committed to bringing down the skyrocketing cost of health insurance, especially in the individual and group markets, so more Americans can access quality, affordable healthcare. This budget recognizes that this will not be accomplished by a one-size-fits-all solution from Washington. It is going to require giving States room to experiment with models that work for them and allowing customers to purchase individualized plans that meet their needs. That is why the budget proposes a historic transfer of resources and authority from the Federal Government back to the States, empowering those who are closest to the people and can best determine their needs. The budget would also restore balance to the Medicaid program, fixing a structure that has driven runaway costs without a commensurate increase in quality.

Third, prescription drug costs in our country are too high. President Trump recognizes this, I recognize this, and we are doing something about it. This budget has a raft of proposals to bring down drug prices, especially for seniors. In part, we are proposing a five-part reform plan to further improve the already successful Medicare part D prescription drug program to lower out-of-pocket costs for senior citizens. These major changes will straighten out

incentives that too often serve program middlemen more than they do our seniors. These changes will save tens of billions of dollars for seniors over the next 10 years, adding to savings we are already generating with reforms to Medicare part B under the 340B drug discount program.

The budget also proposes further reforms in Medicaid and Medicare part B to save patients money on drugs, and provides strong support for FDA's efforts to spur innovation and competition in the generic drug markets. We want programs like Medicare and Medicaid to work for the people they serve. That means empowering patients and providers with the right incentives to pay for health and outcomes rather than procedures and sickness.

Our fourth departmental priority is to use the tremendous power we have through Medicare, as the largest purchaser of medical services in the U.S., to move our whole healthcare system in that direction. The budget takes steps toward that by, for instance, limiting price variation on where post-acute care is delivered, rationalizing payments to physicians and hospital-owned outpatient facilities, supporting investments in telehealth, and advancing the work of accountable care organizations. The future of Medicare must be driven by value, quality, and outcomes, not the current thicket of opaque, unproductive incentives.

The President's budget will help accomplish these three important goals at HHS. First, making the programs we run really work for the people they are meant to serve, including by making insurance affordable for all. Second, making sure that our programs are on a sound fiscal footing that will allow them to serve future generations too. And, third, making the necessary investments to keep Americans safe from natural disasters and infectious threats. Making our programs work for today's Americans, sustaining them for future generations, and keeping our country safe is a sound vision for HHS, and I am proud to support it.

Thank you, Mr. Chairman.

Chairman Brady. Thank you, Mr. Secretary, for your testimony.

Given the time constraints today, we will shorten question time to 3 minutes. We will now proceed, and I will lead off.

So, Mr. Secretary, you made clear the priorities of President Trump's administration are making healthcare more affordable and higher quality, making sure our programs like Medicare work better and last longer, and addressing key issues like the opioid crisis.

The Affordable Care Act remains in place. Congressional Republicans are committed to a smooth transition away from ObamaCare's failures and toward more patient-centered care. So we are going to continue to look for targeted ways to increase market stability, to allow more choice for families, and provide relief for Americans who have seen their premiums double and their out-of-pocket costs skyrocket under the Affordable Care Act. Likewise, you have the opportunity through regulation and guidance to advance patient-centered healthcare from the executive branch.

So can you briefly tell us what the administration has already done in proposals and the budget to ensure healthcare costs can come down, that we can lower healthcare premiums, and shore up some of the damage caused by the Affordable Care Act?

Secretary Azar. Thank you, Mr. Chairman. So one of the things that we have been doing is looking for flexibility and State partners where we can help them with designing alternative programs here under the Affordable Care Act that can help deliver services to their people. For instance, the Alaska waiver that created a reinsurance pool allowing higher-cost individuals to be pulled off into a funded high-risk pool and saving money for all the other individuals in that pool. We continue to look for State partners that want to be innovative and want to try different solutions.

I think, you know, when we are talking about health insurance, there is no one size fits all. There is no magic bullet, no single right way to orchestrate a competitive, well-run risk pool insurance system. And that is why I look forward to working with States under our proposal, or whatever Congress happens to pass, to work with States to develop systems that work for people and make insurance more affordable. We all share the goal. We want folks to have access to affordable health insurance.

Chairman Brady. Absolutely.

Mr. Secretary, on that second priority, making programs like Medicare work better and last longer, I note that under the Affordable Care Act, Medicare was slashed by over $700 billion dollars, a huge hit to that important program. Tax reform gets more people back to work, and we are now starting to see wages go up. That is one of the key funding mechanisms for Medicare, so we expect that to be helpful.

Let me ask you this. Under the budget proposal, while we hear a lot of draconian claims, is it accurate that Medicare continues to grow under the Trump budget at over an 8 percent annual growth rate and that your proposals actually extend the life of that important program? Can you elaborate?

Secretary Azar. Absolutely, Mr. Chairman. So we are making some commonsense changes in Medicare to how we do our payments with providers and how we are organized. These are things that do not impact the beneficiary. They retain the benefits beneficiaries have, don't change the cost sharing for the beneficiaries. If anything, we help them with cost sharing. Like making these changes, overall net to the Medicare program, we are only reducing spending over 10 years by about $250 billion. That is a 2.3 percent change from the current baseline amount of spending.

To give you a sense of perspective, currently, Medicare will grow on an annual basis over 10 years 9.1 percent each year. With our proposed changes, it will grow 8.5 percent each year. And we gain 8 years of additional life of the Medicare program as a result of these modest but important changes to it.

Chairman Brady. Thank you, Mr. Secretary.

Mr. Neal, you are recognized.

Mr. Neal. Thank you, Mr. Chairman.

Mr. Secretary, the overall budget framework which sinks the Nation into deficits that will near $1 trillion a year or recently estimated $7 trillion over the next 10 years, certainly Republicans have moved away from what they used to say about balanced budgets. In addition, they decide that they are going to make cuts to very important initiatives that many people here in America have come to rely upon. And they are, despite what is being said, making cuts to Medicare.

Overall, the budget proposes more than a half trillion dollars, $532 billion in cuts to Medicare over 10 years, $200 billion alone to our hospitals. These

hospitals are the cornerstones of many of our communities, and cuts of this magnitude will result in hospitals closing and losing jobs. A reminder, for virtually every member of this committee as well as Members of Congress, the hospitals have now become the biggest employers. And as I noted earlier, in Massachusetts, first-class healthcare.

The budget proposes another $80 billion in cuts to post-acute providers that treat Medicare beneficiaries who are the most frail and vulnerable, and another $16 billion in cuts to home healthcare agencies through administrative actions. I don't believe that these cuts are tied to improving efficiency or increasing quality. In fact, I believe these cuts could jeopardize quality healthcare for many Medicare beneficiaries.

All of this is done based upon the idea that we could cut taxes by $1.5 trillion immediately, but when you consider the cost of borrowing that money, $2.3 trillion over 10 years with the Federal Reserve Board promising that they intend to raise interest rates by at least three opportunities and maybe four or five.

The administration is promoting these draconian cuts with another $1.4 trillion cut to Medicaid. A reminder, as I noted in my opening statement, Medicaid now is long-term care in America. It is for our seniors. It is for nursing home care. And these proposals, again, were done on the basis of justifying a tax cut for people at the very top and who are the very strongest.

Mr. Secretary, I ask you to reconsider these cuts going forward. The health of our providers in communities depend on us being prudent and not rash. And I hope you can address the issue of graduate medical education as well as to what is proposed there. As you know, that is a big employer for many of us, particularly concentration in big cities across the country. So if you could speak to those issues and address the issue of cuts to Medicaid and nursing home care, that would be most helpful.

Secretary Azar. Ranking Member, Neal, first, I very much look forward to getting the chance to sit with you and working with you in the years ahead, so thank you very much for that opportunity.

In terms of graduate medical education, what we are proposing there is to unify -- we have various streams of graduate medical education right now for training doctors. They are frozen in place as of 1996. We are proposing to pull that together and give us the flexibility so we can actually train doctors that are

focused on underserved specialties and underserved areas. So that is the thesis that we are working from.

Mr. Neal. Thank you, Mr. Secretary

Chairman Brady. Thank you, Mr. Neal.

So 45 years ago, Colonel Sam Johnson returned to America after 7 years as a POW in Vietnam. Every year, we honor what we call the returnaversary of Sam Johnson.

Sam, before I recognize you, on behalf of our committee and everyone in this room, welcome home yet again. Thank you for your service.

Mr. Johnson. God bless you all. All I can say is it is a hell of a lot better being in the United States than in Korea.

Mr. Secretary, welcome. I am sure you know ObamaCare included an effective ban on the expansion of physician-owned hospitals as well as a ban on the construction of new hospitals. What this means is that ObamaCare prevents some of our best hospitals from expanding to better serve our communities such as those in my fast-growing district, and I believe that is wrong.

Mr. Secretary, would you agree that this ban limits competition in the hospital sector? Yes or no?

Secretary Azar. Yes, Congressman Johnson. I do believe physician-owned hospitals can provide effective competition for other hospitals.

Mr. Johnson. Would you also agree that some of the best quality hospitals are physician owned?

Secretary Azar. Yes. It is my understanding that many physician-owned hospitals deliver superb quality care, and we ought to be inspiring competition among providers.

Mr. Johnson. Finally, will you and the administration commit to working with me on repealing the ban as we know it?

Secretary Azar. So I commit to working with you on any changes that we can make to ensure that we are allowing good competition, allowing physician-owned or other owned facilities to compete and deliver the highest

quality, lowest cost service to our beneficiaries, so I am very happy to work with you.

Mr. Johnson. Thank you. Having said that, all of the hospitals in this Nation are better than what I saw in Vietnam.

Thank you very much.

Chairman Brady. Thank you, Mr. Johnson.

Mr. Levin, you are recognized.

Mr. Levin. Well, a special hello, Sam. A special hello. We all welcome serving with you.

Mr. Secretary, we also appreciate the way you have been reaching out, and we thank you.

You said no one size fits all. That was the line for decades. And the problem was that the alternative was that any size at all will fit. And you now have a request, I think, for a waiver of your reviewing the Idaho health proposal that would allow premium rates to be tied to preexisting conditions, I think, in violation of ACA. Are you reviewing that?

Secretary Azar. So, Congressman Levin, first, thank you very much for our phone call. It meant a great deal to me, and I look forward to working with you.

On the Idaho situation, I am not aware of a waiver request. I have seen the media reports about the interactions between the government of Idaho and one plan, but I am not aware that our opinions or views have been solicited on that question yet.

Mr. Levin. Will you look at it?

Secretary Azar. We will look at that when it comes -- whenever it comes to us. Of course, there are rules, and there is a rule of law that we need to -- that we need to enforce.

Mr. Levin. All right. Let me ask you about -- thank you -- the elimination of programs in the President's budget, which we have discussed. I want to start

with LIHEAP. Have you ever known anybody who benefited from the LIHEAP program?

Secretary Azar. I have not personally, Congressman.

Mr. Levin. What are people going to do? It eliminates $3 billion in assistance. What are those hundreds of thousands of people going to do if that is eliminated?

Secretary Azar. So, Congressman, with the LIHEAP program where we provide grants out to States that they could then provide to individuals, one of the challenges we have there is it is a very large program, $3.4 billion. In a limited fiscal environment, the challenge we have with budgeting is if we were to restore funding for LIHEAP, we have to take from somewhere else, and so it is the tough choices of prioritization. We believe the LIHEAP program is duplicative of many State and local and utility protections for individuals, especially in the cold season --

Mr. Levin. Okay. So let me just interrupt because -- let me, if I might -- I have only 25 seconds. I can say it in 25 seconds.

Essentially, what you are saying is because the Republican approach has so increased the deficit, that you have to reach elsewhere for money. The deficit has been increased trillions of dollars, and now LIHEAP is a victim with hundreds of thousands of people. I urge you reconsider.

Thank you.

Chairman Brady. Thank you.

Mr. Reichert, you are recognized.

I would note too that during President Obama's term, Democrats raised the national debt $2 trillion in 1 year.

Mr. Reichert, you are recognized.

Mr. Reichert. Thank you, Mr. Chairman.

Mr. Secretary, congratulations on your new position. As a grandfather of two amazing grandchildren who were born drug addicted but who are thriving

today, I want to thank you for your commitment to addressing the opioid epidemic.

Mr. Secretary, just not too long ago this morning, I was able to tell you personally that I am on a mission. I am on a mission to help patients suffering from lymphatic system failure. While associated with 40 different diseases, it most is commonly acquired secondary to cancer due to the damage caused to the body's lymph nodes and autoimmune functions. There is no cure. There is no cure, but there is hope. And that comes in the form of compression garments, really, and some other treatments that go along with that.

Compression garments replace all or part of the function of the lymphatic system. And sadly, Medicare does not cover these items, leaving millions of patients without access to the care they need. The Veterans Affairs Department, TRICARE in 42 States and the District of Columbia, cover lymphedema compression supplies. My efforts and 362 other House and Senate cosponsors of the Lymphedema Treatment Act, including the majority of this committee, and Mr. Blumenauer, who leads the bill with me, feel strongly about helping Medicare beneficiaries manage this chronic disease.

I was encouraged by your Senate confirmation hearing because it is clear you get it. I could not agree more with you that, too often, we can be penny wise and pound foolish. We say we won't cover something because it doesn't fit in a category, even though we know it improves patients' health and ultimately saves Medicare money by reducing hospitalizations and other costly medical complications. This certainly fits within one of your stated goals. A Medicare value-based system is what you are seeking to accomplish.

In 2001, CMS put out a statement, and I quote: The keystones of lymphedema treatment are elevation, compression, and exercise. Encourage patients to use compression garments between pump sessions to prevent reaccumulation of fluid.

Despite this statement, in 2001, 17 years ago, there is still no solution.

Mr. Secretary, I am just asking you, please, after 6 years of working on this myself, a commitment from you is needed by the people who are watching today or live streaming this hearing. We need a commitment from you to help them solve this problem, please.

Secretary Azar. So, Congressman Reichert, I will work with you to see if we can solve this and, certainly, if it is a legislative fix, work with you to provide any technical assistance. Absolutely.

Mr. Reichert. Thank you.

Chairman Brady. Thank you.

Mr. Lewis, you are recognized.

Mr. Lewis. Thank you, Mr. Chairman.

Mr. Secretary, thank you for being here today. Less than a year ago, your predecessor, a former member of this committee, sat in that very chair and defended a budget that broke every promise to the sick, the elderly, and working families. Last year, I thought the administration budget was mean and spiteful as it tried to balance the budget on the back of the sick, the elderly, and working families. I hope and pray that members of this administration will search their soul.

Instead, you propose yet another budget that help a select few or put a select few ahead of the good of all of our citizens. Instead, you target those struggling to find food to eat, to keep a roof over their heads and heat in their homes. Instead, you attempt to balance the budget on the backs of those living paycheck to paycheck.

Once again, this budget strikes fear in the hearts of those who rely on Medicaid. Once again, this budget slashed billions from Social Security. Once again, this budget seek to dismantle the social safety net. That is not right, it is not fair, and it is not just. Every person watching at home should understand that this budget is dangerous and unrealistic.

Mr. Secretary, people across the country expect their elected representative to call it as it is: to speak truth to power. History will know those -- history will not -- it knows those who try to pretend that this is normal. History will not be kind to those who are quiet in this moment or in this time.

Mr. Secretary, I think indeed that this budget is an affront to the dignity and the well-being of the average American. In my estimation, it is a shame and it is a disgrace. I think we can do better. I would like to ask, in the fifth district of Georgia, can you find a person to appoint as the head of CDC?

Secretary Azar. We have not yet -- we have not yet identified a candidate to run CDC. But I will tell you, I am just delighted that we have such an amazing career professional in Anne Schuchat, who is so respected globally as -- in the world of infectious disease and epidemiology. We as a country are so fortunate to have career professionals like Dr. Schuchat.

Mr. Lewis. Thank you, Mr. Secretary

Chairman Brady. Thank you, Mr. Lewis.

Mr. Roskam, you are recognized, chairman of the Health Subcommittee.

Mr. Roskam. Thank you, Mr. Chairman.

Mr. Secretary, we spoke briefly yesterday about some of the fraud issues. And I just want to direct your attention to this issue, and I know you have got a background in this. The fraud and erroneous payment rate is unacceptable, so let's take error and set that aside, and let's take the enforcement issue and set that aside as well. Can you focus in on predictive modeling; that is, the algorithms that get created to make sure that the money doesn't go out the door at the front end?

I know that you have got a strong background in this. I think that this is an area where there shouldn't be a division among us on a partisan basis, and I think we have done good work on this in the past, but there is a lot of money that can be saved here. And I would be very grateful for your guidance, your insight, and particularly your initiative.

So set aside error and set aside enforcement just for the purposes of this question, and focus in on predictive modeling.

Secretary Azar. Absolutely, Congressman. So this is an area of, actually, great passion of mine also and as well as background. I believe that we can use the very rich pools of data that CMS has access to and apply to it -- interoperable datasets that we then can apply predictive modeling to to look basically for where are trends just out of whack? Where is something wrong that isn't fitting -- that isn't like the rest? And that can enable us to identify outliers and save so much money. And every penny that we save is another penny that we can devote towards benefits for our seniors or extending the life of our program.

So this is something Administrator Verma and I have already talked about. We hope to keep making investments in this IT infrastructure and working with individuals who have the skill set to do exactly what you are talking about.

Mr. Roskam. I am pleased to hear that.

When I chaired the Oversight Subcommittee along with Mr. Lewis as my ranking member, we brought in CMS to give us their fraud and erroneous payment number. They said it was 12.7 percent. Again, fraud and error. There is a distinction there. Part of the challenge, though, is they couldn't distinguish between fraud and error. But I set that aside.

Then just to create a sense of wonder and awe and just jaw-slacking mystery, we brought in the person who is in charge of Visa and asked them the same question, what is your fraud and erroneous payment rate? And he said, "My recollection is, on $10 trillion that went on that system annually, it was .06 percent."

So this is going to take executive leadership. There is a role for us to play. But you know how big institutions work, and particularly the institution that you are now leading. I just want to encourage you to be tenacious, and I think that you will find willing partners here on a bipartisan basis to join with you from a legislative point of view to get this done.

I yield back.

Chairman Brady. Thank you, Mr. Chairman.

Mr. Doggett, you are recognized.

Mr. Doggett. Thank you.

Thank you, Mr. Secretary. Let me ask you to respond in writing to the following specific questions: As you know, last year, President Trump said that Big Pharma was essentially committing murder. He also said, quote, "We have to create new bidding procedures for the drug industry because they are getting away with murder. We are the largest buyer of drugs in the world and yet we don't bid properly. We are going to start bidding. We are going to save billions of dollars," end quote.

Of course, the administration has not begun any bidding. It has done nothing to bring down the spiraling cost of prescription drugs.

I would ask you the same questions that I asked your predecessor, and your staff can turn to his answers as an excellent example of avoiding a real answer and dodging the question, whether you can confirm that the administration has abandoned President Trump's promise to have Medicare price negotiation and to support the safe drug importation to allow a little competition to bring down prices.

Two questions that I will put in the same words that I sent to Mr. Price that he refused to directly answer.

Secondly, instead of addressing the murder, President Trump in his budget proposes to reward the murderers. I want to ask you about President Trump's plan to hike prescription drug premiums for every part D person on Medicare, and whether or not it isn't true that, while you pretend to lower the cost for some, that Medicare has already estimated that premiums will rise as much as $44 per month for every part D recipient because of the change you plan to make in the way Medicare rebates are done, and that this plan will simply put more money in the pockets of Big Pharma and cost taxpayers and part D recipients more.

Next question concerns opioids. As you know, 41 attorneys generals have conducted an investigation of the role that pharma played in causing the opioid crisis. Hundreds of localities have brought legal action against pharma. You know that Medicare covers nearly 4 in 10 nonelderly adults with an opioid addiction. And in 2013, Medicaid spent $9.4 billion for their care.

My question is, can you report to us on what this administration has done to investigate the role of pharmaceutical manufacturers? And when can we expect the administration to bring legal action against these pharmaceutical companies for their role in creating this problem and stop billing it all to the taxpayer?

Finally for today, sir, would you answer as to whether you will commit to provide the information required by law on nonbid contracts that HHS has entered which HHS has refused to provide in accord with law throughout 2017 and into this year, so that we know on contracts and grants what no bid contracts --

Chairman Brady. Thank you. The gentleman's time has expired.

Mr. Doggett. Can you answer on that?

Chairman Brady. Mr. Secretary, since the time has expired, if you would respond to Mr. Doggett in writing, that would be perfect. Thank you, sir.

So, Mr. Smith, Chairman Smith, you are recognized.

Mr. Smith of Nebraska. Thank you, Mr. Chairman.

Thank you, Mr. Secretary, for being here and sharing your time. Several topics to address here, so I will try to make it quick. My district has 55 critical access hospitals. That is still fewer than one per county in the third district of Nebraska. But the beauty of the system is, even though there is a singular designation, there is no two alike in terms of what they do or how they meet the community needs. And so I hope that we can work together on regulatory relief. I know that your department has been working on that. I appreciate the administration's commitment to that, including making the 96-hour enforcement a low priority for contractors. And like I said, I look forward to working with you on that.

Now, I do want to touch briefly on another issue. Last year when we had this hearing, I submitted a question for the record relating to the Bay State Boondoggle. I did not receive a response. So could we work to get more information on the Bay State Boondoggle in that reimbursement formula that I think is clearly broken and really takes resources away from hospitals and so many States across the country?

Secretary Azar. I am not familiar with the issue, but I will ensure that we get you a response on that. I am sorry you haven't heard back yet.

Mr. Smith of Nebraska. Sure. I appreciate that.

Another issue that I hear a lot about recently is the deeming of competitively bid prices for durable medical equipment in nonmetropolitan areas and particularly whether the deemed reimbursement levels are sustainable for providing appropriate service in rural and remote areas. And can you tell me whether CMS compared these reimbursements to the cost of actual delivery of DME in rural areas when making this decision? And I wonder if you might be able to, maybe not today, but to get information for me later on.

Secretary Azar. So I am very concerned about ensuring that our competitive durable medical equipment program works well, especially in rural areas. In the budget proposal, actually, we have ideas there around how to make that work better for rurals, to ensure that rurals are competed and the pricing in the

rural area is based on rural providers and also the bid that the winner gets is their bid, not just a median price. So I would love to work with you. We want to make this work for rural providers and rural citizens.

Mr. Smith of Nebraska. All right. I appreciate that.

One more topic is the MIECHV Program, the, Maternal Infant, and Early Childhood Home Visiting Program, a very successful program. It has bipartisan support. And part of it is because of the benchmarks that are used that can be chosen and to focus on improvements on family economic self-sufficiency. The previous administration decided to define economic self-sufficiency as being in school or having health insurance and not really looking at the employment and wages. So I was wondering if you might be willing to work with us as we do try to accurately reflect self-sufficiency.

Thank you. I yield back.

Chairman Brady. Thank you.

Mr. Thompson, you are recognized.

Mr. Thompson. Thank you, Mr. Chairman.

Mr. Secretary, congratulations on your new post, and thank you for being here today with us.

I am concerned about the $1.4 trillion cuts to the Medicaid program and just want to point out that those don't just hurt low income families. Those cuts hurt State budgets, they jeopardize other priorities like education and infrastructure, they undermine our health infrastructure, and they are limiting our ability to respond to nationwide epidemics such as the opioid crisis.

This proposal also grows our debt, so we are going to end up getting less service for the people that we represent and work hard across this country. And the reward is going to be we are going to have a much bigger debt. I don't agree with this administration on these cuts, nor the damage that this proposal is going to do to our Medicare program.

But I looked hard to try and find some areas of agreement. And one thing that I did like was the fact that, during your confirmation, you responded, I believed positively, to Senators inquiring regarding your view to telehealth. As a matter of fact, I think you called yourself, quote, a big supporter of telehealth and

alternative means for providing healthcare, and said that you are really looking forward to working with Congress on expanding telemedicine to meet the needs of rural and underserved communities.

This is a big priority of mine. I have worked on this forever and was successful way back in 1990s in California being able to incorporate telehealth into the Medi-Cal program in California. Saved a lot of money and, more important, it saved a lot of lives.

So I would like to know, are there specific areas of promise that you see are areas that you support in telehealth where we can together focus our energies?

Secretary Azar. So, Congressman Thompson, thank you for that. And I would love to work together with you and get your -- you, I am sure, know more about this than I do in terms of concrete areas where we can help and enable telehealth. We have some provisions in the budget that we are proposing around Medicaid Advantage and some other areas that will further enable telehealth. But I would love to sit with you or get any suggestions you have how we can enable further.

Mr. Thompson. Thank you. I appreciate that.

And I just want to say, and you can respond in writing on this, that before you arrived at HHS, the administration finalized a rule to cut more than $1.5 billion from our safety net hospitals participating in the 340B program. The rule, I believe, is seriously misguided, and it hurts our hospitals that are big employers and provide critical services. It is bad for jobs, it is bad for our economy, and it is bad for the people that depend upon those services. And I'd like an opportunity to work with you to see if we can't figure out a better solution.

Thank you.

Chairman Brady. Thank you.

Chairman Jenkins, you are recognized.

Ms. Jenkins. Thank you, Mr. Chairman. And thank you, Mr. Secretary, for being here today.

We recognize as well as appreciate this administration's fight against unnecessary and burdensome regulations in the Medicare space. I represent a large rural district in eastern Kansas where care options can be limited, and

addressing any harmful government regulations are crucial as small rural hospitals work to provide care in underserved populations.

Can you talk about any plans that you may have to reduce the burdens placed on providers over the last few years, particularly to rural providers such as our small group physician practices and rural hospitals?

Secretary Azar. You bet. Thank you very much. And we share the concern about care and underservice in the rural environment.

Last year, actually, CMS launched a program called Patients Over Paperwork initiative, which was a collaborative process that tried to evaluate ways in which we were -- our regulations or our practices were impeding physicians or providers delivering care to individuals unnecessarily. And so as part of that initiative, CMS actually reinstated nonenforcement of the direct supervision requirements for outpatient therapeutic services for our critical access hospitals and small rural hospitals having 100 or fewer beds for calendar years 2018 and 2019.

And I would look forward to working with you on that and other initiatives to help our rural providers be sustainable and deliver service.

Ms. Jenkins. Perfect. I will look forward to that.

As a result of a flawed CMS regulation, hospital-based nursing schools have been put in the impossible position of deciding between losing their school's accreditation or preserving vital funding. I have authored legislation which is a commonsense solution to this regulation and will ensure that our Nation's hospital-based nursing programs can continue providing high-quality nursing professionals to our communities.

Will there be movement on relieving this burden for those hospital-based nursing programs placed on them from the Federal Medicare nursing school passthrough funding program administered by CMS?

Secretary Azar. So as the son of a nurse, I am obviously concerned about this issue. But this is -- it is the first I am hearing about this, and I would look forward to learning more from you about that and also working to see if it is something that we can solve.

Ms. Jenkins. Okay. Great.

The bill is H.R. 662. It is called the MEND Act, and we will be in touch with you. We would love to work with you. Thank you so much.

Thank you, Mr. Chairman. I yield back.

Chairman Brady. Thank you.

Mr. Blumenauer, you are recognized.

Mr. Blumenauer. Thank you, Mr. Chairman.

Mr. Secretary, you had an example of sort of the alternative universe that much of our debate is centered. My friend, the chairman, talked about a trillion or $2 trillion deficit under President Obama who inherited an economy in free fall, and the Recovery Act actually put people to work. It had infrastructure, it had research, and it had tax cuts for the bottom 80 percent. Now we have a situation where the economy is strong, yet we are cutting taxes for people who, in the main, don't need it, that are getting most of that benefit. And we are looking at trillion dollar deficits as far as the eye can see. Such a reversal from my friends on the Republican side. But we don't have to spin up everything in fighting some of these less battles and trying to remind each other of facts or have an ongoing arm wrestling contest about blowing up the Affordable Care Act.

One of the things that I appreciated in your testimony during your confirmation was reference to being sensitive to the needs of American families facing challenges at end of life and what can we do to be able to strengthen the protections to make sure they get the care they want. We made some progress. It was more trouble than I thought with the last administration. We are moving some things forward. My good friend, Dr. Roe, and I have bipartisan legislation that has been broadly supported, H.R. 2797.

And I would hope that there would be a way to be able to work with you to drill down to deal with making sure that we advance models like in our legislation to make sure that patients -- all patients have timely access to palliative and hospice care and to be able to have progress dealing with quality measurement to make sure that we are monitoring what is, in fact, happening and that we have confidence in that.

Secretary Azar. Well, Congressman, thank you for your work in that area. I share your goals there. I want to ensure that individuals who are facing end of life can do so and approach it with dignity and that we are helping

them -- helping them in the setting that they wish to be in and, also, that they can face those -- the issues that they are facing with as much clarity for family members and others about their own desires and plans as possible. So I look forward to working with you in this area.

Mr. Blumenauer. Great. I would appreciate the opportunity to refine that, to be able to make sure that their wishes are honored, that they follow them in an era of electronic medical records. I think there is a lot of bipartisan opportunity to get more out of the system. And look forward to working with you on it. Thank you very much.

Thank you, Mr. Chairman.

Chairman Brady. Thank you, Mr. Blumenauer.

Mr. Paulsen, you are recognized.

Mr. Paulsen. Thank you, Mr. Secretary, also for being here this morning.

As you well know, more Americans now are dying of drug overdoses than Americans who died from AIDS at the height of the HIV epidemic more than 20 years ago, and opioid abuse is the main reason why. And, obviously, as the new Secretary at HHS, you are helping lead the government's efforts to stop the spread of opioid addiction. And it is an enormous challenge. You have my full support. You have our full support.

As you refine and now execute an opioid strategy, I would encourage you to also prioritize nonopioid alternatives for providers to help treat patients who are suffering from chronic and acute pain.

We had a recent Ways and Means Health Subcommittee hearing on the opioid crisis where we discussed innovation and minimally invasive medical devices that are FDA approved, that are reimbursed by CMS, and are proven to reduce addiction and pain, but they are prescribed much less than opioids. And the FDA commissioner also testified that the FDA has approved more than 200 different medical devices to treat pain, but a lot of these patients are being denied access to these therapies either because of restrictive CMS coverage or maybe payment policies.

So as you mentioned earlier, the budget calls for increased funding. It will help States fight this epidemic. But are there payment incentives in that budget request that you know of or that you can think of that Medicare and Medicaid

will be able to use to help promote evidence-based care for beneficiaries with chronic pain that will help reduce the risk of developing an opioid addiction?

Secretary Azar. So I -- we have much in the budget, obviously, about the opioid crisis. The issue of CMS payment incentives around it is an important one. I would love to get any insights you have either on any ways in which you think we could do incentives to drive away from opioid treatment for pain. The other would be I would love to learn more about the barriers on any of the reimbursement on nonopioid treatment that we have got. That is a major area of focus.

We are putting $750 million in this budget over at NIH simply to keep working on the nonopioid pathways for pain treatment. So I would love to make sure we are removing any barriers in our own department to that also.

Mr. Paulsen. That would be great if you would be willing to work with us. And I can stay in touch with your operation about those alternative therapies for chronic pain while there are barriers that exist in Medicare and Medicaid. So I appreciate that, Mr. Secretary.

Secretary Azar. Thank you.

Mr. Paulsen. I yield back, Mr. Chairman.

Chairman Brady. Thank you, Mr. Paulsen.

Mr. Kind, you are recognized.

Mr. Kind. Thank you, Mr. Chairman.

Secretary Azar, thank you for coming today. Hopefully, this is the beginning of a very constructive working relationship between you and this committee. And 3 minutes isn't a lot of time, so let me throw a few issues that are paramount on my mind.

I come from a large rural western Wisconsin district. Rural healthcare is obviously very, very important. And yet my constituents would certainly be concerned with the $2 trillion of proposed cuts that we are seeing right now in the administration's budget affecting Medicaid and Medicare funding. You know, in the last 8 years, we have lost 83 rural hospitals. There are over 700 that are listed on the very vulnerable list right now. They are all operating on a very thin margin. And those type of cuts would -- especially given a

population that is very Medicare dependent, could mean life or death to many of these rural providers.

I am looking at Ms. Sewell here, and there are others on the committee that have equal concerns when it comes to -- so I encourage you to work with the rural healthcare caucus that we have established in the House. Myself and Cathy McMorris Rodgers are co-chairing that. So as we bring issues to you, that you will give it due consideration.

But I also want you to keep an eye on Indian health. Very important programs. I come from Indian country myself too and work very closely with them. That is another important area of jurisdiction. And then for me, when it comes to healthcare reform. Hopefully, with your help and leadership we can get out of this box of ACA and no ACA and start focusing on what is working and what isn't in the healthcare system.

And one thing that I see working in my own backyard are healthcare providers with wonderful models of care. I am talking about the Gundersens, the Mayos, the Marshfields, the Auroras, the ThedaCares that go to an integrated, more coordinated, more patient-centered healthcare model producing great results, embracing that type of model where we need to drive the healthcare system today.

But also embracing something that is in the Affordable Care Act, and that is the move to value, to quality, to establishing the payment system based on results and not just doing more. I think that is so fundamental if we are going to get our hands around the rising cost of healthcare in our country and getting the better models of care that produce better results at a better price. And there is an institution that was created in the Affordable Care Act to help us with alternative payment models: the Center on Innovation. Unfortunately, that has come under attack, some partisan attack, i think unjustly. But they are going forward with pilots in experimentation, finding out what will work, what incentives need to be there to encourage the providers to get the outcomes and quality and away from fee for service, just more payments regardless of the results.

So I hope that you embrace the Center on Innovation and the good work that they are doing there. Certainly, you know, reforms and modifications are in order. But there is, contrary to a lot of the political rhetoric, a lot of important things in the Affordable Care Act that will be crucial to getting us to a better outcome and a better payment system within the health.

And also, being from the drug industry yourself, hopefully, you are going to be able to provide insight on what we can do working together to address the rising cost of prescription drugs, which is one of the main cost drivers in the healthcare system. So we look forward to working with you in the future.

Thank you, Mr. Chairman.

Chairman Brady. Thank you, Mr. Kind.

Mr. Marchant, you are recognized.

Mr. Marchant. Thank you, Mr. Chairman.

Secretary, I represent a managerial type district around the DFW Airport, about 15 communities. Most of the constituents are working in those corporations or businesses around the airport. When I have a townhall meeting, the first question I ask is, how many of you have received a service from the government? How many of you receive a check? And well over half always raise their hand. And at the end of the day, most of those people are on Medicare Advantage. So they are getting very good healthcare, and there are few complaints about the quality of the healthcare.

But the question I always get is will Medicare stay solvent, and the assurance I always give them is that that level of care is going to continue, that the Medicare system will stay solvent, and the Federal Government, through innovation, will, with less money, achieve the same levels of care that they are receiving now. Now I get to ask you to speak to them and assure them of what I am telling them is true.

Secretary Azar. Absolutely. The deep commitment to Medicare and especially the Medicare Advantage program, which 40 percent of our seniors are now enrolled in and the majority of aging-in seniors are choosing Medicare Advantage, we want to make sure that that works for people and delivers high-quality, low-cost care for seniors.

You know, part of my job is to make sure that this program which is such a bedrock of our society remains solvent; and that is by taking waste, fraud, and abuse out of that system, by the transformation to value. How can we pay more for outcomes and value? So instead of paying for sickness, pay for good outcomes.

So all of that is with an eye towards the more money we can save and the higher quality outcomes we deliver, the better we are going to serve your constituents that are talking to you about these programs, and keep it there for them in the future.

Mr. Marchant. Thank you, Mr. Chairman.

Chairman Brady. Thank you, Mr. Marchant.

I should note, as we began the discussion, I failed to mention two important things. One, I want to welcome Representative LaHood, who was just here a moment ago, to his first hearing. Thank you, Mr. LaHood -- who won't sit in his seat. Welcome to the committee. We are glad to have you. You jumped in so quickly to the committee's work, I forgot to welcome you to the Ways and Means Committee. Thank you, Mr. LaHood.

And I also forgot, it is the birthday of our esteemed ranking member, Mr. Neal. Happy birthday, Mr. Neal. Welcome for all that you do. Well done, sir.

Mr. Pascrell, you are recognized.

Mr. Pascrell. Thank you, Mr. Chairman.

Mr. Secretary, you have had a splendid reputation for listening in your job, but this is not business; this is government. Very different. So welcome to the combat zone.

I have a couple questions. You know, we have hurt hungry families in the proposed budget, which cuts that budget, the SNAP program, by $214 billion. There is a relationship between nutrition and health, and I don't have to go into those specific details.

And then the rest of the budget cuts, $1.4 trillion for Medicaid, which is the very basis of any State's helping opioid victims and trying to prevent it and trying to respond to those. It eliminates and cuts spending in Medicare by $494 billion.

So good luck to you. You have to defend this stuff. But from your reputation, you could rise above this. I hope that happens.

I want to talk about the HIV/AIDS program. It is very close to me for 30 years of my life, working with people who at first no one wanted to work with; and secondly, to get the Federal Government to understand its responsibilities.

This administration, I personally believe, has abandoned people living with HIV. It wasn't enough that the President had to shut down the Presidential Advisory Council on HIV/AIDS and close the White House Office of National AIDS Policy, but it is also attempting to gut funding for HIV prevention, cure, and treatment. This budget could close the door in the face of all progress that has been made under Democratic and Republican Presidents to curb this horrible disease, both here in America, abroad, and turn the clock back to the 1980s. We don't want that to happen. I know you don't.

So, Mr. Secretary, please explain the rationale behind the domestic cuts to HIV/AIDS funding and, specifically, the $43 million in cuts to the Ryan White Program. Mr. Secretary.

Secretary Azar. So, Congressman, we strongly support the Ryan White Program, and it is a very large program. And I can't remember the exact numbers on where it has come out, but the Ryan White HIV/AIDS Program has our full support and backing, as do so many of the initiatives around HIV/AIDS.

Mr. Pascrell. How do you explain these cuts which are being proposed?

Secretary Azar. So we have got the support for, and then we have, in PEPFAR, continued support abroad on HIV/AIDS. So I would love to work with you. I want to make sure to understand across the board. As the chairman mentioned, I am still getting into the details of so many of our programs and where they stand currently from 10 years ago.

Mr. Pascrell. My point being, Mr. Secretary, I am interested in what you are for. I am interested in how you will fight these cuts, because you have a bigger responsibility than the President of the United States in dealing with those people afflicted and those people who might be afflicted.

Chairman Brady. Thank you, Mr. Pascrell. Time has expired. And, as usual, we will move now to two-to-one questioning so we can balance out the hearing.

Chairman Black, you are recognized.

Mrs. Black. Thank you, Mr. Chairman.

And welcome, Mr. Secretary. I really appreciate you being here. I am going to go in a little different direction about something that really does affect the State of Tennessee and, in particular, our rural hospitals. But all hospitals across the entire State are affected by the area wage index.

And this is something that I have been working on now for, I guess, at least 6, 7, maybe 8 years. I have been trying to try to get some parity because our hospitals are not being treated fairly. As a matter of fact, the formula was intended to reflect a 1.0 average rate. There is not a single hospital in all of Tennessee that gets that rate. So our hospitals are down below .7 in many cases, and especially rural hospitals. This is very damaging to them. They may not be able to stay open unless we do something.

Do you see a path forward with taking a look at this and trying to get some parity?

Secretary Azar. So, Congressman Black, thank you for raising that issue. I suspect that if we polled all the members of the committee, that nobody would be satisfied with the wage index. There are often so many undesirable outcomes for our providers in that. And being budget-neutral, unfortunately, every time there is a change, winners and losers there.

We obviously want to work with you and the Congress if there are any legislative changes around the wage index or administrative that we can do that make things more equitable. And I certainly understand the concerns that you have there and understand that they have real impact on our providers.

Mrs. Black. I would point you to what MedPAC has done over the last several years in their recommendations. They have looked at this issue. They acknowledge that it needs to be addressed. And I think that now that you are the new Secretary, I would really like for you to take a look at this and have your staff spend a little time on this issue and get back to me on what their thoughts are.

Secretary Azar. Will do.

Mrs. Black. Finally -- I only have 1 minute -- I want to applaud you and the administration on looking at mental illness. It is a huge issue. As I travel throughout my State and I talk to law enforcement, anywhere between 20 and

40 percent of the inmates have mental illness. And they are in the jail because there aren't other services for them. And we really must address this.

So I applaud you for the amount of money that is being put into this and also the creative way of thinking about treating people with mental illness. We closed hospitals down in the 1970s when I was a young nurse and we said it was better to put them in the community, but we didn't have community services. We now see them laying on benches without something to eat, out in freezing cold weather. And we have got to do something about making sure we take care of our mentally ill. So thank you for that.

And I yield back the balance of my time.

Chairman Brady. Thank you, Chairman.

Mr. Reed, welcome to the top dais. You are recognized.

Mr. Reed. Thank you, Mr. Chairman. The altitude up here is much higher. I am a little woozy. So if the questioning doesn't make sense, please bear with me, Mr. Secretary.

Mr. Secretary, I wanted to echo something first, before my prepared remarks, from my colleague Mr. Blumenauer in regards to hospice and palliative care. It is something I am very passionate about. Actually, in my personal time, I am a hospice volunteer here in D.C.

So I would encourage you to consider one of the things that I have been working with Charlie Dent from Pennsylvania on our side of the aisle in regards to advanced directive counseling as you enroll in Medicare and as you enroll in Medicaid. Not only do I think that is good sound policy, but I also think that if you look at the bean counters here in D.C., they will give you a positive score effect in regards to the savings that it has in the healthcare arena.

I wanted to also welcome you and to share that I co-chair the Diabetes Caucus here in Washington, D.C. I am a father of a type 1 diabetic diagnosed at 4, and now 17, and so this is something near and dear to me. And I have worked with Diana DeGette on the other side of the aisle over the years. She is co-chair of the Diabetes Caucus. And insulin pricing has been something we have been working on.

In your former role, I will note that the Humalog KwikPen rose from $55 to $105 during your tenure in that private organization. And I would hope you

could explain maybe a little bit as to why those prices went up and maybe specifically what your intentions are as the Secretary of Health to help us try to get those insulin prices under control and going in the right direction. I think we can share needs that prices need to go down, not up.

Secretary Azar. So, Congressman, I need to speak -- because of my recusals that are required as part of government ethics, I would need to speak broadly about what we intend to do around drug pricing. Of course, none of our efforts are targeted at any one sector or part of a therapeutic area.

Mr. Reed. I respect that.

Secretary Azar. The President's budget, I think, has some very important reforms in it that can help us, especially in the Medicare/Medicaid context, because it is in the budget setting right now. But one thing in addition to the proposals we have in the budget right now, we have been radically increasing the number of generic drug approvals. The highest number of generics ever approved in history were done under Dr. Gottlieb's leadership just last year. We have also been -- we have changed, for senior citizens, reimbursement rules that have led to a $3.2 billion reduction over 10 years in what senior citizens will pay out of pocket for their medicine. So those have already happened.

I want to develop a very robust biosimilar market, which is the generic-like versions of these higher cost or injectable products. We want to build the scientific evidence base where eventually those might be interchangeable. We want to ensure that there is a viable commercial marketplace by supporting, through our programs, incentives to the utilization of those biosimilars, because that can, longterm, help pull the cost down and pull the out of pocket for our citizens down.

Mr. Reed. I truly appreciate it. I look forward to working with you. And welcome, Mr. Secretary.

Chairman Brady. Thank you.

Dr. Davis, you are recognized.

Mr. Davis. Thank you very much, Mr. Chairman.

Mr. Secretary, I was pleased to see that the budget included my proposal to triple funding for regional partnership grants, but I am troubled that your war

on healthcare will make it impossible for these community partnerships to be effective, to help motivated parents get treatment and keep their children safe at home.

Medicaid is the program that provides the vast majority of opioid abuse treatment, yet the Trump budget slashes $1.4 trillion from Medicaid and asks us to applaud a couple billion as a heroic effort. These Medicaid cuts would devastate millions of Illinoisans.

Further, Illinois receives over $62 million from Social Services Block Grant, which provides critical support for over 139,000 Illinoisans. The Trump budget eradicates these funds that local communities are using to fight the opioid crisis, funds for childhood and adult protective services, substance abuse prevention and treatment, senior services, disability services, community health, and domestic violence prevention, yet it gives $29.2 billion to the wealthiest fewest States.

Mr. Secretary, I am deeply concerned about your department's proposal to delay 2 years the modernization of the child welfare data system. As you likely know, the final AFCARS rule is the first update in 25 years. The final rule reflects the improvements agreed upon by the child welfare community as needed to improve policies and outcomes for foster youth. Importantly, the improvements supply multiple statutorily mandated upgrades, statutorily mandated improvements to prevent sex trafficking, to improve how Native American children in care are served, and to understand the physical and mental health needs of children in care.

But HHS is blocking the implementation of this critical rule with vague justification of whether the proposed collection of information is necessary or burdensome. I wrote a letter to you this week, with Senator Wyden, expressing our deep concerns that your delays undermine our understanding of the needs of foster youth.

My question: Can I get your commitment to seriously look at rescinding the 2-year delay of the AFCARS rule and implement the laws that have been passed?

Secretary Azar. Congressman, I am glad you raise that to my attention. I was not aware of that issue, and so I will be very glad to look into that and get back to you on that.

Mr. Davis. Thank you very much.

And, Mr. Chairman, could I get permission to insert into the record a report by the SSBG Coalition related to how it protects families and communities affected by the opiate crisis?

Chairman Brady. Without objection, Dr. Davis.

SOCIAL SERVICES BLOCK GRANT (SSBG):

HOW THE BLOCK GRANT PROTECTS FAMILIES AND COMMUNITIES IMPACTED BY THE OPIOID EPIDEMIC

FEBRUARY 2018 | SOCIAL SERVICES BLOCK GRANT COALITION

ACROSS THE COUNTRY SSBG IS HELPING STATES RESPOND TO THE OPIOID CRISIS BY PROTECTING BABIES, CHILDREN, YOUTH AND FAMILIES FROM HARM AND HELPING THEM GET THE HELP THEY NEED TO HEAL AND THRIVE. SSBG PROVIDES FLEXIBLE FUNDS TO HELP STATES MEET THE UNIQUE AND RAPIDLY INCREASING NEEDS OF COMMUNITIES RESULTING FROM THE CRISIS.

SSBG & THE OPIOID EPIDEMIC

PROTECTING CHILDREN FROM ABUSE AND NEGLECT

In 2015, child protective services removed 100,000 babies, children and youth from their parents' care because of the parents' drug or alcohol use. **In 2014, 39 states relied on $329 million from SSBG for to protect and safeguard children who face abuse, neglect and exploitation.**

In Licking County, Ohio, 71 percent of abused or neglected children entering into custody was due to parent drug use – largely related to the opioid epidemic. The intensity of the opioid epidemic, and the need to quickly intervene and assess families to keep children safe requires flexible and maintainable resources such as SSBG.

Faced with the day-to-day reality of the opioid crisis, John Fisher who serves as the Director for Licking County, Job and Family Services, understands the dire need to protect SSBG. "SSBG funds provide the resources to investigate the allegations we receive of child abuse or neglect...and the elimination of these federal funds would create a void which no other funding source is currently available to fill. **Given Ohio's low level of state funding for services to abused or neglected children, SSBG funding is critical in helping keep our children safe during this drug crisis."**

IN 2015, IN LICKING COUNTY, OHIO, 71 PERCENT OF ABUSED OR NEGLECTED CHILDREN ENTERING INTO CUSTODY WAS DUE TO PARENT DRUG USE – LARGELY RELATED TO THE OPIOID EPIDEMIC.

HELPING PEOPLE GET TREATMENT FOR ADDICTION

In 2016, more than **63,000 lives were lost due to drug overdoses, making it the most lethal year yet of the drug overdose epidemic.** Of that number, 66 percent of those overdoses – 42,249 individuals – was due to opioids. With the Administration declaring the opioid epidemic a public health emergency, programs that providing funding for individuals to receive substance abuse services must be protected.

Among these critical programs is SSBG, which provides funding to states to use for almost 30 different types of services, including substance abuse treatment. In fact, in 2014, 11 states relied on SSBG to help people get the treatment addiction to opioids and other drugs. The need for SSBG and the funding it provides is even more important as we see need for drug related services increase. **In fact, SSBG expenditures for substance abuse services increased by 125 percent from $6 million in 2010 up to $13 million in 2014, which helped over 118,000 individuals receive substance abuse treatment or participate prevention programs across the country.**

In Alaska, SSBG plays a crucial role in delivering substance abuse services. For example, Alaska Child Protection workers refer women and their children to primary substance abuse treatment centers, which provide clients with priority access to services or activities that are designed to deter and treat substance abuse. These services are provided by the Alaska Women's Resource Center, which is funded with SSBG dollars, and include counseling, treatment or detoxification services.

SSBG not only offers essential funds for states to provide substance abuse and other family support services to residents, it also helps fill in critical financial gaps for overburdened state foster care systems. With addiction services and foster care systems so underfunded, states, counties and the residents who rely on these services cannot afford to lose SSBG.

SSBG & THE OPIOID EPIDEMIC

SUPPORTING AT-RISK YOUTH

From the earliest days of pregnancy, children whose parents suffer from a substance abuse disorder are at high risk. In addition to prenatal exposure, parents distracted by drugs and without help may be unable to provide children with a stable environment to grow and thrive. No matter what their level of exposure, opioid addiction has a devastating impact**. For parents who are unable to support their children, SSBG provides independent living and special services to help youth at risk get the help they need to thrive as healthy adults.**

As of 2014, the last year for which we have data, seventeen states reported SSBG expenditures for special services for youth at risk, totaling $66 million. **In fact, SSBG expenditures for youth at-risk services in 2014 mark a 62 percent increase from the $42 million invested in 2010 – helping over 75,000 at-risk youth and their families.** SSBG is particularly important to Missouri, which uses a combination of local and SSBG funds to support six strategies and services for at-risk youth. These strategies and services are for youth to age 18, and sometimes up to age 21, that provide an array of services that aim to reduce inappropriate institutionalization by providing alternative arrangements for care.

These six strategies are critical for at-risk youth when it comes to parent battling a substance abuse disorder. For example, Missouri's program, Short-Term Residential provides a short-term intensive residential treatment program for youth that emphasizes group physical and emotional treatment. These services, which can be conducted individually, or with family members, enhance family functioning – a critical component to a healthy and sustainable lifestyle.

CARING FOR OLDER ADULTS

FOR ADULT PROTECTIVE SERVICES, SSBG IS THE ONLY SOURCE OF FEDERAL FUNDING TO PROGRAMS, AND IS A CRUCIAL PART OF MANY STATES' BUDGET.

When communities are battling the impact of a drug crisis, everyone is impacted. Older adults with limited mobility, may be fearful of leaving their home. Family members may be less able to provide the care they need. Vulnerable adults may be at greater risk of abuse and financial exploitation. From Meals on Wheels to transportation to Adult Protective Services, in **2014 SSBG helped provide crucial services to almost 2 million adults over age 60 in 41 states including DC and Puerto Rico and many more with unreported ages.**

For Adult Protective Services, SSBG is the only source of federal funding to programs and is a crucial part of many states' budgets. At-risk adults in states like North Carolina may face a higher risk of abuse by caregivers stealing opioid prescriptions or financial exploitation to support addictions.

"An already dangerously under-resourced system of protection for vulnerable adults, North Carolina's Adult Protective Services (APS) program is being stretched even more as a result of the opioid crisis. Whether an older adult's drug misuse results in self-neglect, drug misuse by a caregiver results in caregiver neglect or abuse, or financial exploitation is perpetrated by a family member, **North Carolina county departments of social services rely on a combination of county dollars and federal SSBG to fund this statutorily mandated service.**" -Nancy Warren, Retired North Carolina APS Program Administrator

Mr. Davis. Thank you.

Chairman Brady. Mr. Meehan, you are recognized.

Mr. Meehan. Thank you, Mr. Chairman.

And, Mr. Secretary, thank you for your service, and you bring a great deal of experience to this. I look forward to working with you. And I am pleased that you have identified a number of priorities, first and foremost among them the concept of value-based payment as we transition away from a fee-for-service model. And it is clear to me that you are looking at a variety of things.

As a former United States attorney, I spent a lot of time working in the area of Stark and Anti-Kickback. And it had its purpose, there was no question about that. But we see opportunities for great new collaboration to take place if we can find the right safe harbors and other kinds of places in which we can incentivize this kind of activity to take place. Now, I know you have got a working group within your own agency, but I think you have, as my colleague from Illinois said, a lot of members here, on a bipartisan basis, that are anxious to work with you.

I would like to ask if you could lay out for us in communications with us the plans for this group and how we can work almost simultaneously with you on legislation that can improve it. There is an interest in doing this, and I would be happy to collaborate with whomever that you would identify.

Second, I am grateful for the work you are doing on opioids. Part of the legislation we passed before talked about one thing called the Lock-In Program, in which we are trying to do a better job with respect to the opioid prescribing and assuring that we monitor this program better. It was a voluntary program. I think there is an effort now to try to make this mandatory. I would like to work with you on that as well, particularly with respect to incentivizing States to talk to each other.

And lastly, I am very appreciative as well of your recognition of a safe and secure effort to protect information for those who utilize the system with health records and other kinds of things. Internet of Things, cyber, we are seeing huge interconnectivity and huge challenges as well. I know that your Cybersecurity Task Force is going to be looking at ways to do a better job of, not only reaching across the broad governmental spectrum, but recognizing unique things, like privacy and other items that are challenges.

I once again want to articulate that we have got numbers of people here who are anxious to work with you on those issues and not to have us working in silos, so that the efforts that we can do can dovetail off the improvements that you can make. So I want to thank you for that, and look forward to working with you in the area of emergency preparedness as well.

Just the last thing on Stark, I think that we are looking at physicians too, but I think that there are things from medical devices to drugs, as you well know, and others that could be included in that dialogue here. I hope you will consider that.

Thank you, Mr. Chairman.

Chairman Brady. Thank you.

Mr. Renacci, I know you had to step out for a budget hearing, but you were here when the hearing began. You are recognized.

Mr. Renacci. Thank you, Mr. Chairman.

I want to thank you, Secretary Azar, for being here to speak with us about the fiscal year budget. Few issues are as important and personal as healthcare to me. I am pleased to see the Department budget reflects a significant focus on tackling the opioid epidemic. This epidemic has ravaged my State. The Ohio Department of Health reported that in 2016, 3,600 Ohioans died of the opioid overdose. It is encouraging to see that the administration is looking to partner with State and local governments in an effort to put an end with this crisis.

Sometimes, much of the conversation about combating opioid epidemic seems to center on increasing access to treatment and recovery services. A lot of the time, it is just about money. What I hear less about is addressing some of the root issues, like why are doctors prescribing high volumes of opioids in the first place and prescribing opioids versus pursuing other pain management practices.

I can tell you personally, when I was 18 years old, I was in a motorcycle accident. I hit a car at 55 miles an hour, went over the car, and ended up 100 yards down the road. I still went to school the next day with a bottle of aspirin. We did not have opioids back then and weren't prescribing opioids.

So some of the problems are our policies, and I would like to hear in the proposed budget if we address some of those issues.

Secretary Azar. You bet. Thank you very much. And just to let you know, I actually just the other day spoke with Governor Kasich to get some of his insights about steps being taken in Ohio around the opioid crisis. We are going to be working with him to get some of the best practices and be sure that we can share that across the States, since you have been so much at the epicenter of it all.

In terms of our budget, one of the things we are proposing is to grant authority to suspend coverage and payment for drugs when those prescriptions present an imminent risk to patients or whenever they are prescribed by physicians who have been engaged in misprescribing or overprescribing drugs with abuse potential, so exactly what you were talking about.

In addition, our proposal provides the Secretary with authority to require additional clinical information on certain part D drug prescriptions, such as diagnosis and incident codes, as a condition of coverage so that we can better get at this problem.

Mr. Renacci. I was intrigued to see that part of your budget proposal included $500 million for public-private partnerships to accelerate the development of strategies to prevent opioid abuse. Has HHS considered other programs and areas where the potential exists to leverage non-Federal resources to make our dollars go further?

Secretary Azar. The main one has been the NIH program. I am not aware of others, but obviously, any time we can leverage external dollars to assist us and stretch the Federal dollars, especially in a crisis like this. So if you have ideas, I would be very glad to hear them.

Mr. Renacci. I appreciate that.

I thank you, Mr. Chairman. I yield back.

Chairman Brady. Thank you.

Ms. Sewell, you are recognized.

Ms. Sewell. Thank you, Mr. Chairman. Due to the fact that we only have 3 minutes, I would like to submit for the record questions that I have and hope that, Mr. Secretary, your office will give us some responses to those.

Chairman Brady. Without objection.

Ms. Sewell. First of all, welcome, Secretary Azar. As you are aware, rural hospitals and providers across the country are struggling to maintain basic services and to keep their doors open. There are several rural hospitals in my district that struggle each month to pay staff. This is because my State, Alabama, has the lowest area wage index in the country and the most bare bones Medicaid program, which reimburses some hospitals at 10 percent of cost.

I would like to join Representative Black in requesting that you look at the wage index. We both cosponsor a wage index bill that all we are asking for is parity and some sort of equality. I think that the current model is really unsustainable, and I believe that our Federal policies should be helping the delivery of Medicare and Medicaid to the most vulnerable in our society.

If I sound frustrated, it is because I am. We have consistently asked rural hospitals to do less with more -- to do more with less, sorry. And as a result, 83 rural hospitals have closed since 2010 across the country.

Mr. Secretary, my home State of Alabama has one of the bare bones Medicaid programs out there, and we didn't expand Medicaid. So there is a direct correlation, I believe, between hospital closures and States that did not expand Medicaid. Do you know what percentage of rural hospital closures since 2010 have happened in States that didn't expand Medicaid? I will tell you: 76 percent. And five of those rural hospitals have been in my home State of Alabama.

The President's budget ignores these facts by repealing the Medicaid expansion for States that have benefited. The proposed budget also cuts $1.4 trillion from the Medicaid program.

Mr. Azar, Secretary Azar, if you are a parent in the State of Alabama, a family of three in Alabama, who makes $10,000 a year, you do not qualify for Medicaid. Can you get any assistance for your own health insurance? And the answer to that is no, because they fall in that Medicaid gap. To qualify for Medicaid in Alabama as a parent of a family of three, how much would you have to make a year to qualify for Medicaid? It is less than $4,000. So if you make anywhere between $4,000 and $10,000 or $21,000 in Alabama, you get no assistance for your healthcare coverage in my State of Alabama.

I think this is unacceptable, and I really believe that our Federal policies should help try to make sure that we level the playing field so that those that need Medicaid and Medicare can actually get access to it. So I --

Chairman Brady. The gentlelady's time has expired.

Ms. Sewell. Thank you, sir.

Chairman Brady. Mr. Secretary, if you would please respond to the questions in writing by Ms. Sewell. Thank you, sir.

Mr. Rice, you are recognized.

Mr. Rice. Thank you.

Mr. Secretary, thank you for being here today. I join with Ms. Sewell and Mr. Kind and our concern about the rural hospitals that have accelerated their closure since the advent of the Affordable Care Act, and hope that we can find ways to mediate the effects of the Affordable Care Act on our rural hospitals, because I have had two close in my district.

But the thing that I hear when I go around my district the most when people are talking to me about healthcare today -- in fact, I did a telephone townhall last night and I had somebody ask me this direct question. They said, thank you very much for the tax cuts, it has made a difference in my budget, but the truth is that with the health insurance premium increases that we continually see under the Affordable Care Act, which should more aptly be named the Unaffordable Care Act, all of my tax refund has gone to these health insurance premiums.

Last year, I know HHS put out a report that said the average premium under ObamaCare from 2014 when it came in place until 2017, was 105 percent. This year, I haven't seen the numbers yet, but I know it is going to be astronomical. And the truth is that the average person simply cannot afford healthcare under the Unaffordable Care Act.

You mentioned earlier a focus on trying to work to get health insurance premiums down. So what I would like to know is your specific ideas on how HHS can help with that. And second, do you have any specific legislative proposals that you might have for us to work on? Given that we are stuck with the Affordable Care Act, what can we do within those confines to try to bring those premiums down or at least slow the acceleration of the premiums and the deductibles?

Secretary Azar. Thank you, Congressman. As you know, the President's budget does propose a version of the Graham-Cassidy legislation that was in

the Senate as a mechanism of creating a grant program to States that would be very flexible. It would still have some core protections around preexisting conditions, under age 26 for coverage of children, maternal care and newborn care, so some baseline core national protections, but then flexibility for States who would then be able to design their own systems that fit their needs and figure out ways to deal with risk pooling. How could you maybe peel off, as Alaska has done, your higher risk individuals, fund that and make sure that they are getting care, but then make insurance vastly more affordable for the rest of folks?

I am quite concerned. It is a deep and lifelong passion of mine around affordable insurance coverage for individuals. And what troubles me so much is that we have 28 million individuals who are out of that market, who are not able to afford access to individual insurance. And so we take that challenge very seriously of what can we do to make the system work better for them.

Mr. Rice. If you have any specific suggestions for legislation, I would love to see them.

Secretary Azar. Thank you.

Mr. Rice. Thank you, sir.

Chairman Brady. Thank you.

Mr. Schweikert, you are recognized.

Mr. Schweikert. Thank you, Mr. Chairman.

Mr. Secretary, you have been on the job for 13 days, so by now you should know everything. I know this is a bit like a machine gun, but when you have 3 minutes, you sort of have to do it that way.

Your current budget is an 8.5 percent increase in spending each year for the next 10 years?

Secretary Azar. The Medicare budget would be 8.5 percent per year for Medicare.

Mr. Schweikert. Okay. So that is for Medicare. So functionally, if you do the compounding on that, over 10 years, it is like doubling.

Secretary Azar. It is a lot of money, yes.

Mr. Schweikert. Doubling. So at some point, we are all gong to have to, on the right and left, have a very honest conversation about doubling that budget over the next decade is a stunning amount of money and terrifying.

I know you put Graham-Cassidy mechanisms in your budget. Some parts of it we like, and some parts I am mathematically concerned with. I don't think you actually get to multiply your efficiency. The State experiments are wonderful, but we are dealing with a mathematical reality, particularly in the individual market, that 5 percent of the population is 50 percent of the cost. In terms of risk sharing, as I think I have actually spoken about, when you mitigate risk here, I lower the premium here. I lower the subsidy. If I lower the subsidy, I can put that up here and buy down more risk. Well, then if I lowered the premium; I lowered the subsidy.

There is this virtual circle created. Because we subsidize both at this level and that level, you could actually bring them into parity and create this virtual circle, if you can lower the premiums by finding a way to do that risk mitigation. And I hope you are going to model that feedback loop, because I think there is a much more direct and much more elegant way for rate efficiency than the convoluted mechanisms that we as politicians have a bad habit of thinking about.

My single biggest passion for you, as you have probably already found out, is that you are where a lot of the money is. And you have group after group after group that is at your doorstep not wanting you to affect their business model.

The Economist Magazine 2 weeks ago wrote a powerful article that technology is about to become my primary care physician, the technology of wearables, the ability to manage my healthcare. You are the single individual who has the power to create the revolution of bringing technology into crashing prices, with everything from pharmaceuticals to healthcares to emergency room visits.

I beg of you, please push innovation technology as hard and aggressively as you can. And you are going to have a lot of folks at your doorstep who are terrified because you are blowing up their business model, but how many times did you go to Blockbuster Video this weekend? Things change.

With that, Mr. Chairman, I yield back.

Chairman Brady. The gentleman yields back.

Ms. Sanchez, you are recognized.

Ms. Sanchez. Thank you, Mr. Chairman.

Mr. Secretary, thank you for being here, but I have to say that, frankly, this budget is a disgrace to the working people of this country. I would be hard-pressed to come up with a budget that is more out of touch with the needs and concerns of everyday people than this budget. The people that I represent and the families that I hear from every day would suffer greatly under the massive cuts in this proposal.

You know, I think about single parents. I think about woman who have to work to support their families, while caring for children and perhaps aging family members at the same time. And this budget really hits them where it hurts. It makes it harder for parents to work and to feed their children by slashing funding for necessities, not luxuries but necessities, like housing, family planning, and food. It puts their health and their lives at risk by jeopardizing and undermining their access to affordable quality health insurance. And it will not reverse the steep decline in families receiving help with childcare. And to those who care for a loved one with disabilities or a parent who needs nursing home care and is covered by Medicaid, this administration basically says, good luck, you are on your own.

And if the very, very worst happens, you get sick and you can't work or your child or parent does and you need to take time off to care for them, this administration wouldn't let you have paid leave for that. So good luck paying your bills, caring for your family, and dealing with serious illnesses like cancer or Alzheimer's. That is completely on the shoulders of those families.

It is absurd and it is cruel. Families back home don't want us to make their lives harder. It is hard enough as it is for them to get by. And putting healthcare and nutrition assistance further out of reach only makes things worse and will make it that much harder for people to work.

We were not sent here to make things more difficult for those hardworking families. Our purpose here is to try to improve the quality of people's lives and give them a fair shot and a fighting chance. And, quite frankly, this budget fails the most basic test.

And I am sorry to unload that on you. I know you are new to the job. But, honestly, I am shocked and I am, quite frankly, appalled that this is, quote/unquote, the best we can do, because we can do better. We are a

powerful country. We are a generous country, generosity of spirit of the American people. But we are not seeing this budget champion the middle class that this President promised he would be a champion for. And I sit here and I scratch my head, because I wait and wait and wait for the followthrough on those promises, and that never comes.

And, with that, I yield back.

Chairman Brady. The gentlelady yields back.

Mrs. Walorski, you are recognized.

Mrs. Walorski. Thank you, Mr. Chairman.

And, Mr. Secretary, my fellow Hoosier, it is good to see you. Welcome.

I wanted to add my yes and amen to Representative Paulsen's comments about opioids, nonopioids, alternatives, and getting insurance companies to be able to cover these things. I have already heard you out. For the sake of time, I wanted to mention one other thing that I look forward to discussing with you: the budget process.

The budget proposes reforming Medicare payments related to bad debts. I have a piece of legislation, H.R. 3920, that would require CMS to implement a 3-year demonstration program to study the use of interest-free payments under Medicare part A. I have a hospital in my district that has implemented this concept of interest-free payments and has seen improved patient satisfaction, improved health outcomes, and a reduction in bad debts.

Is that something you are willing to work with? Are you interested in trying to come up with that kind of a model?

Secretary Azar. Sure. I would be happy to learn more about that. I had not been familiar with that model.

Mrs. Walorski. My other question is this: A group of doctors in my district have expressed to me the need to fund the National All Schedules Prescription Electronic Reporting. It is called the NASPER program. They feel this program provides them with a complete past medical history regarding prescriptions on controlled substances. While State PDMPs are important, they have trouble with a group of patients that either live across a border in Michigan or they are around the entire U.S. for various reasons. Having

up-to-date patient information would empower providers to deny inappropriate treatments or recommend addiction treatments to be started, based on what they discover.

Does funding NASPER help provide funding resources or interoperability between these PDMPs so providers better identify patients at risk for addiction, especially those patients who do not live within a State's border? Do you have any other suggestions on how you think we can empower providers to identify at-risk patients?

Secretary Azar. So the budget actually does propose requiring the State Prescription Drug Monitoring Programs, and I believe there may be something -- I want to get back to you on this -- around the interoperability across State lines, because that is a vital issue. I just cannot remember, but I think there is something in our budget about that.

Mrs. Walorski. Thank you so much.

Mr. Chairman, I yield back.

Chairman Brady. The gentlelady yields back.

Mr. Curbelo, you are recognized.

Mr. Curbelo. Thank you, Mr. Chairman.

And thank you very much, Mr. Secretary, for your testimony and for all your time with us this morning.

The opioid crisis, which we have already heard discussed so much this morning on both sides of the aisle because I think everyone is deeply concerned about it, certainly has hit south Florida. And the budget requests authority to work with the Drug Enforcement Administration to revoke a provider's certificate, which allows a provider to prescribe controlled substances.

How does the process work now, and how would this authority help your office combat the opioid epidemic?

Secretary Azar. So if we were given this authority, this would enable us, whenever we ban a provider within the Medicare system, to immediately transfer that information over to the DEA so that they could also ban them from the controlled substances prescribing system, where now there are barriers

basically to even communication sometimes on that. This would make it automatic that it could go over, and DEA and we could be in sync around banning providers, so that when we identify a pill writer, a pill mill, it goes right over and their license is cut off on that side also.

Mr. Curbelo. So you think this would be an important tool --

Secretary Azar. We do.

Mr. Curbelo. -- that could help you make a difference when it comes to this crisis?

Secretary Azar. We do.

Mr. Curbelo. I want to take you over to the other side of the House, the human services side. And I have been fortunate to work on this committee with Congressman Davis on legislation called Accelerating Individuals into the Workforce Act. And essentially, what we are trying to do is encourage people to move from many of the government assistance programs we have into the workforce, become empowered, become independent, and really achieve their own success, whatever that happens to be.

What is your vision for your collaboration with the Department of Labor, for example, on these programs with how you can help us in our goals that I think bipartisan in nature for the most part, to help individuals move into the workforce and become better citizens?

Secretary Azar. I am glad you asked that question. So one of the proposals we have in our budget is called Welfare to Work, which within our own programs within the administration for children and families, it would enable us to create a holistic set of programs around the individual. You know, we have attacked different problems that individuals in need would have. This would let us build aid for them and a transition to work around the individual.

And my vision would be, once we can prove that that works well, I want to work with Labor and HUD and all the other participants in human services to see if we can help build this type of holistic approach to individuals rather than our old siloed ways of getting at these challenges.

And then we are also working in the budget to shore up our Temporary Assistance for Needy Families programs to genuinely have accountability for the States to get people trained and out there working.

Mr. Curbelo. Well, I appreciate that. And my goal is not to cut any of these programs; it is to reform them so that they are more effective and they actually help people more.

Thank you. Mr. Chairman, I yield back.

Chairman Brady. Thank you. The gentleman yields back.

Ms. Chu, you are recognized.

Ms. Chu. Secretary Azar, given my limited time, I would like to ask you a yes-or-no question. Do you believe that the policy staff at the Department of Health and Human Services should be responsible for writing all Department policy?

Secretary Azar. We don't have a single policy staff. We have got policy experts throughout the 300 programs of the Department.

Ms. Chu. But they are policy staff within the Department?

Secretary Azar. We have individuals. I don't know that they are generally even called policy staff. I am just not -- I don't mean to be difficult. It is just not a categorization that I am familiar with within the Department. We have staff, career and political professionals.

Ms. Chu. Well, thank you. I ask because the ranking member of the House Oversight and Government Reform Committee, Elijah Cummings, announced on Monday that an HHS whistleblower has delivered evidence that the original author of a CMS letter to State Medicaid directors was not someone within the agency but a representative from the Alliance Defending Freedom, an extremist religious group that the Southern Poverty Law Center has designated as a hate group.

According to the whistleblower's documents, on January 11, HHS received a draft letter from ADF, the hate group. That same day, the Department's -- the deputy's HHS Secretary's chief of staff sent an email to CMS, and I will quote her email here. It said, quote: "CMS should be receiving the SMD, or State Medicaid Director, letter today. Please make sure that your clearance process is ready to go on this. We will need a very quick turnaround. Consider an utmost priority," unquote.

Given the timing of the emails and when HHS received this draft letter from the hate group, it appears to Ranking Member Cummings and to myself that the HHS was, quote, taking orders from outside groups in order to write policy.

I am extremely concerned about the idea of a hate group drafting official U.S. Government policy. Furthermore, the policy in question encourages States to defund Planned Parenthood, which provides healthcare to millions of American families.

This is yet another example of this administration siding with religious extremists over the health of women and families in this country. President Trump's budget is no exception. After repeated attempts to defund Planned Parenthood failed in Congress last year, the Trump administration has taken it upon itself to attempt to do so administratively.

I would like to remind you, Secretary, and this committee that the Planned Parenthood health centers provide essential healthcare services, like cancer screenings, STD testing, prenatal consultation, and contraception. At every turn, this budget is a bad deal for women. And, Secretary Azar, I strongly encourage you to reconsider your agency's association with hate groups as you move forward and to work to improve the health of families and women, not undermine it.

I yield back.

Chairman Brady. The gentlelady yields back.

Mr. Bishop, you are recognized.

Mr. Bishop. Thank you, Mr. Chairman.

And thank you, Mr. Secretary, for being here, for your patience, and for being with us and providing your testimony.

I guess I want to first say to you that I appreciate the priorities that you laid out in your opening statement addressing the opioid crisis, reducing the burdensome cost of prescription drugs, making health insurance affordable and accessible, and improving the quality of the Medicare program. These are laudable, important priorities for the Department, and we appreciate that.

I don't have much time so I guess I would like to address what is a major concern for all of us, and that is the opioid epidemic. My colleague Mr.

Curbelo asked a question earlier about the DEA, and I wonder if you might be able to clarify a little bit of your request on the DEA to curb the volume of prescribed controlled substances. I would like to hear more about that. I would like to hear about what is currently being done and how this might enhance your ability to help us address that issue.

Secretary Azar. So thank you. And I am still learning even the extensive operations of the connectivity between HHS and DEA on this front with regard to the opioid crisis. You put your finger, though, on what I think is one of the first of the three big elements that we have got to get at, which is the prescribing of legal opioids that get people started down this pathway. And we have got to find alternative pain management tactics. That is where CDC guidance can be so helpful to steer our providers away from opioids to the best other pain management treatments. We have got to look at issues of State regulation of pharmacy around just how many pills are people getting, which physicians can give those pills to individuals.

So I really want to focus on that entry point at working with DEA on ways that we can control pill mills, and even just bad practice that has become part of our culture of medicine of giving people excessive numbers of pills or opioids when they do not need them.

Mr. Bishop. Each one of us engage our community in some way, shape, or form, whether it is a townhall meeting or just a session with professionals to talk with parents about the issue of the opioid crisis.

I would really like to know, from your perspective, if there are resources that you can provide us to help us with that process of educating parents, educating communities as to the extent to which this opioid crisis exists and whether or not there are ways in which we can all be involved in addressing the crisis?

Secretary Azar. There are. And, in fact, we would be very happy, through our Substance Abuse and Mental Health Services agency, to get you any information there to help as you do townhalls or other meetings.

This crisis is so devastating. It is a there but for the grace of God go I or any family in this country, because someone can slip into addiction so easily off of the legal opioids and fall quickly down this pathway into the illegal opioids and then into treatment and relapse, death and overdose. It is a devastating crisis. We are going to be working to educate the country more through our budget also.

Mr. Bishop. Thank you, sir.

Chairman Brady. Thank you.

Mr. LaHood, you are recognized.

Mr. LaHood. Thank you, Mr. Chairman.

And welcome, Mr. Secretary. When we look at your background and experience, I don't think there is anybody more well-suited for this job or qualified for this job, particularly with your work in the private sector, your prior work at HHS, and your legal background. Obviously, your midwestern common sense is also a benefit. So we wish you much success.

Mr. Secretary, I know several of my colleagues have brought up concerns about access and quality in rural areas, and I represent a rural area in central and west central Illinois. Particularly on that subject, can you elaborate on priorities in the budget specifically to fight the opioid crisis in our rural areas?

Secretary Azar. So with regard to the opioids --

Chairman Brady. Could you grab the microphone there, Mr. Secretary?

Secretary Azar. Thank you very much, Mr. Chairman.

So as part of the budget proposal and through the Bipartisan Budget Act last week, we now have $10 billion that we have asked for for funding in 2019. Of that, we are going to now have, through SAMHSA, $1 billion going out for State-targeted response grants. So that is a doubling of the money that was going to States even in the last 2 years under CARA. So a billion dollars going to States there that will really help in a rural setting.

We also are going to be increasing money to help local communities and first responders buy naloxone, which is the overdose medicine. And then we have another program that we are going to be funding that is actually targeted towards our rural communities and best treatment practices and care, and that is also coming through this budget request, very much around -- we understand the real difficulties in the rural communities around access to treatment facilities and treatment programs.

Mr. LaHood. Well, we look forward to working with you on that.

Switching subjects, I want to talk a little bit about regulatory reform. We continue to be impressed with this administration's fight against unnecessary and burdensome regulations in the Medicare space. And as we move towards a more data-centric healthcare model, challenges in the transition from fee-for-service to value-based reimbursement continue to be filled with regulatory obstacles for physicians.

Can I get a commitment from you and your team that you will continue to identify ways to streamline this transition process and work with Congress on unwinding some of those regulatory burdens?

Secretary Azar. Absolutely. In fact, we have a whole series of workshops that we have had about decreasing burden on providers and physicians as they interact with their patients to make sure that they can spend their time working with the patient and not with us.

Mr. LaHood. Well, we appreciate the work thus far, and look forward to continuing to work with you on that and your commitment.

Secretary Azar. Thank you.

Mr. LaHood. Thank you, Mr. Secretary.

I yield back.

Chairman Brady. The gentleman yields back.

Mr. Higgins, you are recognized.

Mr. Higgins. Thank you, Mr. Chairman.

And thank you, sir, for being here. The healthcare industry in America is a $3.4 trillion annual industry. Health insurance and healthcare is all about quality and cost. I think based on any objective measure, we are not achieving optimal results. I think everybody agrees with that.

But I think like anything else, you know, the Federal Government is a huge, a massive purchaser of healthcare, not only general services, but prescription drugs as well. You have got 74 million under the Medicaid program, which is an insurance program. You have got 57 million people under the Medicare program, which is an insurance program. You have got 30 million under the Veterans Administration. That is a lot of leverage. That is a lot of leverage to

drive down the cost of healthcare and drive up the quality, insisting on it as a major consumer of healthcare.

People on this committee and in this House, we can disagree, and we do, Republicans and Democrats, about the extent to which the Federal Government should be involved in healthcare, but one thing we know is we will be involved. So while we are involved, let's use that leverage.

I have a bill with some other members which would allow individuals to opt in at their own cost into the Medicare program at age 50 to 64, showing a 40 percent savings each and every year when compared to another plan, a gold plan on the exchanges. Again, that is using the leverage. Because every healthcare reform issue that we see, that population between 50 and 64 gets clobbered with huge premiums and very little underlying healthcare for a very simple reason: Insurance companies don't want to write a policy for people that are older and sicker, statistically. So they jack up the premiums, jack up the copays, jack up everything, and those people are uninsurable. It is to this century what the Medicare population was to the 20th century. So we need to do a better job with that.

Finally, you come from the pharmaceutical industry, and you obviously know that that is a big challenge for us relative to cost. The Medicaid program, the Department of Defense, and the Veterans Administration all authorize negotiated discounts with the drug makers. According to the Commonwealth Foundation, each of those organizations experience nearly 25 percent savings each and every year by negotiating volume discounts.

Why in God's name are we not allowing Medicare to negotiate volume discounts to achieve those savings?

Secretary Azar. And I certainly agree. As we look at Part B, for instance, we have no negotiation there, and we have got to look at ways to introduce competition and negotiation into Part B.

Chairman Brady. Thank you. The gentleman's time has expired.

Mrs. Noem, you are recognized.

Mrs. Noem. Thank you, Mr. Chairman.

And thank you, Mr. Secretary, for being here today. I want to change the topic a little bit and go outside of this committee's jurisdiction and talk about Indian

health services. You do have a lot of opportunities to improve the kind of services that our Tribal communities are receiving today.

As you know, thousands of my constituents in South Dakota are served by this agency and they are getting Third World quality healthcare right now. In fact, people are dying because this agency is such a disaster. We have babies being born on the floor and surgical instruments that are being washed by hand. We have doctors and nurses and healthcare providers on drugs. Administrators aren't doing their jobs. And unfortunately, even though several of these facilities have been under review by CMS and even closed by CMS, we haven't gotten any better.

What happened was that the direct service facilities in South Dakota have been cited by CMS for poor care, and the Pine Ridge Hospital lost CMS accreditation for a period of time. The loss came even after CMS and IHS partnered together to provide more quality tools and access to the Hospital Engagement Network and other telehealth capabilities.

So it is so bad in South Dakota and in the Great Plains region that Tribes in neighboring Nebraska have been fed up and are waiting for IHS to fix their hospital, which has been without CMS accreditation since 2015. They have started to take over their hospitals themselves. My Tribes are too poor to do that. They don't have the resources or the dollars to do it, and it is an emergency situation. As many as nine of my constituents have died in ambulances traveling to other facilities over 50 miles away because the other facilities were closed due to such poor quality care. And people continue to suffer and die because of this inadequate leadership.

I am pleased that more dollars have come into IHS. In fact, since 2011, we have increased funding for IHS in Congress, but that doesn't mean it is getting any better. So we can't keep throwing money at a problem that is not getting fixed, and we need a plan for success.

I am wondering, Mr. Secretary, if you are aware of how bad it is and what you are going to do about it.

Secretary Azar. So thank you for raising the important issues, especially about the South Dakota and Great Plains facilities. I am very aware of it. We are very focused on it. And, in fact, we prioritized that in the budget. I am delighted that with the budget proposal, we are requesting an additional $413 million for the Indian Health Service.

Mrs. Noem. But, Mr. Secretary, you know more money is not going to fix it.

Secretary Azar. Well, and $58 million of it plus 29 is actually directed just towards these accreditation and safety issues on the Great Plains and these other hospitals. So that is a major focus for us. CMS is deeply committed to trying to help work with IHS to bring the quality of those facilities up to snuff, and that targeted investment will help.

We also need to ensure that we have got the right people. It is, of course, very difficult to recruit and retain at some of these facilities. And so I look forward to working with you if there are any additional flexibilities that we would need to enable that to be possible.

Mrs. Noem. So I have a piece of legislation that is pretty comprehensive, but I have been working with your staff on this and I would love to have your help. It is Restoring Accountability to the IHS Act. If you would look at it, I need your help.

Thank you, I yield back.

Chairman Brady. The gentlelady yields back.

Ms. DelBene, you are recognized.

Ms. DelBene. Thank you, Mr. Chair.

Thank you, Mr. Secretary, for being here with us. In your opening statement, you called the NIH a crown jewel of American science and that it is a priority. And I agree with you. I have concerns, though, with the budget here. And just if you could give me some quick answers, since we don't have a lot of time.

It is my understanding that the administration is touting a $1.4 billion increase in NIH funding in fiscal year 2019. Is that correct?

Secretary Azar. The total is $34.8 billion plus $750 million of opioid. So I think the total add would be about $1.5 billion, if I remember, off the top of the CR.

Ms. DelBene. Okay. So the opioid number, that $750 million, is something new and a new responsibility. So that is not an increase of the existing budget

of NIH, based on their current responsibility. That is giving them something new and dollars for something new.

Secretary Azar. Well, no, they are very focused. I mean, opioid and pain addiction treatment, that is all part of the core mission of NIH already. This is additional funding for them.

Ms. DelBene. And then it is just not assigned to any institute. So it is kind of -- it is out there, so it is unclear where it is going.

Secretary Azar. It will enable the director, actually, to prioritize, which I think is the best way to do it, that kind of flexibility.

Ms. DelBene. Also, the increase seems to include $255 million for occupational safety research that is currently at the CDC. So that would be moved over from the CDC. Is that correct?

Secretary Azar. That is right. The National Institute of Occupational Safety and Health, we believe that its research mission best aligns with NIH and then can be part of that. I think a lot of synergy is there for working together.

Ms. DelBene. Okay. I don't have a lot of time, so I just want to make sure we get through all this.

Moving that over. That actually has an existing budget, so you are moving that over to the NIH, but that is also part of this increase, but it is not really an increase. You are just moving it from the CDC over.

And then there is also $380 million for healthcare quality research that is currently at HHS that is also proposed to move to NIH. Again, isn't that something that would be moved over that has an existing budget, you are just putting under NIH now?

Secretary Azar. The agency for healthcare quality research also does move over as part of the budget proposal, correct.

Ms. DelBene. So really, when we talk about the budget -- and I just want to be clear, these are the numbers that we have -- the National Cancer Institute, a budget decrease; National Heart, Lung, and Blood Institute, decrease; National Institute of Dental and Craniofacial Research, a decrease in funding; National Institute of Allergy and Infectious Diseases, a decrease.

Most of the national institutes actually see a decrease in funding. And some of the numbers that you have here actually just are movements of responsibilities that were in other parts of HHS, moving them to NIH.

So if we are really going to talk about NIH being a priority and increasing its budget, which I agree with, I don't think this does that at all. And so I hope we will be really straightforward about the numbers going forward and prioritize the research at NIH.

I yield back.

Chairman Brady. Thank you.

Mr. Kelly, you are recognized.

Mr. Kelly. Thank you, Chairman.

Mr. Secretary, thanks for being here. Congratulations on your appointment, and certainly we appreciate your willingness to serve. It just seems sometimes we operate in a situation where people put themselves forward because they are patriotic and they go through an awful lot to do that.

My concern, and I think you are aware of it already, is that there is a transition to a single accreditation system in the GME, and it is going to have a negative impact on smaller medical residency programs. I have very strong concerns that there will be only one accreditor responsible for determining which programs are approved to receive over $15 billion in taxpayer funding each year.

The Lake Erie College of Medicine, or LECOM, which is in the district that I represent, is the largest medical school in the country, and there are certainly other programs in the same district. They are going to be forced to change their business model or close, which many are already doing.

So I know your Department is looking at the impact that the closure of these programs, especially in the smaller and the rural communities, is going to have on addressing the physician shortages. So give any attention you can give to that, because this issue has become so critical.

And I know that we always have the clash of the Titans of who gets what and who determines who gets what, but this idea of the shortage of physicians, LECOM has done such a tremendous job in investing in the future of our

country by getting these people prepared to serve. I just hope that we take a long look at that and make sure that we are being equitable and we are making sure that these schools can actually stay open. So any attention you can give to that is great.

The other thing is that everybody has talked about the opioid crisis and I don't know that you need any more information about that. There is certainly not a person in this room or in this country that has not been touched personally or is not in contact with somebody who has been touched personally with this. I thought the President early on said that, you know, we have to find a way to have nonaddictive painkillers out there. It is absolutely critical. So anything that you can do in that measure would be deeply appreciated.

It is quite a service, again, for what you are doing, and what you are giving up to serve. I can't tell you how much I appreciate that. Thank you. And thanks for being here today.

Mr. Chairman, I yield back.

Chairman Brady. Thank you. The gentleman yields back.

I would like to thank Secretary Azar for being with us today.

So please be advised that members of Congress on the committee have 2 weeks to submit written questions to be answered later in writing, and those questions and your answers will be made part of the formal hearing record.

Mr. Secretary, your focus on priorities on affordable and quality healthcare and making sure programs like Medicare work better and last longer in addressing the opioid crisis, are right on target.

With that, the committee stands adjourned.

[Whereupon, at 12:06 p.m., the committee was adjourned.]

MEMBER QUESTIONS FOR THE RECORD

Questions for the Record

The President's Fiscal Year 2019 Budget

Health and Human Services Secretary Alex M. Azar II

February 14, 2018

United States House Committee on Ways and Means

Representative Adrian Smith

Question: Section 1115A of the Social Security Act (SSA) provides broad authority to waive certain aspects of the title 18 of the SSA. Do you believe this authority allows CMS to waive section 3141 of the Patient Protection and Affordable Care Act? If so, do you plan to use this authority to do so? Please explain your reason in responding to both questions. As you may recall, prior to enactment of this change, Medicare used a state-by-state budget neutrality policy for the wage indexing. On April 28, 2017, I introduced H.R. 2224, Repeal of the Obamacare Bay State Boondoggle, which will address this issue by amending title XVIII of the Social Security Act to apply budget neutrality on a State-specific basis in the calculation of the Medicare hospital wage index floor for non-rural areas.

Response: Section 1886(d)(3)(E) of the Social Security Act requires that payments to hospitals paid under the Inpatient Prospective Payment System (IPPS) be adjusted, in a budget neutral manner, to reflect area differences in hospital wage levels by a factor reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level. Under this law, Medicare uses the wage index to adjust Medicare payments, consistent with the relative costs of labor among hospitals paid under the IPPS in different geographic areas. Section 4410 of the Balanced Budget Act of 1997 provides that, for discharges on or after October 1, 1997, the area wage index applicable to any hospital that is located in an urban area of a State may not be less than the area wage index applicable to hospitals located in rural areas in that State. This provision is referred to as the "rural floor." As you note, section 3141 of the Affordable Care Act requires that a national budget neutrality adjustment be applied in implementing the rural floor.

The Innovation Center was established by section 1115A of the Social Security Act (as added by section 3021 of the Affordable Care Act). Congress created the Innovation Center for the purpose of testing "innovative payment and service delivery models to reduce program expenditures …while preserving or enhancing the quality of care" for those individuals who receive Medicare, Medicaid, or Children's Health Insurance Program (CHIP) benefits. Under the authority of section 1115A(d)(1) of the Social Security Act, the Secretary may waive requirements under titles XI and XVIII and of sections 1902(a)(1), 1902(a)(13), 1903(m)(2)(A)(iii), and 1934 (other than subsections (b)(1)(A) and (c)(5) of such section) as may be necessary solely for purposes of testing such models. At this time, the Innovation Center has not found waiving this requirement necessary solely for purposes of testing any of the current section 1115A models.

Question: As you know, the current structure of the competitive bidding program has had a disproportionately negative impact on rural providers. There is an interim final rule pending at OMB that would address some of the immediate needs of the home medical equipment industry by maintaining the transition rates in the 21st Century Cures law. Can we work together to expedite clearance of this rule and extend relief into 2019?

Response: This regulation is under review by the Administration. I share your interest in this issue and should note that access to durable medical equipment for Medicare beneficiaries is a priority for the Department.

Representative Paulsen

Question: The Medicare Quality Payment Program, enacted as part of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), was created to provide physicians options to deliver care through alternative payment models (APMs) that both improve quality and lower the total cost of care. MACRA also established the Physician-Focused Payment Model Technical Advisory Committee (PTAC)—an expert panel that reviews and evaluates new models presented by public stakeholders. To date, the PTAC has recommended testing six different models.

I believe physician payment models that move away from a volume-based fee-for-service system toward one that promotes value and quality hold great promise to support our nation's physicians who are responsible for managing ever larger numbers of elderly and chronically ill patients. Please explain your plans to move forward with testing of the models approved by the PTAC. Significant work has gone into the development and evaluation of these models, and I believe it is of critical importance for the agency to act swiftly so that progress we have made to advance the delivery of high quality, lower cost health care is not lost. I look forward to supporting your efforts to implement this important congressional priority.

Response: MACRA established the PTAC to review and assess stakeholder proposals for physician-focused payment models. HHS established criteria for physician-focused payment models, which include categories to promote payment incentives for higher-value care; to address care delivery improvements that promote better care coordination, protect patient safety, and encourage patient engagement; and to address information enhancements that improve the availability of information to guide decision-making. PTAC uses these criteria in reviewing these proposals and providing recommendations to the Secretary. We believe that proposals to the PTAC could fill gaps in our current portfolio and ensure that clinicians are able to choose between several physician-focused payment models to find the right one for their practice. So far, the PTAC has submitted recommendations to the Secretary on several proposals, and the Secretary's responses can be found on CMS's website (https://innovation.cms.gov/initiatives/pfpms/**).**[1]

Question: In April 2017, the Department announced its 5-point strategy to address the opioid misuse epidemic, which included "strengthening our understanding of the epidemic through better public health surveillance." The CDC collects and publishes extensive data on opioid misuse, overdoses and opioid-related deaths, however, the agency does not currently surveil the inter-related crisis of chronic pain, which is essential to understanding and adequately addressing both. How will the CDC address this short-coming? Specifically, what plans does the CDC have to collect and make publicly available data that will: elucidate the epidemiology of chronic pain disorders (e.g., prevalence, incidence, risk factors, disparities); understand the morbidity, mortality, and disability imposed by chronic pain disorders; and assess the economic impact (e.g., direct and indirect costs) of chronic pain on our nation?

Response: CDC does not currently have a specific appropriation to address chronic pain. However, there are related disorders, including arthritis, that are closely aligned with the issue of chronic pain. There is a representative from CDC's Arthritis Program on the Interagency Pain Research Coordinating Committee and the National Pain Strategy's (NPS) Implementation Steering Committee, who is co-leading the NPS's Population Health Workgroup. CDC is planning to examine chronic pain prevalence and severe chronic joint pain using current national data sets,

[1] https://innovation.cms.gov/initiatives/pfpms/

such as the National Health Interview Survey (NHIS), as a start to this important work. Also, NHIS has been used historically by the department and others to study chronic pain. Beginning in 2019 NHIS will include additional questions on the impact of chronic pain on the respondent and his or her family.

Question: In April 2017, HHS released its 5-point strategy to address the opioid misuse epidemic, which included "advancing better practices for pain management." In March 2016, HHS released the National Pain Strategy, whose goal is to implement a safe, effective, evidence based pain care system in America. However – two years since its release – the agency has yet to begin formal implementation efforts of this critical Strategy, which is key to advancing better pain management practices and curbing the opioid misuse epidemic. When is the agency planning to implement the National Pain Strategy? How much funding is HHS planning to allocate to implementing the Strategy? Specifically, what plans does the agency have to address objectives in the Strategy related to: improving models of pain care; modifying reimbursement and coverage strategies and developing standardized pain assessments and outcome measures? What is the associated timeline for these implementation efforts?

Response: The Department is in the process of reviewing and refreshing the National Pain Strategy (NPS). The NPS was developed by an interagency committee following the 2011 release of the Institute of Medicine's (IOM) report on "Relieving Pain in America." In light of the current opioid epidemic, more current data and pain management practices must be incorporated into the NPS.

Representative Meehan

Question: We need to address the long-term solvency of the Medicare program by advancing payment and delivery reforms that reduce health care costs and improve health outcomes. One way to achieve those goals is to modernize the Stark Law and Anti-Kickback Statute to support a transition from fee-for-service to value-based health care payment models. I am pleased that the Administration proposes to establish a new exemption to the physician self-referral law for arrangements relating to participation in the Advanced Alternative Payment Models. I understand that the Centers for Medicare and Medicaid Services (CMS) Administrator will convene an interagency working group to explore the barriers created by the Stark Law. Could you describe the goals and timeline for Administrator Verma's Stark Law inter-agency working group?

Response: CMS is currently testing new innovative payment models through the Center for Medicare and Medicaid Innovation and is implementing other value-based programs such as the Medicare Shared Savings Programs. Many of these initiatives qualify as Advanced Alternative Payment Models (APM) under the Medicare Access and CHIP Reauthorization Act (MACRA). Under section 1115A of the Act, the Secretary has the authority to waive applicable fraud and abuse laws, including the physician self-referral law, as necessary to implement the Medicare Shared Savings Program or payment models being tested by the Innovation Center. To date, HHS has determined it necessary to waive the prohibitions of the physician self-referral law (and other fraud and abuse laws) for several Innovation Center models and for the Medicare Shared Savings Program. This limited waiver authority is the only waiver authority for the physician self-referral law available to the Secretary.

To accommodate non-abusive arrangements outside the Medicare Shared Savings Program or Innovation Center models, the Secretary can establish an exception to the physician-self referral law. However, the Secretary can establish such an exception only if it will pose no risk of program or patient abuse. This is an extremely high bar and exceptions created under this standard do not provide the flexibility needed to support the development of APMs.

I understand that CMS plans to convene an inter-agency workgroup to consider how to minimize the regulatory barriers of the physician self-referral law. The workgroup is in the early planning stages. In addition, the FY 2019 President's Budget proposes establishment of a new exception to the physician self-referral law for arrangements that arise due to participation in Advanced Alternative Payment Models. The Department, in consultation with the HHS Office of Inspector General, will identify the types of arrangements and the minimum risk levels and level of participation in the model required for such exceptions.

Question: As you know, Medicare's enrollment rules are complex, and seniors do not receive notice from CMS regarding their responsibility to enroll. This is why I introduced the Beneficiary Enrollment Notification and Eligibility Simplification Act, also known as the BENES Act. Because of these confusing rules, seniors may find themselves subject to a late enrollment penalty. The Part B late enrollment penalty permanently increases a beneficiary's premium by 10 percent for every 12 month period the beneficiary could have had Part B coverage, but did not. Others are paying for private coverage that is secondary coverage to Medicare. Without enrolling in Medicare, these seniors will find themselves responsible for significant out-of-pocket costs. I took note of the Administration's proposal to improve the efficiency and effectiveness of communicating information about Medicare benefits to beneficiaries. Will you commit to working with Congress to ensure that individuals approaching Medicare eligibility are provided with information about the enrollment rules and the coordination of Medicare coverage with other health insurance coverage?

Response: CMS works closely with the Social Security Administration to enroll eligible beneficiaries in the various components of Medicare. As part of this process, enrollees can chose which parts of Medicare they would like to enroll in. Most people should enroll in Part A when they turn 65, even if they have health insurance from an employer because they paid Medicare taxes while they worked and therefore don't pay a monthly premium for Part A. Certain people may choose to delay Part B. In most cases, it depends on the type of health coverage they may have. As you note, if a beneficiary does not enroll on time, they may be subject to a late enrollment penalty of up to 10 percent for each full 12 month period they could have had Part B, but didn't sign up for it. They are responsible for paying this penalty for as long as they have Part B coverage. CMS notifies certain beneficiaries at the beginning of their initial enrollment period (IEP) about their automatic entitlement to hospital insurance (HI) and enrollment in supplementary medical insurance (SMI), if applicable based on where the beneficiary resides, in the IEP package. CMS mails the IEP package three months prior to the 25th month of disability benefit entitlement or three months prior to the month of age 65 attainment (i.e., the first month of the individual's IEP). The IEP package contains a Welcome to Medicare cover letter, the Welcome to Medicare booklet, the beneficiary's official Medicare card reflecting the HI and SMI entitlement dates, and a postage-paid envelope for the individual to use to send their SMI refusal to SSA.

The Administration is committed to making sure the Medicare enrollment process works for beneficiaries including how CMS informs people of their eligibility to enroll in Medicare and the consequences if they delay enrollment.

Question: The Comprehensive Addiction and Recovery Act (CARA) authorized a voluntary drug management program for Medicare Part D plans. The goal of the program is to allow plans to address potential overutilization of commonly abused drugs by beneficiaries identified as at-risk of misuse or abuse. Could you explain the importance of the Administration's proposal to give the Secretary authority to mandate Medicare Part D plans' use of a drug management program?

Response: The Budget includes several proposals that work to address the impact that the opioid epidemic has on our nation's seniors. The Medicare population has among the highest and fastest-

growing rates of opioid use disorders, currently at more than 6 of every 1,000 beneficiaries. Many Medicare beneficiaries take multiple medications and receive prescriptions from multiple doctors, making tracking and controlling any misuse of these prescriptions a substantial challenge. HHS has made tackling this issue, and the opioid epidemic more broadly, a top priority.

The Comprehensive Addiction Recovery Act of 2016 (CARA) required CMS to propose a framework under which Part D plan sponsors may establish a drug management program for beneficiaries at risk for prescription drug abuse or misuse and require those determined to be at risk to only receive opioids from a specifically designated provider(s) and/or pharmacy(ies). The budget proposal strengthens the provisions required in CARA by providing the Secretary with authority to establish a mandatory prescriber and/or pharmacy lock-in program in Medicare Part D that all Part D plans will be required to participate in beginning in 2020.

Question: Industry experts estimate that 85 percent of small- and medium-sized hospitals have no formally trained cybersecurity staff. Yet, the health care industry is a top target for cyber criminals. Hackers often target electronic health records of patients. With information like Social Security numbers, birthdates and driver's license details, criminals can complete a variety of fraudulent transactions. Health care networks have also proven particularly vulnerable to large-scale ransomware attacks. The health care system's interconnectedness keeps providers who have invested in cybersecurity vulnerable to attack through their unprotected affiliates. Last year, the Health Care Industry Cybersecurity Task Force issued a recommendation to modify the Stark Law and the Anti-Kickback Statute to allow health care organizations to share cybersecurity resources and information with their partners. Will you commit to working with Congress on a legislative solution that will enable large hospitals to share cybersecurity information technology and training services with smaller hospitals or physician clinics with the goal of reducing the cybersecurity vulnerability gap between health care providers in the U.S.?

Response: As the Health Care Industry Cybersecurity Task Force has pointed out, "…healthcare organizations of all sizes are targets due to the interconnected nature of the industry..." They further explained that one of the most challenging attack risk scenarios we face is "the compromise of a smaller health delivery organization where the attacker increasingly exploits vulnerabilities until they acquire valid credentials necessary to gain access to a health information exchange and/or partner hospitals." Unfortunately, while smaller organizations can potentially serve as the gateway to an attack on a larger organization, they often lack the resources and expertise to implement their own robust cybersecurity programs.

In the face of these resource constraints, the highest return on cybersecurity investment is often found in collaboration. Collaborative efforts with industry are an essential component of HHS's efforts, as the Sector Specific Agency, to enhance cybersecurity in the Healthcare and Public Health Sector under the partnership model spelled out in Presidential Policy Directive 21 and the National Infrastructure Protection Plan. Through this model and with close coordination with the Department of Homeland Security, we exchange information with health care industry partners regarding threats and vulnerabilities and develop joint products and tools to assist other healthcare organizations in addressing the greatest risks.

In addition to these national-level efforts, many healthcare organizations benefit from collaborative efforts at the local, state, and regional levels. They may work with industry peers or business partners to exchange information and address threats. However, concerns over the legal requirements of the Physician Self-Referral Law and Anti-Kickback Statute often limit their engagement in more tangible activities, such as sharing of cybersecurity software and services. I look forward to working with Congress to identify a path forward that protects the intent of the

Physician Self-Referral Law and Anti-Kickback Statute, while allowing for deeper collaboration on cybersecurity matters.

Question: Section 104 of the Comprehensive Addiction and Recovery Act (CARA) requires the Secretary of the Department of Health and Human Services (HHS) to issue a report by July 22, 2018, regarding the information and resources available to youth athletes and their families regarding the dangers of opioid use and abuse, non-opioid treatment options, and how to seek addiction treatment. Could provide an update on the status of HHS's progress in developing and issuing the report?

Response: HHS is busy implementing provisions of CARA, including Section 104. We understand Congress's interest in the intersection between youth athletes and opioid use and abuse and look forward to releasing the report when it is completed.

Question: Perfluorooctane sulfonate (PFOS) and perfluorooctanoic acid (PFOA) compounds have been detected in public and private groundwater wells in Horsham, Pennsylvania and surrounding communities stemming from the use of certain firefighting foams at the former Naval Air Station-Joint Reserve Base in Willow Grove, Pennsylvania, and the Naval Air Warfare Center in Warminster, Pennsylvania. The Fiscal Year (FY) 2018 National Defense Authorization Act (NDAA) authorized the Centers for Disease Control (CDC) and the Agency for Toxic Substances and Disease Registry (ATSDR) to conduct a study on the health effects of per- and polyfluoroalkyl substances (PFAS), which include PFOS and PFOA, contamination in water. Additionally, the FY 2018 NDAA also requires CDC and ATSDR to conduct an exposure assessment of current or former defense installations known to have contamination in their drinking water. What is the status of the study and the exposure assessment?

Response: CDC/ATSDR is assisting many communities across the United States that are concerned about per- and polyfluoroalkyl substances through their drinking water. The Agency is currently assessing the most appropriate and effective designs for a multi-site study pending fiscal year 2018 appropriations. In addition, CDC/ATSDR is determining the best approach to complete exposure assessments on no less than eight current and former military installations.

Representative Black

Question: On January 26, 2018, the U.S. Department of Health and Human Services (HHS) issued a proposed rule to improve enforcement for 25 existing statutes protecting conscience in the provision of healthcare through HHS-funded programs. The proposed rule states that HHS currently has 35 open complaints pending (see page 27 of rule).

Has the Office of Civil Rights developed a plan for addressing those complaints? When does your Department expect to have these complaints resolved?

Response: The number of conscience complaints now exceeds 130. The Office for Civil Rights has developed a plan for investigating and addressing these complaints through its new Conscience and Religious Freedom Division. OCR is committed to resolving all complaints, including HIPAA and civil rights complaints, as quickly as resources and prudence allow. We do not comment on individual open complaints or progress of enforcement matters. Nevertheless, conscience complaints have tended to be some of our more complex cases.

Representative Holding

Question: Mr. Secretary, in September of last year I wrote your predecessor with a question regarding Medicare Advantage plan prior authorization requirements, but have yet to receive a response. I

understand there has been high turnover at the Department, but would appreciate a reply as I continue to hear from physicians with the same concerns that led me to make the initial inquiry. Can your office provide a response to my original letter and commit to providing more clarity on the limits of prior authorization requirements?

Response: It is my understanding that CMS responded to the letter that you mentioned, and can follow up with your staff to ensure that you have received the response.

As you know, Medicare Advantage organizations offering a Medicare Advantage coordinated care plan (i.e. health maintenance organization or preferred provider organization (PPO)) are required to provide Medicare covered services through a network of contracted providers.
Medicare Advantage plans may use reasonable utilization management techniques, such as prior authorization, to ensure that furnished services are both medically necessary and appropriate. Plans are not allowed to require prior authorization for emergency and urgent care services, or services provided to stabilize an enrollee for discharge or transfer in connection with an emergency medical condition. They also may not require prior authorization for clinical trials.
In addition, PPO plans cannot impose prior authorization requirements for out-of-network plan covered services. To ensure that plans do not restrict access to certain services, the Centers for Medicare & Medicaid Services (CMS) has established a robust appeals process for beneficiaries. If a plan declines to authorize or pay for a service, appeal rights, including expedited appeals, are available to enrollees and physicians acting on behalf of enrollees.

Plans are required to submit information to CMS on the services that require preauthorization each year and must inform enrollees with notice of any coverage restrictions, such as prior authorization requirements. Specifically, Medicare Advantage plans must disclose the existence of any coverage restrictions, such as a prior authorization requirement, in the plan's Evidence of Coverage document. Medicare Advantage plans must ensure that enrollees are able to obtain medically necessary services on a timely basis and that any prior authorization requirements do not impose an inappropriate delay in obtaining those services. In addition, Medicare Advantage plans are encouraged to be transparent with contracted providers regarding their prior authorization requirements and procedures.

CMS carefully monitors enrollee access to services through plan audits, review of beneficiary appeals, and hearing complaints from beneficiaries or other interested parties. When we identify circumstances where plans have inappropriately denied enrollees access to medically necessary care, CMS can take actions, including imposing sanctions such as suspending a plan's ability to enroll and market to beneficiaries, as well as civil money penalties.

Question: Mr. Secretary, the Budget would provide you with the authority to "consolidate certain drugs currently covered under Part B into Part D." The budget also proposes a mandatory pass-through of price concessions to the beneficiary, similar to what CMS contemplated in a Request for Information included in the proposed Part D rule. Implementing the former policy without the latter could result in harmful outcomes for beneficiaries.

The patients who depend on Part B drugs are usually very sick and need access to their treatments to survive. Can you envision a scenario in which one policy would be implemented without the other? And if so, what steps would be taken to ensure beneficiaries' access isn't limited and that they would see the benefits of the savings gained through increased price competition?

Response: This is a complex issue with no single one-size-fits-all solution. The proposals the Administration has put forward represent a comprehensive plan with policies that must work

together in concert to achieve the goal of lowering the cost of prescription drugs for patients in a way that balances the interests of taxpayers, patients and innovation. The Budget makes significant strides toward addressing and reining in drug prices. The legislative solutions would benefit seniors by protecting Medicare beneficiaries from high drug prices, giving plans more tools to manage spending, and realigning incentives in the Part D drug benefit structure. The proposed changes enhance Part D plans' negotiating power with manufacturers; encourage utilization of higher value drugs; discourage drug manufacturers' price and rebate strategies that increase spending for both beneficiaries and the Government; and provide beneficiaries with more predictable annual drug expenses through the creation of a new out-of-pocket spending cap. Also, beginning in CY 2019, this proposal provides the Secretary with authority to consolidate certain drugs currently covered under Part B into Part D. The Secretary will exercise this authority when there are savings to be gained from price competition, and taking into account the impact on beneficiaries' cost-sharing and access to drugs. I am happy to work with you, your staff, and other interested Members of Congress on this proposal to ensure that individuals maintain access to care.

Representative Rice

Question: Secretary Azar, hearing loss is currently the third most common chronic disorder for Americans over 65. Nearly half of seniors over 75 suffer from hearing loss. These individuals are three times more likely to experience a fall and be hospitalized. Additionally, seniors with untreated hearing loss often experience cognitive decline and social isolation. I recently introduced legislation, H.R. 2276, that will streamline Medicare Part B, so that, among other things, patients who have a hearing or balance problem can go directly to the audiologist for help without being denied coverage, just as they can if they have Medicare Advantage or any other public coverage. As I understand it, CMS has the administrative authority to fix this problem and to allow Medicare Part B patients to have direct access to audiologists. Will you work with my office to update Medicare's policies in order to allow seniors direct access to their audiologists under Medicare Part B?

Response: Under current law, Medicare generally covers hearing and balance assessment services as diagnostic tests, including when these services are furnished by qualified audiologists. Because they are diagnostic tests, hearing and balance assessment services require an order from a physician (or other non-physician practitioner as applicable) for such testing in order to be covered. There is no provision in current law for Medicare to pay audiologists for therapeutic services. I am happy to work with your office to learn more about this issue.

Representative Curbelo

Question: I understand that Puerto Rican Medicare Advantage Plans have communicated with CMS and presented data to ensure that reimbursement is fair. In a letter sent jointly with my colleagues in December, we raised concerns that MA payment rates in Puerto Rico were significantly below the national average. We mentioned that this could contribute to other systemic issues affecting the island. In its latest proposal for 2019, CMS proposed no meaningful changes to mitigate this harmful and persistent gap. As Puerto Rico continues recovery efforts from the recent hurricanes, I hope that we can support healthcare on the island, and I think that strengthening the MA there is one way we can do this. Can we work together to find ways to improve the MA programs in Puerto Rico?

Response: As you know, in order to increase benchmarks in Puerto Rico as a percentage of FFS costs, a statutory change would be necessary. The policies proposed in the 2019 Advance Notice and Draft Call Letter will provide stability for the Medicare Advantage program in the Commonwealth and to Puerto Ricans enrolled in MA plans. These policies include basing the Medicare Advantage county rates on only the relatively higher costs of beneficiaries in Fee-For-Service Medicare who

have both Medicare Parts A and B, interpreting the criteria used to determine which counties qualify for an increased quality bonus adjusted benchmark in a way that permits certain Puerto Rican counties to qualify, and applying an adjustment to Puerto Rico FFS costs to reflect the nationwide propensity of beneficiaries with zero claims. In addition, in recognition of the impact that recent natural disasters might have on the underlying operational and clinical systems that CMS relies on for accurate performance measurement in the Star Ratings program, CMS is proposing a variety of strategies to address Star Ratings issues related to plan contracts impacted by extreme and uncontrollable circumstances, in Puerto Rico and elsewhere. This includes adjusting the 2019 and 2020 Star Ratings to take into account the effects of extreme and uncontrollable circumstances that occurred during the 2017 performance period, such as Hurricanes Harvey, Irma, and Maria, and the wildfires in California. We look forward to working together with you to maintain a strong, sustainable MA and Part D program for Puerto Rico and our nation's Medicare beneficiaries.

Representative Levin

Question: The 1987 Nursing Home Reform Law, signed by President Reagan, set federal standards of care for skilled nursing facilities and nursing facilities, established a survey system to determine compliance with those standards, and established a range of intermediate sanctions or penalties that may be imposed when a facility fails to meet the standards of care.

In July 2017, your predecessor Secretary Price issued new guidance to surveyors that changed the way penalties that could be imposed against facilities that violate health and safety standards for residents.

Secretary Azar, we ask that the Department compile the following information about the assessment of penalties before and after this regulatory change in order to better understand the effect of the regulatory and sub-regulatory changes on accountability:

For both skilled nursing facilities and nursing facilities, please provide the dollar amount of penalties (gross dollars and average penalty) assessed by category of deficiencies for the six month periods of: January 2016 – June 2016; July 2016 – December 2016; January 2017 – June 2017; July 2017 – December 2017. Also, please provide the breakdown of type of penalty (per diem or per instance) and breakdown of start date of penalty (date of complaint or date of investigation).

Please specifically identify the number of deficiencies or complaints in each time period related to violations of anti-psychotic patient protections and also related to nursing home evictions/patient dumping.

Response: A top priority for HHS is the health and safety of our beneficiaries. We are committed to strengthening and modernizing the nation's healthcare system to provide access to high quality care and improved health at lower cost. This includes improving the patient experience of care, both quality and satisfaction, improving the health of populations, and reducing the per capita cost of healthcare.

In 2012, CMS launched an initiative aimed at improving behavioral healthcare and safeguarding nursing facility residents from the use of unnecessary antipsychotic medications, the National Partnership to Improve Dementia Care in Nursing Homes. As part of the initiative, CMS has developed a national action plan that uses a multidimensional approach including public reporting, raising public awareness, regulatory oversight, and technical assistance/training and research. This plan is targeted at enhancing person-centered care for nursing facility residents, particularly those with dementia-related behaviors.

CMS requires that skilled nursing facilities and nursing facilities seeking to be Medicare and Medicaid providers must be certified as meeting Federal participation requirements. These requirements require that these facilities must care for its residents in such a manner and in such an environment that promote maintenance or enhancement in quality of life of each resident. CMS has implemented requirements that may lead to a reduction in the unnecessary use of antipsychotic medication and improvements in the quality of behavioral healthcare.

In December 2017, CMS began an initiative to examine and mitigate facility-initiated discharges that violate Federal regulations. This initiative includes a direction to states to refer all involuntary discharge cases to CMS for review and possible enforcement where there is placement in a questionable or unsafe setting, where residents remain hospitalized, where there is a facility pattern, or other circumstances that may raise significant concerns about resident health or safety.

The table below includes the dollar amount of penalties as well as the number of citations for unnecessary medications, including antipsychotic medications and the number of citations for involuntary discharge violations for the time period for which we have complete data.

	A	B	C	D	E	F[2]	G
Timeframe	**Number of Per Diem CMPs Imposed**	**Number of Per Instance CMPs Imposed**	**Gross Dollars Imposed**	**Average Per Diem CMPs Imposed**	**Average Per Instance CMPs Imposed**	**Number of Citations for Unnecessary Medications Including Antipsychotic Medications**	**Number of Citations for Involuntary Discharge Violations**
Jan 2016 - Jun 2016	899	483	$45,739,312	$49,391	$2,767	2025	72
Jul 2016 - Dec 2016	1102	594	$81,401,407	$71,441	$4,565	1785	83
Jan 2017 - Jun 2017	1067	1219	$82,142,671	$69,587	$6,502	1899	111

Question: On January 24, 2018, the Idaho Department of Insurance issued Bulletin No. 18-01, which would allow for the sale of "state-based health benefit plans" or "state-based plans" that are not in compliance with numerous provisions of federal law. According to this Bulletin, insurers within the state of Idaho would be permitted to sell plans that increase premiums for consumers based on their health status, charge older consumers as much as five times what is charged younger consumers, and allow plans to impose annual limitations on benefits of up to $1 million.

Relying on this Bulletin, Blue Cross of Idaho announced on February 13, 2018 that it intends to offer for sale five such state-based plans in the state. These plans would, among other features, charge higher

[2] With regard to Column F, please note that we are unable to separate antipsychotic medication violations from the general category of unnecessary medication violations because, prior to November 28, 2017, CMS did not track antipsychotic medication violations separately. We now have a separate code, F758, which is specific to the inappropriate use of psychotropic medications.

premiums based on consumers' health status, deny patients with preexisting conditions benefits in the event that they do not maintain continuous coverage, and impose annual limitations on benefits of up to $1 million. Blue Cross of Idaho has stated that it intends to offer these plans for sale as soon as March of this year.

Secretary Azar, does the Department of Health and Human Services agree that the sale of these plans is not compliant with provisions in the Affordable Care Act that prohibit discrimination against patients with preexisting conditions, limit age-based variation in premiums to a 3:1 ratio, and prohibit annual and lifetime limitations on benefits?

Please explain what actions the Department of Health and Human Services intends to take to prevent the sale of policies to consumers in clear violation of federal law, including the assessment of fines as stipulated in the ACA.

In the event that other states authorize the sale of unlawful policies in the future, are you willing to commit to fully enforcing all aspects of federal law?

Response: I am committed to working with states to grant flexibility wherever appropriate to provide their citizens the best possible access to healthcare. However, the Affordable Care Act remains the law. CMS informed the State that its State-based plan proposal, as originally issued, is inconsistent with the law.

The Department looks forward to working to explore ways in which Idaho can achieve its policy goals while ensuring that health insurance coverage sold within the state complies with all applicable federal laws and requirements.

Representative Lewis

Question: Has the Administration evaluated the potential effects of Medicaid waivers with work requirements or "lock outs" on beneficiaries with serious medical conditions and infectious diseases? If so, please explain the process, findings, and resulting safeguards.

Response: As you may know, on January 11, 2018 CMS sent a letter to State Medicaid Directors (SMDs) announcing a new opportunity for states that choose to support Medicaid enrollee health and well-being by incentivizing work and community engagement among adult Medicaid beneficiaries who are not elderly, pregnant, or eligible for Medicaid due to a disability.

As CMS indicated in the SMD letter, a broad range of social, economic, and behavioral factors can have a major impact on a beneficiary's health and wellness. A growing body of evidence suggests that targeting certain health determinants, including productive work and community engagement, may improve health outcomes. CMS expects that a request from a state will detail the program design that the state intends to test, including that the requirement for certain adult Medicaid beneficiaries to work or participate in other community engagement activities increases the likelihood that those Medicaid beneficiaries will achieve improved health, well-being, and independence.

It is important to note that states that choose to undertake efforts to incentivize work and community engagement will be required to ensure that certain vulnerable beneficiaries, such as people who are eligible for Medicaid on the basis of disability or pregnancy, continue to receive medical assistance and are not subject to the requirements. The policy announced in the SMD letter was specific to adult Medicaid beneficiaries who are not elderly, pregnant, or eligible for

Medicaid due to a disability. Additionally, the letter makes it clear that states must create exemptions for medically frail beneficiaries and beneficiaries with acute medical conditions validated by a medical professional that would prevent them from obtaining employment or undertaking community engagement activities. We also encourage states to consider other exemptions related to age, responsibility for a dependent, participation in a drug addiction or alcohol treatment and rehabilitation, as well as other exemptions states may find appropriate for their Medicaid populations.

In addition, some beneficiaries who are eligible for Medicaid on a basis other than disability may have an illness or disability (as defined by other Federal statutes) that may interfere with their ability to meet work and community engagement requirements. States must comply with Federal civil rights laws, to ensure that beneficiaries with disabilities are not denied Medicaid for inability to meet work or community engagement requirements, and have mechanisms in place to ensure that reasonable modifications are provided to people who need them. States should include, in their proposals to CMS, information regarding their plans for compliance with these requirements. The reasonable modifications may include exemptions from participation where a beneficiary is unable to participate for disability-related reasons, modification in the number of hours of participation required, and provision of support services necessary to participate, where participation is possible with supports.

I recognize your concern about the potential impact of this policy on vulnerable populations and therefore encourage states to consider a wide range of activities that could satisfy work and community engagement requirements, other than employment, which promote health and wellness, and which will meet the states' requirements for continued Medicaid eligibility. States are encouraged to include procedures that allow for an assessment of beneficiaries' disabilities, medical diagnosis, and other barriers to employment and self-sufficiency in order to identify appropriate work and community engagement activities and services, supports, and any reasonable modifications necessary for those beneficiaries to participate in work and community engagement activities and attain long-term employment and self-sufficiency. Additionally, these community engagement activities should reflect each person's employability and potential contributions to the labor market and could include, but are not limited to, community service, caregiving, education, job training, or participation in substance use disorder treatment. As Secretary of HHS, I will continue to ensure that the work requirements and their associated guardrails are implemented with the goal of lifting people up and out of dependency since that is an important goal of this administration and the Medicaid program.

Question: In August 2017, the National Institutes of Health (NIH) used revised criteria in the request for the Research Centers in Minority Institutions (RCMI) program federal grant application (RFA-MD-17-006). The RCMI program provides grants to institutions that award doctoral degrees in the health professions or health-related sciences and have a historical and current commitment to serving students from underrepresented populations.

The new criteria opens the program up to almost any institution that serves minority students and provides health care services to medically underserved populations. As a result, the program would not focus on institutions with strong minority enrollment.

Please explain the rationale for this decision, particularly given that other branches of the Federal Government continue to issue funding opportunity announcements using the criteria defined as Minority Institutions in Section 365 (3) of the Higher Education Act.

Response: The Research Centers in Minority Institutions (RCMI) program is vital in supporting the National Institutes of Health's (NIH) strategy to promote the next generation of researchers from underrepresented populations and to enhance the goal of turning discovery into health.

The RCMI programmatic content requirements remain fundamentally the same, with continued support to strengthen research capacity, recruit new faculty, enhance professional development activities for investigators, fund a research project within the Center, and fund scientific pilot projects that target postdoctoral trainees and early career investigators.

While it may have been a factor in the past, due to legal considerations, RCMI funding opportunity announcements (FOAs) have not referenced a student demographic percentage as part of eligibility criteria since 2011. Instead, the NIH has focused on ensuring that eligible institutions demonstrate an historical mission to educate students from any of the populations that have been identified as underrepresented in biomedical research as defined by the National Science Foundation (i.e., African Americans or Blacks, Hispanic or Latino Americans, American Indians and Alaska Natives, Native Hawaiians, and U.S. Pacific Islanders).

In addition, eligible institutions include those that received less than an annual average of $50 million in NIH funds within the three years prior to the time of application. It is important to note that all current and previously funded RCMI program participants are below the funding cap and remain eligible to apply for the program.

Question: The Department of Health and Human Services (HHS) recently approved new Medicaid waivers in Kentucky and Indiana. These waivers would allow those states to implement work requirements as a condition for health insurance. Additionally, beneficiaries in these states could be blocked from coverage for up to six months. Since people living with HIV require uninterrupted access to care and treatment for their own health, these Medicaid waivers could have a severe impact on the health and well-being of those living with HIV/ AIDS and efforts to control the HIV epidemic.

How will HHS ensure that these new policies do not cause further harm to people living with HIV and corresponding efforts to end the HIV/AIDS epidemic?

Response: As you may know, on January 11, 2018, CMS sent a letter to State Medicaid Directors (SMDs) announcing a new opportunity for states that choose to support Medicaid enrollee health and well-being by incentivizing work and community engagement among adult Medicaid beneficiaries who are not elderly, pregnant, or eligible for Medicaid due to a disability (many people with HIV who qualify for Medicaid, qualify on the basis of disability). An important safeguard of this opportunity requires states that choose to undertake efforts to incentivize work and community engagement to ensure that certain vulnerable beneficiaries, such as people who are eligible for Medicaid on the basis of disability or pregnancy, continue to receive medical assistance. The policy announced in the SMD letter was specific to adult Medicaid beneficiaries who are not elderly, pregnant, or eligible for Medicaid due to a disability. Additionally, the letter makes it clear that states must create exemptions for medically frail beneficiaries and beneficiaries with acute medical conditions validated by a medical professional that would prevent them from obtaining employment or undertaking community engagement activities. We also encourage states to consider other exemptions related to age, responsibility for a dependent, participation in a drug addiction or alcohol treatment and rehabilitation, as well as other good cause exemptions states may find appropriate for their Medicaid populations.

In addition, some beneficiaries who are eligible for Medicaid on a basis other than disability may have an illness or disability (as defined by other federal statutes) that may interfere with their

ability to meet work and community engagement requirements. States must comply with Federal civil rights laws, to ensure that beneficiaries with disabilities are not denied Medicaid for inability to meet work or community engagement requirements, and have mechanisms in place to ensure that reasonable modifications are provided to people who need them. States should include, in their proposals to CMS, information regarding their plans for compliance with these requirements. The reasonable modifications may include exemptions from participation where a beneficiary is unable to participate for disability-related reasons, modification in the number of hours of participation required, and provision of support services necessary to participate, where participation is possible with supports.

I recognize your concern about the potential impact of this policy on vulnerable populations and therefore encourage states to consider a wide range of activities that could satisfy work and community engagement requirements, other than employment, which promote health and wellness, and which will meet the states' requirements for continued Medicaid eligibility. States are encouraged to include procedures that allow for an assessment of beneficiaries' disabilities, medical diagnosis, and other barriers to employment and self-sufficiency in order to identify appropriate work and community engagement activities and services, supports, and any reasonable modifications necessary for those beneficiaries to participate in work and community engagement activities and attain long-term employment and self-sufficiency. Additionally, these community engagement activities should reflect each person's employability and potential contributions to the labor market and could include community service, caregiving, education, job training, or participation in substance use disorder treatment. As Secretary of HHS, I will continue to ensure that the work requirements and their associated guardrails are implemented with the goal of lifting people up and out of dependency since that is an important goal of this administration and the Medicaid program.

Question: HIV consistently and disproportionately affects people of color in our country, and the southern region of the United States is now the epicenter of the HIV/ AIDS pandemic.

Despite these grave realities, the White House abruptly dismissed all remaining members of the Presidential Advisory Council on HIV/AIDS (PACHA) in December 2017. Alarmingly, the White House Office of National AIDS Policy (ONAP) had no staff for the entire year of 2017. As you know, ONAP and PACHA are responsible for overseeing progress toward the National HIV/AIDS Strategy goals to reduce new HIV infections, improve care, reduce disparities, and achieve a more coordinated national response.

In the absence of White House leadership and staff, how does HHS plan to ensure that we will continue to make progress toward these goals, particularly among African Americans who in 2015 accounted for 54% of new HIV diagnoses in the southern region of the United States?

Response: The Department is, and will continue to be, a world leader in HIV/AIDS prevention and treatment strategies. There is no doubt that our primary focus must be on at-risk populations. A progress report on the National HIV/AIDS Strategy is underway, and the Department will continue working with stakeholders to reduce new infections and improve access to care and treatment outcomes.

Question: In June 2016, The Centers for Disease Control (CDC) identified over 220 counties nationwide that are at risk for localized HIV outbreaks associated with opioids and injection drug use. Several areas in the country hard hit by the opioid epidemic are already reporting increases in new HIV cases attributed to intravenous drug use.

What is HHS doing to prevent the potential for an increase in HIV infections associated with intravenous drug use? How will HHS expand access to substance use treatment and medical care for individuals who inject drugs specifically to stem the spread of HIV, Hepatitis C, and other bloodborne infectious diseases linked to intravenous drug use?

Response: The opioid crisis is fueling a dramatic increase in infectious diseases, particularly bloodborne infections associated with injection drug use. The recent near-threefold increase in hepatitis C, and the 2015 HIV outbreak in Indiana, are powerful evidence that persons who inject drugs are at high risk for both viral hepatitis and HIV. CDC is working every day to address these bloodborne infectious diseases linked to intravenous drug use by sharing the best available science and approaches to prevent the spread of these diseases, get people treated, and reduce the injection drug use that puts people at greater risk of getting infected. The FY 2019 President's Budget requests $40 million for a new initiative that will support efforts to eliminate HIV transmission, hepatitis B virus (HBV), hepatitis C virus (HCV), Sexually Transmitted Infections (STIs) such as syphilis, and tuberculosis, in select states/jurisdictions at high-risk for these infectious diseases, including those with high rates of opioid-related transmission. CDC can leverage its clinical and community-based infectious disease programs to detect and eliminate multiple interrelated infections and help prevent the infectious disease consequences of the opioid crisis in targeted geographic locations. These efforts will include focusing on diagnosing infections and curing people of latent TB infection and active TB disease, STIs including syphilis, and HCV; effectively treating HIV and HBV; and implementing efforts to prevent new infections from these pathogens.

Question: Syringe services programs (SSPs) provide access to sterile needles and syringes free of cost and facilitate the safe disposal of used needles and syringes. SSPs are effective at stopping the spread of blood-borne infections including HIV and Hepatitis C, and in getting people into substance use and mental health care. Despite their proven effectiveness, SSPs are underutilized.
Please explain how HHS will support and encourage the expansion of syringe service programs.

Response: The rising rates of infectious diseases and other health consequences associated with injection drug use are of great concern. Comprehensive community- and school-based opioid overdose prevention services and programs, tailored to persons with opioid use disorder, may include but are not limited to provision of naloxone and overdose prevention training, provision and disposal of sterile injection equipment (where legal and consonant with community support), testing for infection with viral hepatitis and HIV with referral to treatment, syringe services, and provision of or referral to addiction and mental health services including medication-assisted treatment.

Pursuant to appropriations language from Congress, Federal funds can be used to support certain services offered by syringe services programs (SSPs), outside of sterile needles and syringes, under certain conditions. HHS developed guidance for health departments on how to request permission to use Federal funds to support SSPs. CDC has disseminated the guidance through established communication channels with states and via partner organizations. CDC also maintains a webpage with information and a link to the HHS guidance: https://www.cdc.gov/hiv/risk/ssps.html. HHS will implement the law as directed and is happy to work with Congress on this issue.

As of March 2018, 31 states, one territory, and seven counties received CDC's concurrence that the state, territory, or county is at risk for an infectious disease outbreak and were eligible to apply to direct HHS resources to fund approved syringe services program activities. HHS is implementing the law as directed and is happy to work with Congress on this issue.

Question: In January 2018, HHS published a proposed rule on "Conscience Rights" in health care. This rule would allow health care workers to refuse to provide services that conflict with their personal moral or religious convictions.

In the final iteration of the proposed HHS rule on "Conscience Rights," how will you clarify that HHS will not permit discrimination against lesbian, gay, bisexual, and transgender (LGBT) and women patients and/ or any other personal refusal that could harm a patient's health?

Response: We are currently reviewing public comments on the proposed rule, and we cannot predetermine the outcome of the notice and comment rulemaking process. The Federal conscience laws were passed by Congress with bi-partisan support in order to prohibit discrimination and to further diversity in healthcare. The proposed conscience regulation would provide appropriate mechanisms for enforcement of current federal laws that have been under-enforced in the past. HHS is committed to faithfully applying the facts to the law, and to treating all complainants fairly under every statute it enforces.

Question: The "Conscience Rights" rule states that the HHS Office of Civil Rights (OCR) received few complaints regarding religious or moral exemptions compared to the thousands of civil rights and privacy complaints from patients each year as HHS' fiscal year (FY) 2018 Budget Justification.

Further, the proposed rule will cost OCR nearly one million dollars while at the same time the Administration is proposing to cut OCR's budget by eight million dollars in FY19 and to establish a new division within OCR.

Given HHS' limited resources, as well as data showing that there are far fewer religious or moral exemption complaints compared to civil rights and privacy complaints, how will HHS ensure that the new rule will not reduce OCR's ability to protect patient health and privacy?

Response: For too long, conscience protections enshrined in our laws were treated as second-class rights. The new Conscience and Religious Freedom Division was established to correct this imbalance, by giving conscience and religious freedom claims the focused attention they deserve. As a result of this attention, the number of open conscience complaints now exceeds 130 and open religious discrimination complaints number over 800. We are dedicated to continuing to vigorously enforce our civil rights and health information privacy laws, and all our laws, in a fiscally responsible manner.

Question: Please detail how HHS is working to include safeguards to ensure that the proposed rule on "Conscience Rights" will not permit health care workers to refuse medical care and services to lesbian, gay, bisexual, and transgender individuals, couples, and their families.

Response: We are currently reviewing public comments on the proposed rule, and we cannot predetermine the outcome of the notice and comment rulemaking process. Preventing discrimination against the exercise of conscience and protecting religious freedom enhances diversity and gives patients more provider options from which to choose.

Representative Doggett

Question: On November 28, 2017, the Centers for Medicare and Medicaid Services (CMS) provided an analysis to a Request for Information on a proposed change to Medicare rebates. The proposal, also included in the budget, purports to lower the cost for some Medicare beneficiaries, but CMS estimated premiums will rise by as much as $44 per month for all beneficiaries if the changes to rebates are

implemented. This means an increase in prescription drug premiums for every Medicare Part D beneficiary rather than lowering the actual cost of prescription drugs. If implemented, this rebate change is also estimated to cost American taxpayers as much as $130 a month per Part D beneficiary.

How is the Administration implementing this plan to increase both consumer premiums and costs to taxpayers instead of holding pharmaceutical companies accountable for reducing prescription drug costs?

Response: In the proposed Parts C and D rule (CMS-4182-P), we included a Request for Information in which we discussed considerations related to and solicited comment on requiring sponsors to include at least a minimum percentage of manufacturer rebates and all pharmacy price concessions received for a covered Part D drug in the drug's negotiated price at the point of sale. Feedback received will be used for consideration in future rulemaking on this topic. The similar proposal included in the FY 2019 President's Budget is part of a larger package of legislative changes recommended for the Part D program. It is not recommended for implementation as a standalone proposal, but as a piece of a larger set of interdependent changes to the benefit structure that work together to achieve desired impacts.

Question: Following the expansion of the Medicaid mandatory rebate program to managed care enrollees, states collected $17.2 billion rebates in 2013 and the average per-person Medicaid drug spending was reduced from $1,509 in 2005 to $926 in 2013. These enormous savings have resulted in Medicaid spending an average estimate of 32% less per drug as compared to Medicare. The CBO has estimated that expanding the rebate program to low income subsidy enrollees in Medicare Part D would save $121 billion. Does the Administration support an expansion of the Medicaid mandatory rebate program?

Response: We support changes to Federal programs that will put patients in charge of their healthcare dollars and drug choices and changes that will result in lower drug costs.

Question: The Administration's budget offers a very narrow proposal to grant only 5 states the authority to limit their Medicaid formularies in a demonstration project. During your confirmation hearing before the Senate Finance Committee, you stated "The most important thing we have to figure out is, can we reverse the incentive on list prices? …Can we create incentives that actually pull down those list prices so that when the patients walks in needing to pay out of pocket at the pharmacy, that they're not hit with those kinds of costs?" In your statements for the record to the Senate Finance Committee, you reiterated "If I am confirmed as Secretary, one of the critical areas I plan to focus my efforts on is to lower drug prices… I believe that we need to institute policies that lower the list prices of drugs while also maintaining innovative new research and development." However, this budget does nothing to address list prices and instead proposes a very modest demonstration project.

Given your agreement that our first priority must be lowering list prices for prescription drugs, how does the Administration plan to do this? What are the goals of this narrow demonstration project and how will the demonstration lower list prices?

Response: As one part of an Administration-wide effort to address the high costs of prescription drugs and provide states more purchasing flexibility, the Budget proposes a new statutory demonstration authority that will allow up to five states to test a closed formulary under which they negotiate prices directly with manufacturers, rather than participating in the Medicaid Drug Rebate Program. I am happy to work with Congress regarding this legislation.

Question: *President Trump has repeatedly called for both a bidding procedure and drug importation to bring down the spiraling cost of prescription drugs. To date, the Administration has not taken any steps to enact either proposal. I ask that you answer the same questions that*

I posed to your predecessor, Tom Price. I have also provided his answers as an excellent example of avoiding a real answer and dodging the question. I ask that you provide direct responses to my questions below and confirm whether the Administration has abandoned the President's call for Medicare price negotiation and support for safe drug importation to encourage competition as a way of bringing down prices.

In a pre-inaugural press conference on January 11, and again in a speech in Louisville, KY on March 20, President Trump promoted "bidding" as a strategy for bringing down drug prices. He said that this was necessary because "the cost of medicine in this country is outrageous," and because the pharmaceutical industry is "getting away with murder."

Has the Administration rejected President Trump's approach on drug pricing reform? Does it support bidding or price negotiation for Medicare?

Secretary Price's Answer: *High drug prices and costs are an issue of major concern for HHS and for the American people. This includes the millions of seniors who rely on Medicare for their drug coverage, and the taxpayers who have to foot the bill for government spending on this program. As you know, the President has made prescription drug prices an absolute priority and has charged us with making recommendations to his office on reducing drug prices. My team has been meeting with stakeholder groups from across the healthcare spectrum over the past several months in order to understand where there are areas of consensus. It is important that we move forward quickly, but also carefully, so that our policies do not have unintended consequences. We need to balance the goal of ensuring affordability and access with the mandate to continue supporting development of lifesaving innovations.*

Response: One thing that President Trump and I have been clear about on drug pricing is that we consider this a serious issue, in need of serious solutions. Political gimmicks aren't going to do it, and that's what the concept of re-importation is: it's a gimmick. The Congressional Budget Office has assessed it multiple times and has said it would have no meaningful effect.

One of the main reasons is that Canada's drug market is simply too small to bring down prices here. They are a lovely neighbor to the north, but they're a small one. Canada simply doesn't have enough drugs to sell them to us for less money, and drug companies won't sell Canada or Europe more just to have them imported here.

On top of that, the last four FDA commissioners have said there is no effective way to ensure drugs coming from Canada really are coming from Canada, rather than being routed from, say, a counterfeit factory in China. The United States has the safest regulatory system in the world. The last thing we need is open borders for unsafe drugs in search of savings that cannot be safely achieved.

As for Medicare negotiation of drug prices, I want to be clear about this: Medicare does negotiate for drug prices, and pretty successfully, through private Part D plans. The President believes strongly in tough negotiation from Medicare, and that's why such a big piece of our plan is strengthening negotiation where it already exists in Medicare, Part D, and bringing it to where we don't currently negotiate, in Part B.

There are calls for a different approach, where Medicare would directly negotiate with drug companies. This is a political gimmick, and we need serious solutions, not political gimmicks. The Congressional Budget Office and the Office of Management and Budget have assessed the idea of direct negotiation, and found that savings would be negligible.

The only way that serious savings would be generated from direct negotiation is if we are willing to exclude coverage of certain drugs from Medicare entirely, or set prices by government fiat. Both of these ideas are the kinds of policies that have given socialized healthcare systems in Europe such a poor reputation for quality and access. Americans should know this: President Trump believes in negotiating for drugs in a way that preserves our seniors' access and choice. Those saying we need to go further and engage in direct negotiation are calling for rationing and price-setting.

Does it support drug importation, which President Trump also previously endorsed?

Secretary Price's Answer: *I share the President's concerns about the cost of prescription drugs and the need to ensure that Americans have access to medical products. As Congress pursues various policy options to address drug pricing, issues related to product safety, effectiveness, and quality should be considered. Policies must ensure that individuals are not receiving drugs that are contaminated, counterfeit, or contain varying amounts of active ingredients.*

Response: Many people may be familiar with proposals to give our seniors access to cheaper drugs by importing drugs from other countries, such as Canada. This, too, is a gimmick. It has been assessed multiple times by the Congressional Budget Office, and CBO has said it would have no meaningful effect.

Question: Substantial evidence continues to mount on the role pharmaceutical companies played in contributing to the opioid crisis. President Trump's own Commission on Combatting Drug Addiction and the Opioid Crisis found the pharmaceutical industry "embrace[d] and exploit[ed] the flawed claims [that opioid narcotics are safe to use universally for chronic pain] with aggressive marketing and 'educational outreach.'" Forty-one State Attorneys General are investigating the marketing practices of pharmaceutical companies and their aggressive promotion with misleading information on the risks and addictive qualities of opioids. Hundreds of cities, counties, and states have brought legal action against manufacturers for their role in the crisis.

On February 27th, Attorney General Sessions announced the Department of Justice is coordinating with the Department of Health and Human Services to explore legal remedies. Taxpayers have made significant investments in treating the opioid crisis. Medicaid covers nearly 4 out of 10 nonelderly adults with an opioid use disorder. Additionally, in 2013, Medicaid spent $9.4 billion for care for individuals with an opioid use disorder.

Has the Department of Health and Human Services investigated the role of pharmaceutical companies in the opioid epidemic? If so, what are the results of the investigation? Do you agree that pharmaceutical companies contributed greatly to the opioid crisis?

Response: The issue of opioid misuse and abuse remains one of my highest priorities. I believe it will take carefully developed, sustained, and coordinated action by everyone involved, including the pharmaceutical industry, to adequately address the addiction and death afflicting our communities. At the Department, we are focused on a five-point strategy to begin to stem the tide of the opioid epidemic. Just as many factors contributed to this crisis, no one solution will solve it. We are intent on addressing prevention, treatment, and recovery as part of our strategy, and the Budget makes a significant investment in addressing the crisis by allocating $10 billion to address opioid abuse and serious mental illness.

Question: Section 517 of the Labor, Health and Human Services, Education, and Related Agencies Appropriations bill requires you, as Secretary, to submit a report on the amount of contracts, grants, and cooperative agreements in excess of $500,000 awarded by the Department, on a quarterly

basis, which are awarded non-competitively. This report is to include the names of the awardee, amount awarded, purpose, and justification for the noncompete award. The Department has failed to provide any such reports during the Trump Administration.

Going forward, will you commit to providing this information in a timely manner to Congress, as required by law? Please provide all of the previous reports required through the date of your answer.

Response: The Department of Health and Human Services works to meet all reporting requirements required by law and, furthermore, commits to providing the report on non-competitively awarded grants, contracts, and cooperative agreements in excess of $500,000 in a timely fashion to the Congress. Please find attached the report for FY2017 and we will provide the FY2018 Q1 report shortly. The FY2018 Q2 timeframe closes on March 31, 2018, and the Department will submit the report to the Congress within the 30 day time period provided to complete the report. From this point forward all future reports will be submitted on time.

Representative Larson

Question: To date, why has the FDA failed to publish a solicitation of public comments in the Federal Register when the agency indicated in June of 2017 that comments solicitation would occur that summer?

Response: I am pleased to inform you that, on March 9, 2018, FDA published a Federal Register notice soliciting public comments on a proposed determination that the European Union (EU) food safety control system for raw bivalve molluscan shellfish intended for export to the U.S. is equivalent to the U.S.

Question: When does the FDA now expect to issue a Federal Register publication to solicit public comments?

Response: As noted above, on March 9, 2018, FDA published a Federal Register notice soliciting comments on a proposed determination that the EU food safety control system for raw bivalve molluscan shellfish intended for export to the U.S. is equivalent to the U.S. The comment period closes on May 23, 2018.

Question: If the FDA does not anticipate publication in the Federal Register soon, what is the explanation for the continued delay?

Response: See above answers.

Question: Following publication of the solicitation of public comment in the Federal Register, what steps does the FDA intend to take to finalize equivalence determinations in order to resume access to the EU market for US shellfish growers?

Response: I recognize the impact that the trade restrictions have had on U.S. shellfish growers, and FDA has been actively working to move the equivalence determination process forward. The publication of the Federal Register notice was a critical step to enable the resumption of U.S. shellfish exports to the EU. Several steps remain to resume trade. First, the administrative procedure to finalize the FDA equivalence determination must be completed, including consideration of comments received on the Federal Register notice. For the European Commission, the process involves submitting an equivalence determination to the EU Council for consideration and adding the U.S. to the list of approved countries from which shellfish can be imported. The

FDA and European Commission will need to implement operational details associated with a resumption of shellfish shipments.

Once the EU process is complete, raw and processed molluscan shellfish harvested in the U.S. from approved growing areas in Massachusetts and Washington State would be eligible for export to the EU. The FDA and the European Commission have also worked out a process for additional U.S. states to be added to the list of states approved for export of molluscan shellfish to the EU, which is described in FDA's "Supplementing Information on International and Interagency Coordination/International Cooperation/Equivalence" webpage.

Representative Pascrell

Question: This budget proposes a 26 percent reduction to programs that serve newly arrived refugees, asylees, and Special Immigrant Visa recipients. Now is not the time to abandon America's commitment to the world's most vulnerable. Refugee resettlement has a bipartisan history reflecting long-held American values. Reduced funding would take away refugees' access to fundamental services like language instruction and job training, which enable them to contribute to their local economies. This budget would also chip away the federal support to states and localities that receive refugees.

Secretary Azar, without this federal investment, how can states be expected to provide basic supports for people who have fled violence and persecution to legally enter this country?

Response: HHS remains committed to serving refugees. The President has lowered the ceiling for refugee admissions, so the number of refugee arrivals is decreasing and with it, the resources needed to support them. Given the challenging budget environment, we try to target our resources as efficiently as possible. HHS distributes Federal funding to those states most impacted by new arrivals. We also provide opportunities for states to implement funding in a manner that best meets the state's needs. Additionally, we encourage states and localities to form private partnerships that leverage existing resources in their communities and have been proven to help refugees successfully transition to their new lives in the United States.

Question: We all agree that the opioid epidemic is a national crisis. It's ripping families apart, pulling people out of the workforce, and killing tens of thousands of our neighbors each year. In my State of New Jersey, nearly 2,000 people died of opioid overdoses last year alone. Experts estimate that 220 billion dollars is needed to cover those needing substance use disorder treatment. And that's with the help of the Medicaid program, which is the largest payer for substance abuse treatment.

This budget would effectively gut Medicaid by 1.4 trillion dollars, while at the same time only providing 10 billion dollars of additional funding to cover opioid abuse and mental health services.

Secretary Azar, how does the administration intend to rectify the discrepancy between what's needed to curb the opioid crisis and what's allocated under this budget?

Response: The Budget makes a substantial investment in addressing the opioid crisis. It targets the funding to help HHS address all five points of our strategy, including improving access to treatment and recovery services. The Budget proposes $1 billion for the State Targeted Response to the Opioid Crisis program. This will allow states, like New Jersey, to develop their own targeted approaches to prevention, treatment, and recovery support. In addition, community health centers will receive an additional $400 million to help address substance abuse, including opioid abuse, and the overdose crisis.

Question: In the hearing, I asked about the administration's cuts to domestic HIV/AIDS programs, and specifically the Ryan White program. Secretary Azar said he was not aware of those cuts because he was still reviewing the budget. I would like a response outlining the rationale behind those cuts.

Response: The FY 2019 Budget prioritizes programs that provide direct healthcare services. While the overall proposed budget for the Ryan White HIV/AIDS Program (RWHAP) shows a decrease, the Budget maintains funding for the RWHAP Parts A, B, C, D and F Dental, which support direct healthcare services for patients. The RWHAP Special Projects of National Significance and the AIDS Education and Training Centers do not provide direct services. As a result, the FY 2019 Budget eliminates funding for these two programs.

Representative Crowley

Question: President Trump's proposed budget would reform federal funding for graduate medical education (GME) by consolidating all GME spending from Medicare, Medicaid, and the Children's Hospitals GME program into one grant program. The program would use Fiscal Year 2016 spending levels as the base year for funding and grow that amount each year by the Consumer Price Index (CPI-U) minus one percent. This change would effectively create a GME block grant that would cut GME programs across the country by $48 billion over the next decade. By 2030, the U.S. will confront a physician shortage as high as 104,900 physicians, nearly 40 percent of which represent primary care doctors. Given the number of years it takes to train one physician, it is critical for the U.S. to take swift action and address this impending physician supply crisis.

How does President Trump's proposal to reform and cut federal GME funding address the impending physician shortage? What is the structural need to change the federal financing of GME to a single grant program? Why does President Trump's proposed budget cut federal GME funding by $48 billion over 10 years?

Response: The Budget proposes to better focus Federal spending on GME by consolidating spending that is currently in the Medicare, Medicaid, and Children's Hospital GME Payment Program into a new capped Federal grant program. In an effort to improve the distribution of specialties in healthcare, to address healthcare professional shortage areas, and to incentive better training of professionals, funding would be distributed to hospitals that are committed to building a strong medical workforce and would be targeted to address medically underserved communities and health professional shortages.

The Health Resources and Services Administration and the Centers for Medicare & Medicaid Services would jointly determine program requirements and the formula for distribution. Payments would be distributed to hospitals based on the number of residents at a hospital (up to its existing cap) and the portion of the hospital's inpatient days accounted for by Medicare and Medicaid patients. Funding for this consolidated, single grant program for teaching hospitals would be equal to the sum of Medicare and Medicaid's 2016 payments for graduate medical education, plus 2016 spending on children's hospitals graduate medical education, adjusted for inflation. Funding would increase at a rate of inflation minus 1 percentage point each year. This grant program would be funded out of the General Fund of the Treasury.

In addition, the National Health Service Corps (NHSC) and Teaching Health Center GME (THCGME) programs will continue to address health professions shortages The NHSC serves as a vitally important recruitment tool for community health centers and other healthcare entities nation-wide operating in underserved areas where shortages of healthcare professionals exist. In FY 2017, the NHSC had over 2,000 physicians providing healthcare services in NHSC-approved

sites. The THCGME program supports primary care medical and dental residency programs in community-based ambulatory patient care settings. In Academic Year 2017-2018, the THCGME program supports the training of 732 residents in 57 primary care residency programs.

Question: The Balanced Budget Act of 1997 limited the number of resident physicians that can be counted toward a hospital's Medicare indirect medical education (IME) and direct graduate medical education (DGME) reimbursement. Arguably, this twenty-year-old cap is outdated and unrepresentative of the shift in national population demographics.

Do you believe these caps must be lifted to confront the looming physician shortage? If lifting the caps is not a priority for addressing the physician shortage, then what are your specific proposals to increase the national supply of physicians?

Response: As you are aware, the President's Budget consolidates Federal graduate medical education spending from Medicare, Medicaid, and the Children's Hospitals Graduate Medical Education Payment Program into a single grant program for teaching hospitals. Total funds available for distribution in FY 2019 would equal the sum of Medicare and Medicaid's 2016 payments for graduate medical education, plus 2016 spending on the Children's Hospitals Graduate Medical Education Payment Program, adjusted for inflation. This amount would then grow at the Consumer Price Index for all Urban Consumers minus one percentage point each year. Payments would be distributed to hospitals based on the number of residents at a hospital (up to its existing cap) and the portion of the hospital's inpatient days accounted for by Medicare and Medicaid patients. The new grant program would be jointly operated by the Administrators of CMS and the Health Resources and Services Administration. This grant program would be funded out of the general fund of the Treasury. The Secretary would have authority to modify the amounts distributed based on the proportion of residents training in priority specialties or programs (e.g., primary care, geriatrics) and based on other criteria identified by the Secretary, including addressing healthcare professional shortages and educational priorities. The President's Budget makes our new GME payments system accountable by allocating GME resources to those programs and institutions which deliver better quality and meet high education standards. By rewarding quality outcomes and stressing accountability in the system, resources can be better allocated to address the physician shortage and prepare the next generation of physicians.

Question: In your statements for the record to the Senate Finance Committee during your confirmation process, you stated, "I believe that we need to institute policies that lower the list prices of drugs while also maintaining innovative new research and development." Is President Trump's budget reflective of these policies to lower the list price of prescription drugs? If so, what are these specific policy proposals? If not, what are your plans to institute policies that lower the list price of drugs from your position at HHS? If they require Congressional action, will you work with Congress to enact these policies into law?

Response: The prices Americans pay for prescription drugs are too high. The President's Fiscal Year 2019 Budget proposes a range of legislative measures to build on the proven success of the Medicare Part D prescription drug program, including through giving drug plans more tools to negotiate with manufacturers and encourage use of higher value drugs. In addition, the Budget discourages rebate and pricing strategies that increase spending for both beneficiaries and the Government and, for the first time in the program's history, provides beneficiaries with more predictable annual drug expenses through the creation of a new out-of-pocket spending cap for seniors with especially high drug costs.

Representative Higgins

Question: I was pleased that the Bipartisan Budget Act of 2018 included a provision to extend the transitional payment rules for certain radiation therapy services through calendar year 2019. Does HHS anticipate the release of a Request for Applications for an episodic alternative payment model (APM) as a follow up to the "Report to Congress: Episodic Alternative Payment Model for Radiation Therapy Services submitted in November 2017" to be released during calendar year 2018?

Response: The CMS Innovation Center studied the cost, utilization, and quality of cancer treatment with radiation therapy; consulted with radiation therapy stakeholders; and considered design elements to develop the Report to Congress on an episodic APM for radiation therapy. This Report to Congress addresses each of these topics while exploring key design elements for a radiation therapy services episodic APM.

The Report presents a series of important considerations that are critical to effective model design. CMS will consider these issues before moving forward with any future episode payment model on radiation therapy services. In addition, CMS would also continue to seek input from stakeholders on these important issues.

Question: Last fall, Centers for Medicare & Medicaid Services (CMS) Administrator Seema Verma announced the Meaningful Measures Initiative, which intends to focus data collection on outcome-based measures addressing the highest priorities for quality measurement for patients and their families. Patient-reported outcomes (PROs) data has been shown to provide information that is most meaningful to patients when evaluating quality of care—such as functional status and quality of life after treatment. Will you commit as Secretary to working with organizations that are willing and able to incorporate this important data into quality reporting programs?

Response: CMS will continue to find ways to reduce burden on providers while empowering patients along the way. By identifying the highest priorities for quality measurement and improvement, the Meaningful Measures initiative provides a framework for core issues that are most vital to improving patient outcomes. In support of "Patients over Paperwork", this framework will guide CMS in the reduction of reporting burden on providers while focusing quality improvement efforts on the most critical areas through the adoption of the most meaningful quality measures to drive better patient outcomes at lower costs. HHS and CMS are committed to working with clinicians and other stakeholders to ensure that we are measuring quality without increasing burden.

Question: The President's proposed budget includes a historic reduction in graduate medical education (GME) funds. The budget proposal would consolidate GME spending from Medicare, Medicaid, and the Children's Hospital GME (CHGME) program into a single grant program. The available funding would be based on FY 2016 spending levels and adjusted each year by the Consumer Price Index (CPI-U) minus one percent. According to the budget, the consolidation and use of FY 2016 as a base year would cut GME funding by a staggering $48 billion over the next 10 years. New York has built a premier infrastructure for training doctors, and because of that, our residency program graduates practice all over the country after completing their training. More than a third of states have at least 10% of their active physicians trained by New York institutions. If funding is reduced, New York's premier teaching hospitals may start to reduce the number of physicians they train. Moreover, the Association of American Medical Colleges estimates that the nation faces a shortage of between 40,800 to 104,900 physicians by 2030. The Health Resources Services Administration has similarly issued reports regarding an impending shortage of physicians. The President's budget GME proposals would cause enormous harm to the future physician supply in this country if enacted. The stability of our teaching hospitals and the pipeline of physicians are too important to put them at such risk. Given these concerns,

can you describe how you expect teaching hospitals to absorb these cuts to GME funding and how you would propose we ensure that funding for doctor training is protected?

Response: The Budget proposes to better focus Federal spending on GME by consolidating spending that is currently in the Medicare, Medicaid, and Children's Hospital GME Payment Program into a new capped Federal grant program. In an effort to improve the distribution of specialties in healthcare, to address healthcare professional shortage areas, and to incentive better training of professionals, funding would be distributed to hospitals that are committed to building a strong medical workforce and would be targeted to address medically underserved communities and health professional shortages. Funding would increase at a rate of inflation minus 1 percentage point each year.

Question: I appreciate the work done by the Department to marshal efforts to combat the opioid epidemic wreaking havoc on our nation. As you pursue your strategies for expanding access and treatment, what more can be done within the Administration to improve prevention strategies through non-opioid pain management therapies. Promising research is taking place both in the public and private sectors on how we can limit the need for opioid use through these alternatives, and our coordinated multi-faceted strategy to end the epidemic must include efforts to both facilitate and advance the work currently being done. There are exciting therapies in development that, with the right marketplace incentives, could fill the gap in providing for patients with pain who need therapeutic solutions beyond traditional—and often highly addictive—opioid-based solutions. Beyond development, there will also be reimbursement and access challenges arising once new therapies become available. Could you please describe how you intend to support progress in this promising new field?

Response: At HHS, we recognize that improving pain management is key to reducing our reliance on prescription opioids, and that evidence is needed to support best treatment practices. In recognition of the urgency to address the opioid epidemic and the chronic pain crisis, the NIH recently launched a public-private initiative beginning with a series of workshops in June and July 2017. The first workshop focused on development of medications for opioid use disorder and overdose prevention and reversal. The second workshop focused on development of safe, effective, and non-addictive pain treatments. The third workshop focused on understanding the neurobiological mechanisms of pain with the goal of developing novel pain treatments. A set of action items to move the research agenda forward were released and are being developed as research strategies. The Administration has demonstrated its commitment to this research by providing $500 million to NIH for a public-private partnership to accelerate the development of safe, non-addictive, and effective strategies to prevent and treat pain, opioid misuse, and overdose.

Representative Sewell

Question: Under current law, “frontier” states are recognized for special Medicare payment considerations. I understand that frontier considerations are necessary due to the low population in these states, which include MT, NV, ND, SD, and WY, with special provisions for AK. While population density is an important factor in determining payment policies that address access issues, socioeconomic factors should not be left out of the equation. According to Census data, my home state of Alabama has a lower median household income and per capita income than all of the “frontier states” with special Medicare payment considerations. Would you consider supporting legislation or implementing guidance that provides more assistance to states like Alabama that are not be among the least densely populated states but have socioeconomic factors that contribute to poor outcomes and an overall unstable healthcare infrastructure?

Response: I understand the challenges some states face with regard to the statutory structure of the Medicare payment provisions. I am happy to work with your office to learn more about this issue.

Question: We have consistently asked rural hospitals to do less with more. As a result, 83 rural hospitals have closed since 2010 across the country and five in my home state of Alabama. Of the rural hospital closures since 2010, 76 percent have been in states that haven't expanded Medicaid. I am concerned with the fact that this Administration would want to double down on the policies and inadequate reimbursements that have led to this crisis. The President's budget contains deep cuts to Medicaid and ends Medicaid expansion nationwide. Can you provide to the Committee evidence that demonstrates that residents of non-expansion states are healthier than those in states that expanded Medicaid? Can you include data on premium increases in expansion states in comparison to those that did not expand Medicaid? Can you provide coverage tables showing the impact of the President's budget proposals on Medicaid in terms of individuals covered over the ten year window (by category – 65 and older, blind and disabled, children, adults)?

Response: Department staff would be happy to discuss the particulars of this data request and share the existing public data we have for the Medicaid program. I am happy to provide data which further demonstrates the need to reform a program to better target resources for our most needy citizens. The FY 2019 Budget provides additional flexibilities to states, puts Medicaid on a path to fiscal stability by restructuring Medicaid financing, and refocuses on the populations Medicaid was intended to serve—the elderly, people with disabilities, children, and pregnant women. Annual Federal Medicaid spending will grow from $421 billion in FY19 to $702 billion in FY28 over the budget window.

The FY 2019 Budget also repeals the Medicaid expansion and the Exchange subsidies and replaces these programs with the $1.2 trillion Market-Based Health Care Grant program through the Graham-Cassidy-Heller-Johnson legislation.

Question: Since I come from a state that has a Medicaid program with some of the strictest eligibility requirements and covers among the least amount of services in the country, I am skeptical that restricting the program nationally will improve health outcomes and our economy.
With a 70 percent FMAP, I have concerns that plans to cut Medicaid will only further exacerbate negative health outcomes in Alabama. In Alabama, I haven't identified a correlation between a strict Medicaid program and better economic or health outcomes.

The President's budget would only exacerbate troubling trends for our rural hospitals with an $80 million cut to rural health programs, including cuts to the State and Federal Offices of Rural Health Policy, changes to the 340B Drug Pricing Program, telehealth, the Rural Hospital Outreach Grant program, and others. It includes a cut of $532 billion to Medicare, including more than $200 billion in cuts to hospitals. And it cuts $1.4 trillion from the Medicaid program.

If the President's budget were implemented, does the agency have plans in place to shield rural hospitals from the cuts proposed in the budget? Secretary Azar, can you provide the committee with analysis showing how much each hospital in the country would lose under the proposed budget? Do you have data by state? Do you have dollar estimates by state over the budget window?

Response: I share your concerns about preserving access to care in rural communities. Last year, CMS launched a program called Patients Over Paperwork, which was a collaborative process that is evaluating ways in which our regulations or practices were impeding physicians or providers, which we know is particularly important to rural providers.

CMS also provided relief to rural hospitals by reinstating the non-enforcement of the direct supervision requirements for outpatient therapeutic services for our Critical Access Hospitals, and small rural hospitals having 100 or fewer beds for calendar years 2018 and 2019. I look forward to working with you on that and other initiatives to help our rural providers be sustainable and deliver service.

Question: If implemented, the reintroduction of Graham-Cassidy in the President's budget would dramatically reduce the reimbursement funding available to state Medicaid programs and the coverage for children, who are the cheapest Medicaid recipients. Nationally the Medicaid program eligible are 60% children who consume less than 25% of the Medicaid spending.

Do you expect those providers to be able to continue serving children to do so when even the current reimbursement is well below the cost of care?

To be clear, the enormous cuts to rural hospitals, rural health care providers, Medicaid, and Medicare far outweigh any benefits that could be seen from the red tape the proposed budget seeks to cut.

Response: The Budget's Medicaid proposal is modeled after the Graham-Cassidy-Heller-Johnson bill, which includes a modernization of Medicaid financing and repeal of Obamacare's Medicaid expansion. Medicaid financing reform will empower states to design individual, state-based solutions that prioritize Medicaid dollars for traditional Medicaid populations and support innovations like community engagement initiatives for able-bodied adults. Additionally, the Market-Based Health Care Grant Program included in the Graham-Cassidy-Heller-Johnson legislation will provide more equitable and sustainable funding to states to develop affordable healthcare options for their citizens. The block grant program will empower states to improve the functioning of their own healthcare market through greater choice and competition, with states and consumers in charge. By putting states back in charge of their Medicaid dollars and decisions, they will be able to better target resources to the most needy citizens and healthcare providers. With greater ownership over healthcare dollars via a block grant or per capita cap, states will be encouraged to find efficiencies since a dollar in savings will be a dollar returned to the states, whereas the current structure does not provide as robust an incentive for states to create efficiencies.

Question: Secretary Azar, there is a hospital in my district that has been struggling for years to provide basic services and pay their staff. I have been working with CMS to find solutions for this hospital and those in surrounding counties for years. This particular hospital has an inpatient payer mix of almost 93% Medicaid, Medicare, and uninsured. Their outpatient payer mix is almost 80% Medicaid, Medicare, and uninsured.

This hospital and the one in the neighboring county have been diverting patients at times because they struggle to recruit and maintain physicians. This has put the hospital in jeopardy of losing their Medicare and Medicaid reimbursements due to possible EMTALA violations for diverting patients during doctor shortages. This is like trying to pick apples from a tree that's been deprived of sunlight and water and blaming the tree for its inability to bear fruit.

Newly trained physicians aren't flocking to rural Alabama counties like the ones I represent. The President's proposed $48 billion cut to graduate medical education payments would undermine federal support that already doesn't adequately cover the costs associated with training future providers. How would the proposed GME changes in the budget address the known pediatric physician workforce shortages? What about the rural primary care physician shortage?

Response: The Budget proposes to better focus Federal spending on GME by consolidating spending that is currently in the Medicare, Medicaid, and Children's Hospital GME Payment Program into a new capped Federal grant program. In an effort to improve the distribution of specialties in healthcare, to address healthcare professional shortage areas, and to incentive better training of professionals, funding would be distributed to hospitals that are committed to building a strong medical workforce and would be targeted to address medically underserved communities and health professional shortages. Children's hospitals would remain eligible for funding.

In addition, the National Health Service Corps (NHSC) and Teaching Health Center GME (THCGME) programs will continue to address health professions shortages. Specifically, NHSC serves as a vitally important recruitment tool for community health centers and other healthcare entities nation-wide operating in underserved areas where shortages of healthcare professionals exist. In FY 2017, the NHSC had over 490 pediatricians, pediatric dentist, and pediatric nurse practitioners and physician assistants providing healthcare services in NHSC approved sites. Roughly one-third (34 percent) of NHSC clinicians are serving at rural sites as of September 30, 2017 and 20 percent are primary care physicians. In addition, the THCGME program supports primary care medical and dental residency programs in community-based ambulatory patient care settings. In Academic Year 2017-2018, the THCGME program supports the training of 732 residents in 57 primary care residency programs. Three of the 57 THCs are pediatric residencies and 12 THCs are located in rural communities.

Question: Secretary Azar, I, along with Senator Shelby, previously Senator Strange, and now Senator Jones, have been working to secure a Critical Access Hospital Designation in Sumter County, Alabama. The current hospital there, Hill Hospital, has a wage index of .68 and has had such a doctor shortage in recent years that the hospital has been diverting patients from the Emergency Room when physicians don't come to work. They struggle to make payroll each month and the citizens of the county have just approved a sales tax increase, to help improve health care services in the county. They already pay more than 10 cents in sales tax. A Critical Access Designation would be a desirable outcome because it would bring the hospital's reimbursement for services provided to Medicare patients at 101 percent of reasonable costs.

My colleague Rep. Adrian Smith mentioned that he has 55 Critical Access Hospitals in his district alone during our March 14th hearing. I understand that Nebraska is a much larger state than Alabama. There are only four in all of Alabama. CMS is denying a designation for us in Sumter County due to the 35-mileage requirement. In previous years, however, CMS has provided waivers to hospitals to be designated as Critical Access despite being closer than 35 miles to the nearest hospital. In 2007, CMS issued guidance allowing hospitals to be eligible for a 15-mile standard due to mountainous terrain or lack of primary roads. In Rep. Adrian Smith's district, I understand that there are some hospitals that are fewer than 15 miles from one another. But I also understand that there hasn't been a CAH designated in Nebraska since 2005. Nebraska has only had one rural hospital closure since 2010, whereas Alabama has had five.

We have had an increasingly difficult time securing this designation. Can you explain, in as much detail as possible, why Region 4 is not approving Critical Access Designations at the same rate as other regions? If CMS policy has changed over the past decade regarding new designations and this isn't a regional issue, can you explain in detail to the committee what those administrative changes have been?

Response: My understanding is that CMS policy has not changed over the past decade, rather, the underlying statute that authorizes payment for CAHs has a strict mileage criterion. A CAH must be located more than a 35-mile drive from any other hospital or CAH (in mountainous terrain or in areas with only secondary roads available, the mileage criterion is 15 miles); or is certified by the

State in the State plan as being a necessary provider of healthcare services to residents in the area. I'm happy to have my staff reach out to review these issues with you.

Question: There are serious physician shortages in pediatric healthcare. The Children's Hospitals Graduate Education Program was created in 1999 by a bipartisan Congress to provide funding for the 50 or more freestanding children's hospitals who are ineligible for Medicare dollars as their patients are not of Medicare age. This group of hospitals serves predominantly Medicaid patients. The two children's hospitals in Alabama are program participants, currently training above the 1996 established residency caps, and Medicaid patient comprises more than 60% of their patient population.

The President's budget targets two big programs vital to their ability to serve all of Alabama's children, train pediatric physicians and health professionals, and be vehicles for research to improve care and reduce costs. The President's budget indicates that under the proposal "funding will be distributed to hospitals that are committed to building a strong medical workforce." Do you have evidence of specific hospitals today that are receiving GME funding to train physicians who are not "committed to building a strong medical workforce? If so, can you provide the committee with that information?

Response: As you are aware, the President's Budget consolidates Federal graduate medical education spending from Medicare, Medicaid, and the Children's Hospitals Graduate Medical Education Payment Program into a single grant program for teaching hospitals. Total funds available for distribution in FY 2019 would equal the sum of Medicare and Medicaid's 2016 payments for graduate medical education, plus 2016 spending on Children's Hospitals Graduate Medical Education Payment Program, adjusted for inflation. This amount would then grow at the Consumer Price Index for all Urban Consumers minus one percentage point each year. Payments would be distributed to hospitals based on the number of residents at a hospital (up to its existing cap) and the portion of the hospital's inpatient days accounted for by Medicare and Medicaid patients. The new grant program would be jointly operated by the Administrators of CMS and the Health Resources and Services Administration. This grant program would be funded out of the general fund of the Treasury. The Secretary would have authority to modify the amounts distributed based on the proportion of residents training in priority specialties or programs (e.g., primary care, geriatrics) and based on other criteria identified by the Secretary, including addressing healthcare professional shortages and educational priorities. Under this Administration's proposal, funding would be allocated to the greatest areas of need and based on sound data and evidence with the intent of improving health outcomes. For example, the Budget is responsive to MedPAC and others' recommendations to modernize Medicare's GME payments by increasing transparency and accountability and targeting resources to those programs which improve the value of our healthcare delivery system.

Question: Research suggests that increasing the percent of women who breastfeed exclusively for 6 months or more would save billions of dollars in economic losses, including foregone medical costs and loss of wages. Despite the requirement under HHS's Women's Preventive Services Initiative (WPSI) that comprehensive lactation support services be covered with no cost-sharing as a preventive service for all women during the antenatal, perinatal, and postpartum periods, many women still do not have sufficient access to lactation services, support, and supplies through their health insurance providers.

Secretary Azar, does your agency have plans to build upon some of the advancements made in recent years to improving access to breastfeeding supplies and services and lactation support?
Will you work with the insurance industry to provide women with a) lactation services with no cost-sharing and b) counseling, education, and breastfeeding equipment and supplies?

Response: As you know, over the past few years, HHS, together with the Departments of Labor and the Treasury, have worked to implement section 2713 of the PHS Act, including clarifying the obligations of health insurance issuers and group health plans to cover, without cost-sharing, certain recommended preventive services such breastfeeding services and supplies. We will continue to work collaboratively with health insurance issuers and other stakeholders to answer questions and help people understand the laws and benefit from them, as intended.

Representative DelBene

Question: In January, I met with a Planned Parenthood center in my district that was using Teen Pregnancy Prevention grants to educate teens on topics such as HIV/AIDS, harassment prevention, healthy relationships, delaying sex, and family communication. I was incredibly impressed by the work they are doing and I am confused as to why this administration wants to zero out Teen Pregnancy Prevention grants that are helping our kids' lead healthier, safer lives.

If that isn't bad enough, the administration, in what seems like an effort to take with one hand and then take again with the other, proposes to change the Maternal, Infant, and Early Childhood Home visiting program, which has been demonstrated to improve child and maternal health, from guaranteed funding and subject the program to the annual appropriations. It seems the only reason to do this would be to have the opportunity to make cuts to this critical program.

How does cutting the Teen Pregnancy Prevention Program and home visits for infants and their mothers support child and maternal health?

Response: We all share a commitment and desire to decrease unintended teen pregnancies. We take that commitment seriously, and as such, the Department is making sure that is done so through effective programs. The Teen Pregnancy Prevention (TPP) program serves less than one percent of teenagers in the United States. Though the teenage pregnancy rate has declined significantly, TPP has not been a major driver in that reduction. With respect to the TPPprogram, I understand that an evaluation of a number of TPP projects published in 2016 on the HHS website showed that many were ineffective and that few showed sustained positive results. The FY 2019 Budget includes $400 million in discretionary resources for the Maternal, Infant, and Early Childhood Home Visiting program. This funding will improve access for at-risk families to voluntary, evidence-based home visiting services where nurses, social workers, and other professionals provide support for their children's health, development, and ability to learn.

Question: Kidney disease education (KDE) teaches ESRD patients how to take the best possible care of their kidneys and gives them the information needed to make informed decisions about their care. KDE patients learn how manage their health conditions, how their medications work and about their treatment options. This is all covered by Medicare. Yet, according to the United States Renal Data System, in 2011 and 2012, less than 2% of eligible Medicare beneficiaries used the benefit. And, according to MedPAC, Medicare paid for KDE for about 4200 patients in both 2011 and 2012, but that number fell to only 3600 patients in 2013.

In 2015 the Government Accountability Office recommended that CMS examine the utilization of the KDE, and if appropriate seek legislation to revise the current benefit. This is because the uptake of KDE is low and continues to fall. How would you propose to increase KDE?

Response: Medicare covers a variety of different chronic kidney disease services, but I recognize that CMS needs to take additional steps to support the coordination of care within and around these services, including kidney disease education.

Medicare Part B covers up to six sessions of kidney disease education for beneficiaries with Stage IV chronic kidney disease to help delay the need for a kidney transplant or dialysis and prevent kidney disease complications. Kidney disease education teaches beneficiaries how to take the best possible care of their kidneys and gives the information they need to make informed decisions about their care. We include information for both providers and beneficiaries about these valuable services in the Medicare & You handbook, on Medicare.gov and CMS.gov, including a link to the National Kidney Disease Education Program.

We agree that these are important services and will work to continue to inform beneficiaries and providers of the availability of these services.

PUBLIC SUBMISSIONS FOR THE RECORD

TESTIMONY OF

PHYSICIANS COMMITTEE FOR RESPONSIBLE MEDICINE

BEFORE THE
HOUSE COMMITTEE ON WAYS AND MEANS

ON

THE DEPARTMENT OF HEALTH AND HUMAN SERVICES' FISCAL YEAR 2019
BUDGET REQUEST

FEBRUARY 14, 2018

PhysiciansCommittee
for Responsible Medicine
PCRM.ORG
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The Physicians Committee for Responsible Medicine, a nonprofit organization based in Washington DC working to advance medical research with the support of over 12,000 physicians and more than 175,000 members, strongly supports the National Institutes of Health (NIH) commitment to seek knowledge to enhance human health. As the House Committee on Ways and Means discusses the Department of Health and Human Services' Fiscal Year 2019 budget, we urge the Committee to consider shifting the allocation of NIH's funding toward human-based research and away from animal-based research to better achieve this goal.

The FY19 Budget emphasizes that the use of animals in research is intended to improve human health. However, a growing body of evidence suggests that using animals to model human disease, and the use of animals in the testing of medical products, rarely translates to human outcomes. In fact, the NIH states that approximately 95% of new medicines that appear safe in animal tests later fail in humans, and medicines that are found to be unsafe or ineffective in animals may not be so in humans. Further, the NIH has funded research that suggests the best investment for the future likely lies in human-based approaches, such as tissue chips, human induced pluripotent stem cells, and computational methods. To build on this scientific knowledge and improve the return on investment of research funding, it is crucial that NIH reallocates its budget to increase funding of human-based research to better ensure public health and safety.

The scientific and regulatory consensus is that for a more effective research and testing program, we need to move beyond animal experiments. Just last week, the National Toxicology Program Interagency Center for the Evaluation of Alternative Toxicological Methods (NICEATM) released *A Strategic Roadmap for Establishing New Approaches to Evaluate the Safety of Chemicals and Medical Products in the United States*.[1] The report provides steps it will take to engage regulatory agencies to ensure the development and use of nonanimal approaches to make regulatory decisions.

In December, the Food and Drug Administration released a Predictive Toxicology Roadmap[2] which aims to transform the development, qualification, and integration of new toxicology methods across FDA centers. The group will identify gaps in current test methods and determine where newer approaches—such as tissue chips and computer simulations—may be identified, further developed, scientifically evaluated, and implemented.

[1] https://ntp.niehs.nih.gov/iccvam/docs/roadmap/2018_01_04_roadmap-fd-508.pdf
[2] https://www.fda.gov/downloads/ScienceResearch/SpecialTopics/RegulatoryScience/UCM587831.pdf

Innovative, forward-thinking small businesses and academic labs across the nation are also developing fantastic new models of human disease: placenta-on-a-chip[3] and lung-on-a-chip[4] (or any other organ you can imagine), invasive tumor cells growing in an in vitro liver model to test drugs against metastasized cancers,[5] and mini-brain organoids[6] from patient cells which allow researchers to get a better understanding of neurological conditions such as autism or Alzheimer's disease.

But they need more support. Currently the preponderance of NIH extramural grant funding goes to research using animals. NIH must foster increases in innovation such that the majority of NIH extramural grant recipients are using next-generation human-based technologies rather than animals to bring us closer to the goal of personalized medicine.

The addendum to the FY19 budget, released with the budget, provides an additional $9.7 billion to be spent across NIH Centers and Institutes at the discretion of the Office of the Director. We urge you to ensure this money is spent rewarding and supporting innovation in the form of new computational and human-cell-based models instead of animal experiments.

As President Trump discussed in his State of the Union Address, reducing the cost of pharmaceuticals and making these essential products readily available to patients is a top priority. Our recommendation to fund more human-based research will inevitably address this mandate as well. Replacing animal experiments with human-based studies may produce more predictive models of disease and shorten the path to clinical trials by providing more human-relevant insights. By reducing the waste of costly animal experiments and their failures, the cost of developing new drugs will also drop for the benefit of all.

We appreciate your consideration of this testimony and would be happy to provide additional information in person or via email.

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[3] http://www.pcrm.org/research/research-news/placenta-on-a-chip-for-studying-pregnancies
[4] http://www.pcrm.org/research/research-news/human-lung-on-chip-model-reveals-how-breathing-regulates-lung-cancer
[5] http://www.pcrm.org/research/research-news/liver-drug-metabolism-device
[6] http://www.pcrm.org/research/research-news/miniature-brains-in-dish-offer-insight-into-brain-development

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February 28, 2018

The Honorable Kevin Brady
Chairman, Committee on Ways and Means
United States House of Representatives
Washington, DC 20510

The Honorable Richard Neal
Ranking Member, Committee on Ways and Means
United States House of Representatives
Washington, DC 20510

Dear Chairman Brady and Ranking Member Neal:

Prevent Blindness is the nation's leading nonprofit, voluntary organization committed to preventing blindness and preserving sight. Prevent Blindness represents millions of people of all ages across the country who live with low vision and vision-related eye diseases. We appreciate the opportunity to submit a Statement for the Record in response to the United States House of Representatives Committee on Ways and Means' February 14, 2018 hearing with United States Secretary of Health and Human Services (HHS) Alex Azar to consider the Fiscal Year 2019 HHS Budget Request. Specifically, we would like to outline to the Committee our concerns for the future of our nation's vision and eye health and ask for your support in developing policies that improve patient access to cost-effective, preventive care.

Our Nation's Vision and Eye Health

Eyesight is highly valued: it is central to an adult's employability, a child's success in school, and sustaining our independence as we age. **A recently released Robert Wood Johnson Foundation study ranks eye disorders as the 5th leading chronic condition among those aged 65 years and up and 7th across all age groups.** People with vision impairment are more likely to experience other chronic conditions, including diabetes, hearing impairment, heart problems, hypertension, joint symptoms, low back pain, and stroke as well as falls, injury, motor vehicle collisions, depression, social isolation, diminished health-related quality of life, and premature death. The financial impact of these problems is enormous, costing our country $145 billion in health care costs and lost productivity.

In our nation's children, vision impairments caused by refractive error, amblyopia, strabismus, and/or astigmatism are common conditions, affecting 5 to 10 percent of all preschoolers and nearly 1 in 4 school-aged children. If not detected and treated early, vision impairment could affect all aspects of life, negatively impacting a child's cognitive, motor, and social development, ability to learn, athletic performance, and self-esteem. Vision problems in children bring with them a tremendous long-term cost to our economy. Annually, the economic burden of eye conditions among the U.S. population younger than age 18 is $6.1 billion, and untreated amblyopia alone costs the U.S. nearly $7.4 billion in earning power.

Due to an aging population and shifting demographics, without significant planning and intervention, costs could rise to as much as $717 billion by the year 2050. We encourage the Committee's support of resources for existing adult vision programs at the Centers for Disease Control and Prevention (CDC), advanced eye health research at the National Eye Institute (NEI) with the National Institutes of Health (NIH), and specific pediatric eye health needs addressed through Maternal and Child Health Bureau at the Health Resources and Services Administration (HRSA) grants. It is imperative that we address the incoming tide of vision problems facing our nation.

NASEM Recommendations for Vision in Public Health

In September 2016, the National Academies of Sciences, Engineering, and Medicine (NASEM, formerly the Institutes of Medicine) issued a report, *Making Eye Health a Population Imperative: Vision for Tomorrow* highlighting the significance of our nation's increasing vision impairment problem and making recommendations to address it. A coordinated approach to interventions that support key stakeholders and state-based public health systems is needed to expand early detection, prevention, patient support, and research to lessen the burden of vision disorders on working adults and our nation's public health infrastructure.

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Specifically, the NASEM recommendations include:

1. Motivating nationwide action toward achieving a reduction in the burden of vision impairment across the United States
2. Coordinating a public awareness campaign to promote policies and practices that encourage lifelong eye and vision health, reduce vision impairment, and promote health equity.
3. Creating an interagency workgroup to develop grant programs that target the leading causes, consequences, and unmet needs of vision health and impairment.
4. Convening a panel to develop a single set of evidence-based clinical and rehabilitation practice guidelines and measures that can be used by eye care professionals, other care providers, and public health professionals to prevent, screen for, detect, monitor, diagnose, and treat eye and vision problems.
5. Developing a coordinated surveillance system for eye and vision health in the United States.
6. Building state and local public health capacity by prioritizing and expanding the CDC's vision grant program in partnership with state-based programs and stakeholders

The NASEM report also acknowledges the important—yet underfunded—roles of the Vision Health Initiative (VHI) at the CDC, the National Eye Institute (NEI) at the NIH, and the National Center for Children's Vision and Eye Health program through HRSA as leading examples of the importance of quality improvement in advancing population health. We believe the NASEM's framework for responding to our nation's vision health provides a realistic path forward, and we urge the Committee to consider Prevent Blindness's Fiscal Year 2019 requests for HRSA, CDC, and the NEI, outlined below.

Health Resources and Services Administration

Investing in programs that keep people healthy is important for the vitality of our nation. HRSA programs have been successful in improving the health of those at highest risk for poor health outcomes. The agency supports efforts that drive quality care, better leverage existing investments and achieve improved health outcomes at a lower cost. HRSA is well positioned to address these issues and to continue building on the agency's many successes, but a stronger commitment of resources is necessary to effectively do so.

- **Maternal and Child Health Bureau:** Specifically, we ask Congress to consider the unaddressed need for children's vision screenings as an essential part of a child's healthy development and support Prevent Blindness's request of **$3.5 million** to establish a children's vision and eye health coordinating center at MCHB and to provide up to 10 grants to state departments of public health. This state-level grant funding will allow the MCHB to provide assistance to states developing children's eye health programs that promote early detection and follow-up to an eye care professional, as well as coordination of programmatic efforts for children's vision across federal agencies.

Centers for Disease Control and Prevention

Prevent Blindness supports a strong, robustly-funded CDC to respond to current and emerging public health programs that threaten Americans' way of life. In addition to safeguarding our nation's health, CDC is faced with unprecedented challenges and responsibilities ranging from the prevention of diabetes, heart disease, stroke, cancer, lung disease and other chronic diseases, reducing health disparities, and for needed public health research and health statistics.

- **Vision Health Initiative:** We ask the Committee to support Prevent Blindness' request for **$3.3 million** to the VHI in FY 2019 to expand its role in addressing vision as a serious comorbidity, integrating vision interventions into current public health work, and addressing needed surveillance of eye diseases. The impact of the VHI's work can be felt at state and local levels as some of its main objectives include helping

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states develop the capacity to implement effective state-based surveillance systems, facilitate partnerships to preserve, protect, and enhance vision health, deploying evidence-based and cost-effective public health interventions, increase access to needed eye care, and reduce health disparities among people with or at high risk for vision loss.

- **Glaucoma:** We ask the Committee to support Prevent Blindness's request for **$3,300,000** to the Glaucoma Project with the National Center on Chronic Disease Prevention and Health Promotion at the CDC. Adequate FY 2019 resources will allow the program to continue to improve glaucoma screening, referral, and treatment and ultimately protect work readiness, positive productivity, and economic independence and security for Americans. The program is intended to reach those populations experiencing the greatest disparity in access to glaucoma care through an integrated collaboration among private and public organizations.

- **Prevention and Public Health Fund:** We have serious concern about the most recent continuing resolution, which cut $750 million from the Prevention and Public Health Fund (Prevention Fund) and will put Americans at greater risk for illnesses, injuries and preventable deaths. These cuts represent a 17 percent cut to the Prevention Fund over several years, including an 11 percent cut in fiscal year (FY) 2019. We ask you to reject any additional cuts to the Prevention Fund and restore this lost funding to the CDC.

National Eye Institute at the National Institutes of Health

The National Eye Institute, which was created by Congress in 1968 and charged with protecting and prolonging the collective vision of the American people, is celebrating its 50th anniversary in 2018. This significant milestone could not have been achieved without the continued support of Congress and the recognition of the essential but often overlooked role that vision plays in Americans' physical and emotional health, employability, readiness to learn in school, childhood development, and sustaining our independence as we age.

As such, we ask Congress to provide the NEI with **$800 million** for FY 2019 in order to bolster efforts to identify the underlying causes of eye disease and vision loss, improve early detection and diagnosis, and advance prevention and treatment efforts. At the current rate of funding, the U.S. is spending $2.30 per person, per year on vision research while the cost of treating low vision or blindness is $6,680 per person, per year. This funding request would restore the NEI's operating budget and ensure a pattern of sustained and predictable funding while restoring some of the NIH's 25% of purchasing power lost since 2003.

Advancing Health Reform

In the FY2019 HHS "Budget in Brief," Secretary Azar indicates his intention to implement reforms modeled similarly to the proposals set forth in the Graham-Cassidy-Heller-Johnson legislation considered by the United States Senate in the fall of 2017. Prevent Blindness has very serious concerns with the precedent that Secretary Azar's proposals establishes for patients seeking vision and eye healthcare services.

- **Impacts of a Block Grant Medicaid Program:** The proposals set forth to convert federal funding into a block grant program will force states to cut eligibility for vulnerable patients. In some states, Medicaid is often the only source of vision and eye care for many adults and children. Facing an uncertain and underfunded future of the Medicaid program, states will likely have no choice but to cut vision screenings and eye health services that can potentially curb the progression of and, in some cases, prevent altogether incidents of vision loss for children, aging Americans, and patients with chronic diseases.

- **Protections for Patients with Pre-Existing and Chronic Conditions:** As well, we remain alarmed that the proposals supported by the Administration do not go far enough to ensure, without question, that patients with a pre-existing condition will be able to acquire affordable insurance plans. Under such

financial constraints, patients will not be empowered to prioritize their vision and eye health and will likely forgo cost-effective, sight-saving preventive care.

- **Essential Health Benefits:** Early detection is oftentimes the key to preserving sight from such progressive diseases as glaucoma, cataracts, diabetic retinopathy, and macular degeneration. We are troubled that the Administration supports, as a manner of achieving cost-savings, removing a truly cost-effective approach to early detection and preventive services for both children and adults with chronic diseases for which vision loss is a serious complication. As we outline above, vision impairment is a true cost burden on our economy and our nation's health. We urge the Ways and Means Committee to ensure that Americans of all ages have access to basic, preventive measures that will help them avoid permanent vision loss.

As the House of Representatives Committee on Ways and Means begins to consider the budgetary proposals put forth by the Trump Administration for HHS in FY 2019, Prevent Blindness stands ready to assist the Committee as needed, and urge you to work in a bipartisan manner to confront our nation's healthcare challenges. If you should have any questions, please reach out to Sara D. Brown, Director of Government Affairs at (312) 363-6031 or sbrown@preventblindness.org.

Sincerely,

Hugh R. Parry
President and Chief Executive Officer

Comments for the Record
United States House of Representatives
Committee on Ways and Means
Hearing on the Department of Health and Human Services'
Fiscal Year 2019 Budget Request
Wednesday, February 14, 2018, 10:00 A.M.
1100 Longworth House Office Building

By Michael G. Bindner
Center for Fiscal Equity

Chairman Brady and Ranking Member Neal, thank you for the opportunity to submit these comments for the record to the Committee on Ways and Means on the HHS FY 2019 Budget Request.

Most of our proposals are about tax and entitlement policy and the process of estimating discretionary spending, rather than specific recommendations for departmental budgets. We are wondering, however, why this hearing, which mainly presents discretionary budget request data for the subject fiscal year, is still being held when on Friday last an Omnibus Appropriation for the period in question was passed and signed into law. For the record, we fully support the increases to the NIH budget, which was horribly underfunded of late. Regardless, our comments still apply so we will preface them with our comprehensive four-part approach, which will provide context.

- A Value Added Tax (VAT) to fund domestic military spending and domestic discretionary spending with a rate between 10% and 13%, which makes sure very American pays something.
- Personal income surtaxes on joint and widowed filers with net annual incomes of $100,000 and single filers earning $50,000 per year to fund net interest payments, debt retirement and overseas and strategic military spending and other international spending, with graduated rates between 5% and 25%.
- Employee contributions to Old Age and Survivors Insurance (OASI) with a lower income cap, which allows for lower payment levels to wealthier retirees without making bend points more progressive.

- A VAT-like Net Business Receipts Tax (NBRT), which is essentially a subtraction VAT with additional tax expenditures for family support, health care and the private delivery of governmental services, to fund entitlement spending and replace income tax filing for most people (including people who file without paying), the corporate income tax, business tax filing through individual income taxes and the employer contribution to OASI, all payroll taxes for hospital insurance, disability insurance, unemployment insurance and survivors under age 60.

Discretionary activities of the Department of Health and Human Services would be funded by the VAT. While some of our VAT proposals call for regional breakdowns of taxing and spending, they do not for this department. While some activities, such as the Centers for Disease Control, exist outside the Washington, DC metro area, even these are site specific rather than spread out on a nation-wide basis to serve the public at large. While some government activities benefit from national and regional distribution, health research will not.

The one reform that might eventually be considered in this area is to more explicitly link government funded research with ownership of the results, so that the Department might fund some of their operations with license agreements for some of the resulting research, enabling an expanded research agenda without demanding a higher budget allocation.

Of course, regionalization is possible if the Uniformed Public Health Service is put into the role of seeing more patients, particularly elderly patients and lower income patients who are less than well served by cost containment strategies limiting doctor fees. Medicaid is notoriously bad because so few doctors accept these patients due to the lower compensation levels, although we are encouraged the health care reform is attempting to reduce that trend. Medicare will head down that road shortly if something is not done about the Doc Fix. It may become inevitable that we expand the UPHS in order to treat patients who may no longer be able to find any other medical care. If that were to happen, such care could be organized regionally and funded with regionally based taxes, such as a VAT.

The other possible area of cost savings has to do with care, now provided for free, on the NIH campus. While patients without insurance should be able to continue to receive free care, patients with insurance likely could be required to make some type of payment for care and hospitalization, thus allowing an expansion of care, greater assistance to patients who still face financial hardship in association with their illnesses and a restoration of some care that has been discontinued due to budget cuts to NIH. This budget contains even more cuts. These should not be allowed. Rather, previous cuts must be restored.

The bulk of our comments have to do with health and retirement security.

One of the most oft-cited reforms for dealing with the long-term deficit in Social Security is increasing the income cap to cover more income while increasing bend points in the calculation of benefits, the taxability of Social Security benefits or even means testing all benefits, in order to actually increase revenue rather than simply making the program more generous to higher income earners. Lowering the income cap on employee contributions, while eliminating it from employer contributions and crediting the employer contribution equally removes the need for any kind of bend points at all, while the increased floor for filing the income surtax effectively removes this income from taxation. Means testing all payments is not advisable given the movement of retirement income to defined contribution programs, which may collapse with the stock market – making some basic benefit essential to everyone.

Moving the majority of Old Age and Survivors Tax collection to a consumption tax, such as the NBRT, effectively expands the tax base to collect both wage and non-wage income while removing the cap from that income. This allows for a lower tax rate than would otherwise be possible while also increasing the basic benefit so that Medicare Part B and Part D premiums may also be increased without decreasing the income to beneficiaries. Increasing these premiums essentially solves their long term financial problems while allowing repeal of the Doc Fix.

If personal accounts are added to the system, a higher rate could be collected, however recent economic history shows that such investments are better made in insured

employer voting stock rather than in unaccountable index funds, which give the Wall Street Quants too much power over the economy while further insulating ownership from management. Too much separation gives CEOs a free hand to divert income from shareholders to their own compensation through cronyism in compensation committees, as well as giving them an incentive to cut labor costs more than the economy can sustain for consumption in order to realize even greater bonuses.

Employee-ownership ends the incentive to enact job-killing tax cuts on dividends and capital gains, which leads to an unsustainable demand for credit and money supply growth and eventually to economic collapse similar to the one most recently experienced.

Congress just adopted a Chained CPI, but no additional fund has been proposed for poor seniors or the disabled, which means there will be suffering. This should not be allowed without some readjustment of base benefit levels, possibly by increasing the employer contribution and grandfathering in all retirees. This is easily done using our proposed NBRT, which replaces the Employer Contribution to OASI and all of DI and should be credited equally to all workers rather than being a function of income.

The NBRT base is similar to a Value Added Tax (VAT), but not identical. Unlike a VAT, an NBRT would not be visible on receipts and should not be zero rated at the border – nor should it be applied to imports. While both collect from consumers, the unit of analysis for the NBRT should be the business rather than the transaction. As such, its application should be universal – covering both public companies who currently file business income taxes and private companies who currently file their business expenses on individual returns.

A key provision of our proposal is consolidation of existing child and household benefits, including the Mortgage Interest and Property Tax Deductions, into a single refundable Child Tax Credit of at least $500 per month, per child, payable with wages and credited against the NBRT rather than individual taxes. Ending benefits for families through the welfare system could easily boost the credit to $1000 per month for every family,

although the difference would also be made up by lowering gross and net incomes in transition, even for the childless.

Assistance at this level, especially if matched by state governments may very well trigger another baby boom, especially since adding children will add the additional income now added by buying a bigger house. Such a baby boom is the only real long-term solution to the demographic problems facing Social Security, Medicare and Medicaid, which are more demographic than fiscal. Fixing that problem in the right way adds value to tax reform. Adopting this should be scored as a pro-life vote, voting no should be a down check to any pro-life voting record.

The NBRT should fund services to families, including education at all levels, mental health care, disability benefits, Temporary Aid to Needy Families, Supplemental Nutrition Assistance, Medicare and Medicaid. Such a shift would radically reduce the budget needs of HHS, while improving services to vulnerable populations, although some of these benefits could be transferred to the Child Tax Credit.

The NBRT could also be used to shift governmental spending from public agencies to private providers without any involvement by the government – especially if the several states adopted an identical tax structure. Either employers as donors or workers as recipients could designate that revenues that would otherwise be collected for public schools would instead fund the public or private school of their choice. Private mental health providers could be preferred on the same basis over public mental health institutions. This is a feature that is impossible with the FairTax or a VAT alone.

To extract cost savings under the NBRT, allow companies to offer services privately to both employees and retirees in exchange for a substantial tax benefit, provided that services are at least as generous as the current programs. Employers who fund catastrophic care would get an even higher benefit, with the proviso that any care so provided be superior to the care available through Medicaid. Making employers responsible for most costs and for all cost savings allows them to use some market power to get lower rates, but not so much that the free market is destroyed. Increasing

Part B and Part D premiums also makes it more likely that an employer-based system will be supported by retirees.

Enacting the NBRT is probably the most promising way to decrease health care costs from their current upward spiral – as employers who would be financially responsible for this care through taxes would have a real incentive to limit spending in a way that individual taxpayers simply do not have the means or incentive to exercise. While not all employers would participate, those who do would dramatically alter the market. In addition, a kind of beneficiary exchange could be established so that participating employers might trade credits for the funding of former employees who retired elsewhere, so that no one must pay unduly for the medical costs of workers who spent the majority of their careers in the service of other employers.

Conceivably, NBRT offsets could exceed revenue. In this case, employers would receive a VAT credit.

The Administration believes that the Affordable Care Act is failing. It was not, but it will soon with the end of mandates. Rates will soon start going up as incentives for the uninsured are not adequate in the light of pre-existing condition reform to make them less risk averse than investors in the private insurance market, the whole house of cards may collapse – leading to either single payer or the enactment of a subsidized public option (which, given the nature of capitalism, will evolve into single payer). While no one knows how the uninsured will react over time, the investment markets will likely go south at the first sign of trouble.

We suggest to the Secretary that he have an option ready when this occurs. Enactment of a tax like the NBRT will likely be necessary in the unlikely event the ACA collapses. It could also be used to offset non-wage income tax cuts proposed by the House, rather than cutting coverage for older, poorer and sicker Americans. Single-payer is inevitable unless the President is simply blowing smoke about the ACA failing.

Thank you for the opportunity to address the committee. We are, of course, available for direct testimony or to answer questions by members and staff.

Contact Sheet

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Committee on Ways and Means
Hearing on the Department of Health and Human Services'
Fiscal Year 2019 Budget Request
Wednesday, February 14, 2018, 10:00 A.M.
1100 Longworth House Office Building

All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears:

This testimony is not submitted on behalf of any client, person or organization other than the Center itself, which is so far unfunded by any donations.